Regulation and Resistance:

Migrant and Refugee Women's Negotiation of Sexual and Reproductive Health

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Dedication

I dedicate this thesis to my participants.

In particular, to the brave women who were willing to share the most intimate of stories with me, a complete stranger, I say thank you.

I also dedicate this thesis to the strong and inspiring women in my family.

My sister Lana, mother Wendy and grandmothers, Margaret and Beverley.

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Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

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Alexandra Jane Hawkey

Outcomes of this Thesis

This thesis is presented as a series of four academic papers, three that have been accepted for publication and one paper that is currently under review. I am the first author on all papers presented in this thesis. Further details surrounding contributions are provided in the methods section of this thesis.

Peer-reviewed journal articles included in this thesis:

Hawkey, A. J., Ussher, J. M., Perz, J., & Metusela, C. (2017). Experiences and constructions of menarche and menstruation among migrant and refugee women. *Qualitative Health Research*, 27(10), 1473-1490. doi:10.1177/1049732316672639

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Hawkey, A. J., Ussher, J. M., & Perz, J. (2017). "If you don't have a baby, you can't be in our culture": Migrant and refugee women's experiences and constructions of fertility and fertility control. *Women's Reproductive Health*, 5(2), 75-98. doi:10.1080/23293691.2018.1463728

Relevant co-authored peer-reviewed project papers published during candidature:

Ussher, J. M., Perz, J., Metusela, C., Hawkey, A. J., Morrow, M., Narchal, R., & Estoesta, J. (2017). Negotiating discourses of shame, secrecy, and silence: Migrant and refugee women's experiences of sexual embodiment. *Archives of Sexual Behavior*, 46(7), 1901-1921. doi:10.1007/s10508-016-0898-9

Metusela, C., Ussher, J., Perz, J., Hawkey, A., Morrow, M., Narchal, R., . . . Monteiro, M. (2017). "In my culture, we don't know anything about that": Sexual and reproductive health of migrant and refugee women. *International Journal of Behavioral Medicine*, 24(6), 836-845. doi:10.1007/s12529-017-9662-3

Co-authored book chapters:

Ussher, J. M., Hawkey, A. J., & Perz, J. Sexual embodiment of young migrant and refugee women: A discourse of silence, secrecy and shame. In. S. Lamb & J. Gilbert (Ed.), *The Cambridge Handbook of Sexual Development: Childhood and Adolescence*. In press.

Conference presentations relevant to this thesis:

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Hawkey, A. J., Ussher, J. M., & Perz, J. (2017, July). Shame, secrecy and silence: Sexual and reproductive health of migrant and refugee women. Paper presented at BPS Psychology of Women Section conference, Windsor, U.K

Professional reports relevant to this thesis:

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Abbreviations

ABS: Australian Bureau of Statistics

AIDS: Acquired immune deficiency syndrome

ARC: Australia Research Council

HIV: Human immunodeficiency virus

HPV: Human papilloma virus

IOM: International Organization for Migration

IUD: Intrauterine device

IVF: In vitro fertilisation

LARC: Long acting reversible contraception

NGO: Non-governmental organisations

OHCHR: Office of the United Nations High Commissioner for Human Rights

U.K: United Kingdom

UN: United Nations

UNFPA: United Nations Fund for Population Activities

UNHCR: United Nations High Commissioner for Refugees

UNICEF: United Nations International Children's Emergency Fund

U.S: United States (of America)

WHO: World Health Organization

Abstract

The way in which women construct and experience their sexual and reproductive health is dependent on the cultural, historical and political context in which they are embedded. Research conducted in the West has primarily explored sexual and reproductive health from the perspectives of White, middle- class, educated women, with less research considering the beliefs and practices of women with other intersecting identities; including adult migrant and refugee women from diverse cultural and religious backgrounds. Increasing our knowledge of constructions and practices surrounding sexual and reproductive health is important in understanding the conditions that shape a woman's embodied experience, particularly within the context of migrant and refugee diaspora. It is also of growing importance due to migrant and refugee women's underutilisation of sexual and reproductive healthcare services.

The purpose of the research presented in this thesis was to explore how recent migrant and refugee women negotiate discourses and practices in relation to their sexual and reproductive health, when transitioning from countries where cultural constructions and practices associated with sexuality and reproduction may differ from those of their new countries of residence, Australia or Canada. Aspects of women's sexual and reproductive health covered in this thesis are: menarche and menstruation, sexuality prior to marriage, sexual agency within marriage and women's fertility and fertility control.

In this study 78 individual interviews and 15 focus groups (with a total of 82 participants) were conducted with women who had migrated from Afghanistan, Iraq, Somalia, South Sudan, Sudan, Sri Lanka, and South America. A material-discursive-

intrapsychic theoretical framework was adopted, situated within a critical realist epistemological paradigm. Intersectionality was also drawn on to consider how categories of difference, such as gender, culture and religion intersect to shape women's lives, practices and discourses. Constructions and experiences of sexual and reproductive health were analysed using thematic-decomposition.

Across each of the cultural groups who took part in this study, cultural and religious discourse intersected to regulate women through their sexual and reproductive bodies. Regulation began at the beginning of the reproductive life cycle, where a discourse of shame, secrecy and silence prohibited women from learning about their reproductive bodies at menarche, contributing to women's negative attitudes towards menstruation. It continued through adulthood, with a virginity imperative serving to inhibit young women from exploring themselves as sexual beings prior to marriage. Cultural and religious discourse and practice shaped the way women entered into marital relationships and the manner in which women could express themselves sexually. It also strongly influenced women's fertility practices and autonomy in relation to contraceptive choices. While patriarchal cultural and religious discourse did effectively regulate many participants' sexual rights, subjectivity and agency, other women gave accounts that suggested they were challenging or resisting these hegemonic discourses to negotiate their own meanings and practices in relation to sexual and reproductive health. Women's experiences were not static or monolithic, but complex and fluid, demonstrating heterogeneity in cultural and religious discourse and practices associated with women's sexual and reproductive bodies, both across, and within, the cultural groups interviewed.

The findings of this thesis provide insight into the everyday lived experiences of migrant and refugee women's sexual and reproductive health across significant

aspects of their sexual and reproductive life-course. The broader implications of these findings suggest that migrant and refugee women need access to comprehensive sexual and reproductive health information and healthcare services that reflect their complex sexual and reproductive health needs. Implications of these findings for future research are also examined.

Preface

My motivation to be involved in research addressing women's sexual and reproductive health began in childhood. I grew up in small, very 'White', middle-class, coastal town in New Zealand. Positioned on an island at the bottom of the world I felt isolated, aware of an absence of cultural diversity, and from a very young age I developed a growing fascination with other cultures. While in the late nineties most children were eager to get their hand on the first Harry Potter books, I did not share their enthusiasm. My interest was in women's stories, stories of culture, stories of women's struggles, their resistance and resilience. I was lucky enough to have a mother who has always fostered my interest, and consequently I had no shortage of books to fuel my curiosity. Desert Flower (Dirie & Miller, 2001), Mayada, The Daughter of Iraq (Sasson, 2004) and The Hospital by the River (Hamlin & Little, 2001) were amongst the first of my continually growing collection. I clearly remember being unable to put them down, both fuelled by fascination and disbelief. How can women's lives be so vastly different by virtue of being born in a different space in this world?

My hunger and interest continued throughout my high school years, with my role as a prefect requiring me to support the newly arrived international students. Following my undergraduate degree in health sciences, I wanted to continue studies focused in overcoming health inequity, particularly with respect to women's health. I enrolled and completed a Masters of Public Health in Sydney and undertook every course possible in relation to sexual and reproductive health. I then extended my Master's program to complete an internship exploring menstruation within migrant communities at a local Family Planning clinic. It was also during this time I began to coordinate a literacy program for women and children of refugee backgrounds, in

Western Sydney. Over the five years I led this program, I had the opportunity to intimately get to know women and their families and see firsthand the challenges of being a migrant or refugee in a foreign country.

While most young New Zealanders spend their humble savings on an 'OE' or 'overseas experience', drinking their way around the UK, I was again unique in my interests. Following the completion of my degree, I chose to travel to Ethiopia, to see, feel, and experience the contexts so very often described in the books I devoured. Following a stint of research in the public health sphere, I then undertook an additional travel period to teach menstrual hygiene in rural India, followed by a gender, equity in health and human rights internship with World Health Organization (WHO) in Manila. During my time with WHO, I distinctly recall discussing a study looking at birth outcomes and access to services for women to deliver babies in Cambodia. Despite living two kilometres away from a newly established healthcare facility, women were not attending to give birth to their babies in this 'safe' new environment. It got me thinking. Having overcome the material barriers to access through the provision of a close and low-cost service, why were women not utilising this new facility? I began to realise the difficulty that a population-based study would have in closely capturing the nuanced beliefs and experiences of women in this community. It was during this time I began to understand the limitations of epidemiology and statistical methods in the public health world, and I again went searching for an opportunity that would allow me a greater depth of understanding and exploration into health inequities, from the perspectives of women. It was also during this time I was lucky enough to be selected to undertake a PhD in the area of sexual and reproductive health with migrant and refugee women; and thus, my exploration of health, culture, and women's stories continues.

Chapter One: Introduction

This thesis will examine the way in which new migrant and refugee women living in Australia and Canada construct and experience their sexual and reproductive health. In particular, this thesis will take a life-course approach to consider women's negotiation of their sexual and reproductive health with respect to menstruation, premarital sexuality, and sexual agency within marriage, as well as fertility and fertility control. This thesis will then consider the implications of women's experiences and constructions on their sexual and reproductive health and will examine how this knowledge may inform health education, health service provision and health policy.

This introductory chapter is presented in two sections. It first provides background to the study detailing the research questions and qualitative framing of the research. I then define terms used to describe people who migrate under humanitarian circumstances, as well as voluntary migrants. Next, I describe where recent migrant and refugee women are migrating from, and the diversity of the Australian and Canadian population. Following this, I explore how women's experiences of migration may affect their health and wellbeing. I also provide background information in relation to the importance of considering women's sexual and reproductive health and barriers preventing access to sexual and reproductive health services. In the second section I review the literature surrounding the topics selected for exploration in this thesis. I conclude the chapter by presenting the overall outline of this thesis.

Setting the Research Scene

The study of human sexuality is not a new phenomenon. Scientists, researchers, sociologists and feminists alike have been interested in the sexual body and human sexual behaviour for many decades. Traditionally in the fields of medicine and psychology, most human experience has been considered from a realist perspective, grounded in a positivistic framework, with an aim to discover 'truth' or observable 'facts' (Ussher, 1997a). Sexual and reproductive health research has often entailed measuring sex hormones or changes to sexual organs to dictate aetiology of the 'dysfunctional' sexual body (Masters & Johnson, 1966; Ussher, 1997a). For example, within this paradigm physical changes experienced by some women during menopause, such as vaginal dryness or hot flushes, are described as 'symptoms' associated with changing hormone levels during midlife, which necessitate 'treatment' through the use of hormone replacement therapy (Griffiths, 1999; Ussher, 1997a). In these circumstances, the physical body is the focus in the provision of treatment for sexual 'illness', denying the sociocultural, historical and discursive constructions of bodily experience (Tiefer, 2004; Ussher, 1997a). With this in mind, there has been a call for research that considers the material-discursive and intrapsychic aspects of women's experience, research which acknowledges the corporeality of women's sexual and reproductive bodies, but also the discursive cultural contexts that shape experiences and women's intrapsychic negotiation of such experience (Ussher, 2000).

More recently, a growing body of literature by psychologists, social scientists and feminist researchers seeks to capture women's embodied constructions and experiences of sexual and reproductive health. This involves a close examination into "the experience of living in, perceiving, and experiencing the world from the very

specific location of our bodies" (Tolman, Bowman, & Fahs, 2014, p. 760). What is striking however, is the predominance of research that focuses on White, Western, middle-class, heterosexual and able-bodied women, a perspective that dominates and thus limits our understanding of how minority women, such as lesbian and bisexual women, women with disability and women from diverse cultural backgrounds construct and experience their sexual and reproductive health (Tolman et al., 2014). This highlights the need to understand women's sexual and reproductive health and subjective experiences from an intersectional perspective (Davis, 2008; Hankivsky et al., 2010). Such a perspective strives to understand "what is created and experienced at the intersection of two or more axes" (Hankivsky et al., 2010, p. 3); it demands analyses that do not focus on gender alone, but contextualises women in their diverse sociocultural settings by simultaneously taking into account other forms of social difference such as race, culture, religion, class and ability (Varcoe, Hankivsky, & Morrow, 2007).

In this vein, the aim of the research presented in this thesis was to explore how new migrant and refugee women negotiate discourses and practices in relation to their sexual and reproductive health when transitioning from countries where cultural beliefs, norms and practices differ in relation to sexuality and reproduction. Australia and Canada, the context of this study, were selected due to an existing research relationship with researchers from Simon Fraser University, situated in Vancouver, Canada. Australia and Canada also have comparable migrant and refugee populations, as well as a geographical, political, economic and sociocultural likeness; it also allows for exploration into the potential influence of geographical location on women's experiences.

To address the research aim, the following research questions will be asked:

1. How is sexual and reproductive health constructed and experienced among recent migrant and refugee women living in Australia and Canada?
2. What are the implications of these constructions and experiences for the sexual and reproductive health of migrant and refugee women?

This study adopts a qualitative research design, utilising semi-structured interviews and focus groups, with women who were born in and migrated from Afghanistan, Iraq, Somalia, Sudan, Sri-Lanka, South Sudan and South America. This thesis utilises a material-discursive-intrapsychic analytical framework (Ussher, 2000), situated within a critical realist epistemology, drawing on an intersectional framework (P. Collins, 1999; Hankivsky et al., 2010).

Qualitative inquiry is perceived as a critical step in understanding how people experience their health and illness (Liamputtong, 2016). It is widely accepted that to understand people's behaviour, it is important to understand the meanings and interpretations people give to such experience (Liamputtong, 2016). Qualitative enquiry relies heavily on the words or narratives that people tell us to understand meanings and experience (Braun & Clark, 2013), it asks the 'what', 'why' and 'how' questions in relation to the realities of one's health and wellbeing (Green & Thorogood, 2014). Qualitative research is thus considered an important method to capture the voices of marginalised people in society, as its in-depth nature allows participants to express feelings and experiences from their own perspective, using their own words (Braun & Clark, 2013; Liamputtong, 2016). In this regard, this thesis will adopt a qualitative approach to hear women's voices and better understand the meanings, interpretations and subjective experience of sexual and reproductive health of migrant and refugee women.

Defining Migrant and Refugee People: The Context of This Study

Under the 1951 convention relating to the status of refugees, the term refugee is used to describe a person who is living outside of their own country and is unable or unwilling to return due to war, violence or fear of persecution because of their race, religion, nationality, political opinion or membership in a particular social group (UNHCR [United Nations High Commissioner for Refugees], 2007). Asylum seekers are people who have fled their home countries due to persecution or serious harm, and are in search of safety in a country other than their own (IOM [International Organization for Migration], 2017). They have the right to apply for refugee status, and be recognised as a refugee, under humanitarian grounds, if it is established their fear of persecution is well-founded once they have arrived in their new country of intended residence (UNHCR, 2014). People who are forced to flee their homes because of internal conflict or natural disasters, but do not cross an international border, are known as Internally Displaced Persons (IDPs) (UNHCR, 2017a). Unlike refugees, IDPs are not protected by international law or eligible to receive aid, as they are under the protection of their own government (UNHCR, 2017a). In contrast to these circumstances, the term migrant is typically used to describe people who choose to move countries, not as a result of direct threat of persecution or death, but to improve their lives through finding work, education and family reunion (UNHCR, 2017b). Unlike refugees and asylum seekers, migrants can establish themselves either permanently or temporarily in another country, and are generally free to return safely to their home countries at any time they choose (UNHCR, 2017b).

In Australia, "culturally and linguistically diverse" (CALD) is typically used as a broad term to describe voluntary migrants, and people of refugee or

humanitarian background, who have a cultural heritage different from the dominant Anglo Australian culture (Department of Health, 2016a). CALD replaces the previously used term of people from a "non-English-speaking background" (NESB). In Canada however, the term CALD is not utilised, with 'immigrant' and 'refugee' being the dominant language to describe people who are born in a country other than Canada, or who have migrated on a Humanitarian Visa. Given immigrant is not as commonly utilised in an Australian context, the study sample in this thesis is defined as "migrant and refugee women." This includes women who have voluntarily migrated for work or family reunification, as well as women who have migrated as asylum seeks and refugees.

Global Migration and Displacement: A Record High

International migration is a hotly debated issue in the current global context. The number of migrants, or people residing in a country other than the one where they were born, has reached a global figure of 244 million in 2015, a 41% increase compared to the year 2000 (UN [United Nations], 2016). Two thirds of international migrants live in Europe (76 million) and Asia (75 million), with Northern America (54 million) hosting the third largest number of international migrants (UN, 2016). While people choose to migrate for a range of economic and social reasons, increasingly, people are being forced to move due to inequality, a lack of adequate employment and conflict (UN, 2016).

In 2016, an unprecedented 65.6 million people globally were forced to leave their homes, among them over 22.5 million refugees – the highest number since World War II (UN, 2016; UNHCR, 2016). This extreme growth was concentrated between 2012 and 2015, largely driven by the conflict in Syria, contributing to 12 million forcibly displaced persons (UNHCR, 2016). In addition, people from

Colombia (7.7 million), Afghanistan (4.7 million), Iraq (4.2 million), South Sudan (3.3 million), Sudan (2.9 million), Democratic Republic of the Congo (2.9 million) and Somalia (2.6 million) were significantly affected by recent and ongoing conflict (UNHCR, 2016). At the end of 2016, Syria (5.5 million), Afghanistan (2.5 million), South Sudan (1.4 million), Somalia (1.0 million) and Sudan (650, 600) contributed the greatest number of refugees (UNHCR, 2016). Neighbouring countries disproportionality host the large majority of these refugees (84 %), which is problematic given they are low-income countries poorly resourced to respond to the needs of people who are seeking refuge (UNHCR, 2016). By the end of 2016, developed countries who received the largest number of refugees were United States of America (96, 900), followed by Canada (46, 700) and Australia (27, 600) (UNHCR, 2016). Given the current state of global conflict and the large number of refugees resettling in countries such as Australia and Canada, consideration of the experiences of migrant and refugee women is of significant value (Deacon & Sullivan, 2009).

Migrant and Refugee Populations in Australia and Canada

Australia and Canada host some of the largest and most diverse populations of migrant and refugee persons globally. As of June 2016, 28.5% of people living in Australia were born overseas (6.9 million people) (ABS [Australian Bureau of Statistics], 2016). The Australian government provides two permanent immigration programs. The Migration Program and The Humanitarian Program: The Migration Program, which accepts up to 190, 000 people per year, caters for skilled people wanting to work in Australia (~68.9% of the Migration Program) and for people wanting to reunite with family (~30.8% of the Migration Program), most of whom are granted Partner visas (Department of Immigration and Border Protection, 2017a).

The highest numbers of migrants from non-English speaking backgrounds living in Australia are from China, India, or the Philippines (ABS, 2016).

The Humanitarian Program assists refugees and others in humanitarian need to resettle and rebuild their lives in Australia (Department of Immigration and Border Protection, 2017b). Australia processes Humanitarian Visas both onshore, which aims to provide options for people who apply for protection (seeking asylum) after arriving in Australia, and offshore (refugees), the majority of whom are referred by the UNHRC for resettlement to Australia (Department of Immigration and Border Protection, 2017b). In addition, a subclass 'Woman at Risk' visa is available for those women and their dependants identified by UNHCR as being in particularly vulnerable positions; this includes living outside of their home country with an absence of a male relative for protection, and women who are in danger of victimisation, harassment or serious abuse because of their gender (Department of Immigration and Border Protection, 2017b). In total, from 2015-2016 Australia granted 17,555 humanitarian entrant visas, with this number expected to increase due to the Australian Government's recent commitment to accept more refugees in response to the conflicts in Syria and Iraq (Department of Immigration and Border Protection, 2016). From 2015-2016 Australia received its majority of refugees from Iraq (28.0 %), Syria (27.4 %), Myanmar (12.5%), Afghanistan (11.0%) and the Democratic Republic of the Congo (4.2%) (Department of Immigration and Border Protection, 2016). The majority of offshore humanitarian visas were granted to people between the ages of 18-49 years old (47.4%), with 50.3% of all visas being issued to women (Department of Immigration and Border Protection, 2016).

Similar to Australia, admission for migrants to Canada occurs through economic and family reunification, as well as through refugee or other humanitarian

visas (Statistics Canada, 2016a). In 2014, people from the Philippines, India, and China made up the greatest proportion of migrants coming into Canada (Statistics Canada, 2016a). By the first quarter of 2016, Canada had received the largest number of migrants in a single quarter since 1971, when such demographic counts were initiated (Statistics Canada, 2016b). According to the most recent population estimates, in 2016, by the third quarter, 240, 548 migrants had arrived in Canada (Statistics Canada, 2016b). In 2011, 52.3% of immigrants were women, with the majority (79%) of recent migrant women identifying as belonging to a visible minority group (Statistics Canada, 2016c). While the majority of people migrate to Canada on economic visas, such as the skilled workers program (Statistics Canada, 2016a), the sudden increase in migration over this period was largely a result of the arrival of 25,000 Syrian refugees between November, 2015 and February, 2016 (Citizenship and Immigration Canada, 2017; Statistics Canada, 2016b). By January 2017, a total of 40, 081 refugees had resettled in Canada (Citizenship and Immigration Canada, 2017). The majority of refugees arrived from Iraq, Iran, Democratic Republic of the Congo, Somalia, and Eritrea (Statista, 2017). Given the current global climate, particularly the ongoing war and conflict in Syria, Iraq and South Sudan, and the fact that many of the migrants and refugees arriving in Canada and Australia are women, there is an increasing need to consider the specific healthcare requirements of women in these communities.

Health and The Migration Journey

A number of studies demonstrate that on arrival adult migrants are typically healthier than the native-born population (Vang, Sigouin, Flenon, & Gagnon, 2017). Known as the ‘healthy migrant effect’, it is likely this relationship is explained through health screening and eligibility criteria placed on migrants before entering

Australia and Canada, ensuring only those in good health are accepted (Beiser, 2005; Chiswick, Lee, & Miller, 2008). However, with increased duration of residence, this health advantage eventually dissipates, and in many instances, migrants end up with poorer health than that of the receiving society (Beiser, 2005; Urquia, O'Campo, & Heaman, 2012). This gradual loss in health is associated with multidimensional social factors such as isolation or loss of pre-existing support networks, unemployment, language barriers and vulnerability due to poverty, prejudice and discrimination (Beiser, 2005; Kawar, 2004). Complex health systems or unfamiliarity with new health practices, barriers to accessing services, and the adoption of unhealthy behaviours also likely contribute to this overall health decline (Delavari, Sønderlund, Swinburn, Mellor, & Renzaho, 2013; McMichael, 2016).

Different types of migration, as well as stage of migration, give rise to unique health risks and health profiles (Zimmerman, Kiss, & Hossain, 2011). While voluntary migrants, may have greater preparation for migration – for example, some labour migrants receive health-education about health-service entitlements before departure (McMichael, 2016), this may not be the case for involuntary migrants, who often have pressing health, material and economic needs (Vissandjée, Thurston, Apale, & Nahar, 2007). Asylum seekers, for instance, may have significant legal and financial restrictions limiting their access to emergency healthcare only (Fang, Sixsmith, Lawthom, Mountian, & Shahrin, 2015). While refugees are a heterogeneous population, transitioning from differing parts of the world with unique pathways to resettlement (Annamalai, 2014), they often share a number of pre-migratory experiences. In countries of displacement, refugee camps or while transitioning between countries, refugees are often exposed to prolonged periods of extreme poverty, living in cramped conditions, with lack of access to shelter, food,

water and health services (McMichael, 2016; Schweitzer, Melville, Steel, & Lacherez, 2006). Asylum seekers and refugees often migrate from countries that have a higher prevalence of certain infectious diseases and thus may be at greater risk of being infected with tuberculosis, HIV, hepatitis B and other parasitic infections (Gibney et al., 2009; Paxton, Sangster, Maxwell, McBride, & Drewe, 2012).

Non-communicable diseases, including musculoskeletal disease as a consequence of trauma or emotional distress, cardiovascular disease, diabetes and chronic respiratory diseases are also prevalent in refugee populations (Amara & Aljunid, 2014). Due to stresses of migration, experiences of trauma, loss or separation from family, refugee populations are also particularly susceptible to mental health conditions (Schweitzer et al., 2006; Uribe Guajardo, Slewa-Younan, Smith, Eagar, & Stone, 2016), such as depression, anxiety and post-traumatic stress syndrome (Johnson & Thompson, 2008; Slewa-Younan, Uribe Guajardo, Heriseanu, & Hasan, 2015).

Asylum seekers are also vulnerable to poor health outcomes because of immigration and border control policies. For example, in Australia, government policy requires that all asylum seekers who arrive without a legitimate visa be placed in mandatory detention (McMichael, 2016). Detention centres are often situated in very isolated areas, limiting access to social, health or legal services (Silove, Steel, & Mollica, 2001). Many of the people detained have experienced severe trauma and abuses prior to reception, which is often exacerbated in the context of detention because of ongoing persecution and exposure to violence (McMichael, 2016). Consequently, they suffer extremely high levels of mental ill health, with time spent

in detention positively associated with severity of distress (Robjant, Hassan, & Katona, 2009; Steel et al., 2004).

Women and war: Implications for health.

War and conflict affect individual and public health in a number of complex ways. In addition to physical and psychological trauma, war often results in the detrition of health infrastructure, which affects women's health disproportionally (Gasseer, Dresden, Keeney, & Warren, 2004). In many cases, refugee women are migrating from countries where medical resources are scarce or non-existent due to war, or where a system for women's health does not exist (Fink, Helm, Belknap, & Johnson-Agbakwu, 2014). For example, attacks on health professionals in countries such as Iraq have caused a significant deficiency in healthcare providers as they have fled the country in search of safety (Mowafi, 2011). Consequently, prior to escaping, refugee women may not have received appropriate preventative healthcare, such as access to cervical cancer screening and/or adequate prenatal or maternity care (Fink et al., 2014).

During periods of war and conflict, as well as in refugee camps, unequal gender power, crowding, women's dependency on men and sub-standard housing, with a lack of privacy, mean women are at risk of violence (Byrskog, Olsson, Essén, & Allvin, 2014; Petchesky, 2008). Refugee women often report having suffered traumatic experiences, including being victims of physical violence, sexual abuse, rape and extortion, prior to migration, and during the migration process (Byrskog et al., 2014; Keygnaert, Vettenburg, & Temmerman, 2012). A recent meta-analysis across 14 countries estimated more than 21% of refugee and internally displaced women experienced sexual violence, a number which is likely to be underestimated due to underreporting (Vu et al., 2014). Experiences of sexual abuse have serious

consequences for women's psychosocial, and sexual and reproductive health, including: exposure to STIs and HIV, unwanted pregnancy, miscarriage as a result of violence, forced abortion and the development of sexual disorders (Keygnaert et al., 2012). It is also reported some refugee camps do not have appropriate measures in place to prevent sexual violence or provide clinical care for rape survivors (Krause et al., 2015).

War also results in a change in sexual and reproductive behaviours that may not reflect women's pre-conflict life. For example, since fleeing to Lebanon and Jordan, young Syrian refugee women are increasingly subjected to early marriage, due to their poor financial situation and ongoing circumstantial uncertainty (Cherri, Gil Cuesta, Rodriguez-Llanes, & Guha-Sapir, 2017; Save the Children, 2014). Child marriage, or marriage before the age of 18 years old, can have severe health consequences for women. These include adversely affecting mental health because of forced sexual activity and premature motherhood, and isolation from family, affecting women's ability to access health services (Save the Children, 2014). Young married women also experience increased vulnerability to domestic violence, compared to their peers who marry later (International Center for Research on Women, 2014). Early childbearing increases women's risk of pregnancy at a young age and childbirth complications, which is the second leading cause of death among young women between 15 to 19 years old globally (WHO [World Health Organization], 2018a).

When women arrive at refugee camps, cost and poor knowledge of free sexual and reproductive health services limits access to resources, such as contraception (Cherri et al., 2017; Tanabe et al., 2017). Health services vary in terms of availability of contraception options, including long-lasting or permanent

methods, and emergency contraception (Tanabe et al., 2017). Refugee women describe a reluctance to access available sexual and reproductive health services due to unhygienic facilities, long wait times, experiences of discrimination at services, and a lack of female providers, privacy and confidentiality (Krause et al., 2015; Tanabe et al., 2017). In addition, despite many migrant and refugee women having access to basic maternity care in refugee camps, maternal mortality in some humanitarian situations continues to remain significantly high (Bartlett et al., 2002; Gornall, 2015). Large-scale displacement also complicates the delivery of maternal and obstetric care in host countries, placing women at increased risk of unsafe childbirth, morbidity and mortality (Gornall, 2015). In Lebanon, for example, Syrian refugees are increasingly unable to cover the 25% healthcare cost not covered by the UN, leading to an estimated 70, 000 pregnant women at risk of unsafe deliveries (Gornall, 2015). These findings demonstrate that migrant and refugee women are vulnerable to both acute and chronic health conditions, in addition to complex sexual and reproductive needs, both prior to, and during the migration process. The following section describes patterns of sexual and reproductive health within migrant and refugee communities, once they have migrated to dominant refugee receiving countries, such as Australia and Canada.

Why Explore the Sexual and Reproductive Health and Embodiment of Migrant and Refugee Women?

Before describing what is known about the sexual and reproductive health of migrant and refugee women, I define what is meant by ‘sexual and reproductive health’. Within this thesis, I draw upon the definitions provided by the WHO. The current WHO working definition of sexual health is;

> Physical, emotional, mental and social well-being in relation to sexuality… a positive and respectful approach to sexuality and sexual relationships…the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence…[where] the sexual rights of all persons must be respected, protected and fulfilled. (WHO, 2006a)

Similarly, reproductive health implies that a person is able to have a:

> Responsible, satisfying and safe sex life…the capability to reproduce…freedom to decide if, when and how often to do so…to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation… [and] appropriate health care services to enable safe pregnancy and childbirth for women. (WHO, 2017a)

I will now discuss the importance of understanding embodiment and the benefits of an embodiment lens for understanding women's wider sexual and reproductive health.

The cultural context of embodiment.

As outlined at the beginning of this thesis, embodiment is defined as living in or experiencing the world from the location of our bodies (Tolman et al., 2014). Everything we know and do is mediated through the body (Chrisler & Johnston-Robledo, 2018). The human body is a fluid and permeable barrier between ourselves and the outside world (Fahs & Swank, 2015, p. 149), with our corporeality, or "bodiliness", influencing our relations with other people (Csordas, 2011, p. 137). How we experience our bodies, and our bodily sensations, is culturally and socially determined, subject to dominant discourses, practices and bodily disciplines (Csordas, 2002). The development of embodiment theories has allowed researchers

to formulate questions that seek to understand how bodies are experienced, made sense of and understood within the social structures within which they exist (Tolman et al., 2014). An embodiment lens moves beyond a realism-constructionism or mind-body divide, side-stepping the unnecessary distinction between the objective and subjective, and equally considers the material, discursive and intrapsychic aspects of an embodied experience (Ussher, 2005).

The recent turn to embodiment studies has resulted in the body being a central focus in a number of disciplines, including critical psychology, gender studies, sexuality studies and cultural studies (S. Brown, Cromby, Harper, Johnson, & Reavey, 2011). For example, embodiment theories have been used to explore women's subjective experiences of their sexual bodies following cancer treatment (Parton, Ussher, & Perz, 2016), women's experiences of orgasm (Fahs, 2014) and experiences of breastfeeding (Schmied & Lupton, 2001). Exploring how women subjectively make sense of and experience their bodies is important as it has direct implications for women's health, including sexual and reproductive health. For instance, women who describe more positive attitudes towards their genitalia, also report that they engage in more genital self-examinations and gynaecological appointments (Herbenick et al., 2011). In a further example, findings from a study by Wigginton et al. (2015) reported that contraceptives that were "felt" during coital sex, such as the IUD or the vaginal ring, were "embodied evidence that supported women's discontinuation or inconsistent use" (p.g. 192). These examples highlight the importance of an embodiment lens when searching for deeper understanding to women's sexual and reproductive health behaviours and practices.

Understanding migrant and refugee women's embodied sexual and reproductive knowledge is of particular importance. Migration has the potential to

introduce women to new and competing discourses surrounding aspects of their sexual and reproductive health (Dean, Mitchell, Stewart, & Debattista, 2017; Salad, Verdonk, de Boer, & Abma, 2015), while at the same time, changing the social, cultural and political context in which this embodiment is lived (Spitzer, 2009). However, little is known about how migrant and refugee women negotiate or embody their sexual and reproductive health, a shortcoming in the literature that is likely to reflect wider bias in research, where minority women's experiences have historically not been prioritised (Tolman et al., 2014). While all women have experiences of embodiment, understanding migrant and refugee women's sexual and reproductive embodiment is also of increasing concern as they often experience significant inequities in sexual and reproductive health in their new countries of residence, compared to native-born populations, I will now explore these below.

Inequities in sexual and reproductive health among migrant and refugee women.

Migrant and refugee women are less likely to access and utilise sexual and reproductive healthcare services compared to native-born women (Botfield, Newman, & Zwi, 2016; Manderson & Allotey, 2003; Rade, Crawford, Lobo, Gray, & Brown, 2018) and consequently, are less likely to participate in preventative cancer screening, such as cervical screening (Beckett, 2016; Lofters, Moineddin, Hwang, & Glazier, 2011; Morrison, Flynn, Weaver, & Wieland, 2013). Migrant and refugee women are less likely to utilise reliable methods of contraception, such as intrauterine devices (IUD), contraceptive implants or contraceptive pills (Family Planning New South Wales, 2013; Omland, Ruths, & Diaz, 2014). Many migrant and refugee women, particularly from Sub-Saharan countries, have a greater number of children compared to native-born women, which in itself is not always problematic,

however women are more likely to access maternity services late (Raleigh, Hussey, Seccombe, & Hallt, 2010). They are also more likely to have closer birth spacing (Carolan, 2010), which may contribute to migrant and refugee women experiencing higher rates of negative birth outcomes, such as caesarean sections and stillbirths (Gardosi, Madurasinghe, Williams, Malik, & Francis, 2013; Small et al., 2008).

Understanding the reasons for poor sexual and reproductive health service utilisation and negative sexual and reproductive health outcomes in migrant and refugee women is important for a number of reasons. Firstly, accessing appropriate sexual and reproductive health services is associated with positive mental health outcomes, greater quality of life and sexual well-being (Aggleton & Campbell, 2000; WHO, 2009). It also provides an opportunity for women to obtain adequate information for informed decision-making, associated with good sexual and reproductive health outcomes (Benson, Maldari, Williams, & Hanifi, 2010). Those women who do not access services are less likely to know about, and participate in, preventative health strategies, such as cervical cancer screening or human papillomavirus (HPV) vaccination, sexually transmitted infection (STI) testing and contraception use (Salad et al., 2015; Watts, Liamputtong, & Carolan, 2014). This places women at increased risk of cervical cancer (Allotey, Manderson, Baho, & Demian, 2004) or unintended pregnancy (Rademakers, Mouthaan, & de Neef, 2005)- which has implications for women's health and psychosocial wellbeing (Tsui, McDonald-Mosley, & Burke, 2010), even if the pregnancy ends in abortion (Kirkman, Rowe, Hardiman, & Rosenthal, 2011).

In addition, to provide comprehensive and culturally safe sexual and reproductive health care to migrant and refugee women, healthcare providers need to be aware of cultural beliefs and practices in relation to sexual and reproductive health

(Mengesha, Perz, Dune, & Ussher, 2017). However, current evidence suggests healthcare professionals feel under prepared to treat migrant and refugee women, suggesting they too require further knowledge about cultural constructions of sexual and reproductive health across migrant groups in order to better support women in practice (Mengesha, Perz, Dune, & Ussher, 2018).

Understanding factors that may impede a woman's access to sexual and reproductive health services is also a human rights priority. Recognition of sexual and reproductive health rights is vital to women achieving sexual and reproductive health. The United Nations International Conference on Population and Development held in Cairo in 1994, and the Beijing Fourth World Conference on Women in 1995, were major events that put sexual and reproductive health and rights on the international agenda (Corrêa, 1997). Sexual and reproductive rights align closely with human rights, and include the right to seek and receive information, the right to the highest attainable standard of healthcare, the right to bodily integrity, to choose whether or not to be sexually active, to choose one's partner and to decide whether or not, with whom and when to have children (Corrêa, Petchesky, & Parker, 2008, p. 4; WHO, 2006a). Migrant and refugee women are often transitioning from countries where a discourse for women's sexual and reproductive health rights may not be upheld, and where sociocultural beliefs and practices surrounding sexual and reproductive health differ vastly from that of their countries of resettlement. Thus, understanding how women negotiate such differences in the context of migration is necessary in order to offer the most appropriate healthcare and support.

Barriers to Migrant and Refugee Women's Access to Sexual and Reproductive Health Services

Providing equitable access to sexual and reproductive health services to migrant and refugee women poses a number of challenges for receiving host countries. Migrant and refugee populations are particularly vulnerable to poor health outcomes and often experience barriers that limit or prevent their ability to access appropriate health services. Women in particular face unique challenges with respect to accessing appropriate sexual and reproductive health care. The following section will provide an overview of these barriers.

Unfamiliar and inaccessible healthcare systems.

Migrant and refugee women's experiences in utilising health services in their country of origin influence how they experience and perceive health services in their new country of residence (Agu et al., 2016; Mengesha et al., 2017; Rogers & Earnest, 2014). Primary and preventative health services may not exist in many of the developing countries women are coming from, therefore available services may be unfamiliar and underutilised by newly arrived migrants and refugees (Morrison, Wieland, Cha, Rahman, & Chaudhry, 2012).

Migrant and refugee women often report that sexual and reproductive health information and services are not easily accessible to them (Agu et al., 2016; Hach, 2012; Small et al., 2008). Difficulty in accessing services is partly related to women finding health systems challenging to navigate, as well as having limited understanding about what services are available, further discouraging engagement (Hach, 2012; Phillimore, 2015). In addition, material barriers, such as perceived or actual cost of services, transport, childcare and waiting times impede women

accessing appropriate services (Betancourt, Colarossi, & Perez, 2013; Hach, 2012; Ochoa & Sampalis, 2014).

Navigating complex health systems in a new country with limited knowledge of the local language is also a significant barrier (A. Clark, Gilbert, Rao, & Kerr, 2014), with women from migrant and refugee backgrounds reporting being unable to read and utilise information due to their limited English proficiency (Hoang, Le, & Kilpatrick, 2009; Rogers & Earnest, 2014). Often women have been denied access to formal education in their country of origin or have had disrupted education due to war (Benson et al., 2010; A. Clark et al., 2014). While provision of health materials in the native language of women may help overcome one of the many barriers to healthcare access, it also assumes literacy in a woman's own native language, which is not always the case (Zanchetta & Poureslami, 2006). In addition, a lack of appropriately trained interpreters to assist women when they do access services is a further barrier to women receiving adequate knowledge and care (Hach, 2012; Ochoa & Sampalis, 2014; Riggs et al., 2017). This may also result in women having poor experiences when using services, potentially shaping their willingness to return, and resulting in women's sexual health literacy remaining low (Hach, 2012).

The intersection of culture and religion.

In this thesis, the term culture is used to refer to a way of life that is similarly practised by a group of people; shared beliefs, values and behaviours that are transmitted from one generation to the next (Hall & Graham, 2012; Matsumoto, 1996). It is important to acknowledge however, that culture is dynamic and relational, rather than being static and fixed (Hall & Graham, 2012). While religion is related to culture, they are not synonymous; for instance, while many religions prescribe rules and restrictions in relation to sexuality and reproduction, to what

degree these religious mores translate into behaviours and practices vary across cultural contexts (Hall & Graham, 2012).

Feminist studies have highlighted that culture and religion impacts significantly on all women's sexual and reproductive health, including access to healthcare and treatment of women. For example, women's bodily pain is less likely to be taken seriously, meaning women experience significant delays in diagnosis with serious conditions such as endometriosis (Young, Fisher, & Kirkman, 2015). Women also report experiences of symptom dismissal by health care providers when experiencing cardiac problems during pregnancy (Dekker, Morton, Singleton, & Lyndon, 2016). In addition, most religions have patriarchal threads, that may control women's access to resources, such as contraception (Srikanthan & Reid, 2008); this is discussed in further detail below.

Migrant and refugee women's access and utilisation of sexual and reproductive health services is also influenced by the intersections of culture, religion and migration. Health beliefs encompass an understanding of how the body works to cause disease and determine appropriate treatment (Benson et al., 2010). Concepts of health and illness in the Western world, which largely follow a biomedical model, may not be recognised or accepted in migrant and refugee populations (Gagnon, Merry, & Robinson, 2002; Pavlish, Noor, & Brandt, 2010; Stapleton, Murphy, Correa-Velez, Steel, & Kildea, 2013). While fatalistic beliefs surrounding women's reproductive health occur in non-migrant communities (Bell & Hetterly, 2014), they have also been found to impact on migrant women's knowledge and willingness to participate in sexual and reproductive preventative health measures, such as screening (Allotey et al., 2004; Carroll et al., 2007). For example, fatalistic ideologies which place a woman's health at 'God's will' means some Somali women

have rendered cervical screening unnecessary (Abdullahi, Copping, Kessel, Luck, & Bonell, 2009; Ghebre et al., 2015). Similarly, some migrant and refugee women believe certain obstetric procedures routinely performed, such as ultrasounds and screening for foetal abnormalities, are inappropriate because they may bring "bad luck" to the pregnancy (Allotey et al., 2004).

Mismatches in cultural constructions of 'good' healthcare have also shaped women's utilisation and experiences of using services (Allotey et al., 2004; Pavlish et al., 2010). For example, some migrant women have described frustration over brief consultation times, which leave them feeling rushed in their healthcare encounters, not listened to, and unable to trust healthcare providers (Pavlish et al., 2010). Healthcare professionals' poor understanding of migrant and refugee women's sexual and reproductive health issues, as well as negative attitudes and stereotypes towards migrants and refugees, are also reported to shape women's access and experiences of using services (Hach, 2012; Tsianakas & Liamputtong, 2002). Health professionals who have little awareness about cultural and religious concerns of migrant populations may negatively influence a woman's experience of care, making patients feel threatened or judged (Drummond, Mizan, Brocx, & Wright, 2011a; Matin & LeBaron, 2004). These experiences of stigma and culturally insensitive care may explain the avoidance of sexual and reproductive health services by migrant and refugee women (Beck, Majumdar, Estcourt, & Petrak, 2005; Drummond et al., 2011a).

Lastly, the discussion of sexual matters is a challenge in many societies, including Australia (Kirkman, Rosenthal, & Feldman, 2005). It is also an issue reported amongst migrant and refugee communities where sexual and reproductive health talk is considered inappropriate, private and taboo, especially for women (Agu

et al., 2016; Rogers & Earnest, 2015; Ussher et al., 2012). Given this sensitivity, women may not feel comfortable freely discussing such topics, discouraging women to seek advice from family and healthcare professionals (Maticka-Tyndale, Shirpak, & Chinichian, 2007). Differing attitudes between parents and their children in relation to sexual and reproductive health may also mean young migrant and refugee people cannot address issues within their family (Dean et al., 2017; Kingori, Ice, Hassan, Elmi, & Perko, 2016; Rawson & Liamputtong, 2010). This may lead to some women seeking information from unreliable sources, including the internet or peers (Kingori et al., 2016; Rawson & Liamputtong, 2010; Rogers & Earnest, 2015), and being poorly equipped to negotiate sexual and reproductive health risks, such as STIs and unintended pregnancy. While the internet is an important source of health information for people around the world (Buhi et al., 2009; Evers, Albury, Byron, & Crawford, 2013), being unable to seek support and information from family, may mean migrant and refugee women may be more reliant on online information (Botfield, Zwi, Rutherford, & Newman, 2018a).

The influence of gender on women's sexual and reproductive health.

Patriarchal belief structures have concrete impacts on the sexual and reproductive health of women around the world (Dudgeon & Inhorn, 2004). Gender-based power relations can negatively affect a woman's ability to access information about sexual and reproductive health, they may also influence women's decision-making about their health and shape their capacity to take action to improve or protect their health (Blanc, 2001). For example, patriarchal ideologies may reduce the bargaining power of women, decreasing their ability to negotiate access to contraception and putting them at increased risk of unplanned pregnancy and STIs (Quelopana & Alcalde, 2014).

Traditional gender-role adherence and hyper-masculinity is associated with increased sexual violence towards women (Tharp et al., 2013), which is directly linked to poor sexual and reproductive health outcomes for women (Speizer et al., 2009). Similarly, societal beliefs around gender roles encourage women's sexual passivity, meaning women often engage in unwanted sex or sexual practices that they do not enjoy to please their partners (Kelly et al., 2017). Gender roles even influence the way in which women experience the most intimate parts of their sexual lives. For example, Fahs (2014) found that women in a Western context often felt pressured to have orgasms during sex and would fake orgasms as a strategy to reinforce their male partner's sexual skill, protecting their ego.

The above examples demonstrate that most women around the globe are made to negotiate gendered discourses that have significant material impacts on their sexual and reproductive health and lives. However, the intersections of gender and migration may result in further barriers to sexual and reproductive health which are specific to migrant and refugee women. Patriarchal control over migrant and refugee women's health may be exacerbated in the context of migration, where men may feel threatened by a woman's freedom in their new country of residence, potentially restricting their mobility and capacity to access services (Casimiro, Hancock, & Northcote, 2007). Following migration, women also face multiple challenges which result in their sexual and reproductive health needs not being prioritised (Hach, 2012; McMichael & Gifford, 2009). These include finding employment, securing housing, learning the local language, adjusting to a new culture and coming to terms with their pre-migratory trauma (Benson et al., 2010). Underutilisation of sexual and reproductive healthcare services may also be a result of prescribed gender roles that discriminate against women (Adanu & Johnson, 2009). For example, traditional

gender roles often require women to take on the position of primary family caretaker, which may result in the needs of their families frequently being prioritised ahead of their own (Benson et al., 2010). This may be intensified in the context of migration, where women are often required to cope without their usual support networks, as they have migrated without their extended family (Meadows, Thurston, & Melton, 2001).

Summary of barriers.

Despite prior research identifying barriers to migrant and refugee women's access to sexual and reproductive health services and information, inequities in health outcomes persist. This highlights the need for further investigation into how women make sense of, and experience, their sexual and reproductive health, from their perspectives, across a range of health topics, particularly when migrating from one cultural context to another. The following section describes the focus and scope of the research presented in this thesis.

Gaps in the Literature Addressing Migrant and Refugee Women's Sexual and Reproductive Health

While some qualitative research considers migrant and refugee women's sexual and reproductive health, it largely focuses on migrant women's encounters of accessing healthcare for pregnancy or birth (Gagnon et al., 2010; Grewal, Bhagat, & Balneaves, 2008; Owens, Dandy, & Hancock, 2016; Renzaho & Oldroyd, 2014; Riggs et al., 2012; Robertson, 2015; Tobin, Murphy-Lawless, & Beck, 2014). Qualitative studies that do explore sexual health topics focus predominantly on sexually transmitted infections (STIs), particularly HIV/AIDS (Arrey, Bilsen, Lacor, & Deschepper, 2015; Barrett & Mulugeta, 2010; De Jesus, Carrete, Maine, & Nalls, 2015; Hirsch, Higgins, Bentley, & Nathanson, 2002; McMichael & Gifford, 2010;

Ndirangu & Evans, 2009; Palmer, Lemoh, Tham, Hakim, & Biggs, 2009) and cervical cancer screening (Abdullahi et al., 2009; Anaman, Correa-Velez, & King, 2018; Carroll et al., 2007; Gany, Herrera, Avallone, & Changrani, 2006; Howard et al., 2009; Jackowska et al., 2012; Madhivanan, Valderrama, Krupp, & Ibanez, 2015; Matthew, Burns, Mair, & O'Donnell, 2014). While these topics are of great importance in informing healthcare practice and policy, other elements of women's sexual and reproductive health remain neglected. This is reflected in systematic reviews that call for research that considers broader topics of sexual and reproductive health for migrant women, including sexuality and sexual wellbeing, sexual health behaviours and contraceptive use (Gagnon & Redden, 2016; Mengesha, Dune, & Perz, 2016). It is due to these existing gaps in the literature that menarche and menstruation, premarital sexuality, sexual agency in marriage, and fertility and fertility control are explored in this thesis. These topics tell a narrative of women's experiences and negotiation of their sexual and reproductive health across aspects of their reproductive life-course and represent under researched themes in the literature.

A Focus on Menstruation, Sex and Fertility: Exploration of the Literature

This second half of the chapter provides a critical overview of research literature in relation to the topics selected for investigation in this thesis: menarche and menstruation, unmarried women's sexuality, women's sexual agency in marriage, and women's fertility and fertility control. The first section, '*Becoming a Woman'* covers topics in relation to menarche and menstruation. I begin by outlining sociocultural representations and hegemonic discourses surrounding menarche and menstruation in the West, the context in which migrant and refugee women are transitioning to. I then explore menstruation across a range of non-Western cultural

contexts and examine the similarities and differences in relation to menstrual discourse and practice.

In the next section '*Becoming a Sexual Women'* I first explore cultural discourse and practices in relation to virginity, both in the West and across the globe. I then consider cultural meanings and practices associated with marriage, particularly its role as being a marker of 'appropriate' sexual expression. Finally, I discuss hegemonic heteronormative Western discourses in relation to women's sexuality and contrast these in relation to the limited cross-cultural research in this sphere.

In the last section of this literature review, *"Becoming a Mother"*, I explore the importance of motherhood across cultural contexts. I also explore current literature in relation to the use of contraception methods for fertility control, including how contraception is constructed across differing cultural contexts and women's experiences of use. I conclude by considering the impact of such cultural constructions on migrant and refugee women's access to and use of contraception for fertility control.

Becoming a Woman: Menarche and Menstruation

> The little girl, not yet in puberty, carries no menace, she is under no taboo and has no sacred character… But on the day she can reproduce, woman becomes impure; and rigorous taboos surround the menstruating female. (de Beauvoir, 1972, p. 180)

Menstruation is a material reality at some point in most women's lives. However, how menarche and menstruation is experienced is influenced by the sociocultural, political and historical context in which a woman is embedded (Ussher, 1989). As pointed out by Fahs (2016), the topic of menarche and

menstruation has often been labelled “trivial”, however it has, in fact, significant material implications for women’s sexual and reproductive health. Menarche, a woman’s first menstrual cycle, is the beginning of the reproductive lifecycle, and is considered an important milestone in sexual development (Lee, 1994). It is intimately linked to fertility, sexual health, a woman’s sense of belonging and gender identity (Brantelid, Nilvér, & Alehagen, 2014; M. Sommer, Ackatia-Armah, Connolly, & Smiles, 2015; Teitelman, 2004). I now explore dominant discourses and material practices aligned with menarche and menstruation in the West.

Menstruation in the West: A “bleeding” shame.

In the West, menarche is constructed as a symbolic transition from childhood to womanhood, a period of growth and change, often linked with sexual maturation (Lee & Sasser-Coen, 1996). The physical changes girls experience at menarche, such as body hair and menstrual bleeding, often signify feminine excess, an out of control body, and reinforce women as ‘other’ (Ussher, 2006). Negative constructions of menstruation have long been reported in the literature (Delaney, Lupton, & Toth, 1988; Kissling, 1996; Koff, Rierdan, & Jacobson, 1981; Ussher, 1989), with menstrual blood constructed as poisonous or toxic (Buckley, 1988), a disease capable of spiritual corruption (Read, 2013) or as failed reproduction (E. Martin, 2001). Historically, menstruating women have been constructed as dangerous or contaminating, resulting in isolation and the development of social and behavioural restrictions with which menstruating women must comply (Delaney et al., 1988).

Remnants of these cultural constructions persist today (Johnston-Robledo & Chrisler, 2013). Menarche and menstruation are still experienced negatively by many young women, and continues to be discursively positioned as embarrassing, shameful and disgusting (Beausang & Razor, 2000; Burrows & Johnson, 2005; Lee,

2008). Shame towards menstruation reflects the societal messages women receive from media and educational resources (Erchull, 2013; Erchull, Chrisler, Gorman, & Johnston-Robledo, 2002; Kissling, 2006; Rosewarne, 2012), where menstruation is positioned as dirty, a "hygenic crisis", and a problem to be cleaned and concealed. Menstrual products are advertised as "feminine hygiene products" or "feminine protection", reinforcing the notion that women need saving from their menstruation, and that women's menstruating bodies are inherently unhygienic and dirty (Fahs, 2016; Kissling, 2006).

Allegorical images, including hearts and flowers, euphemistically signify freshness and delicacy (Merskin, 1999), a cherished ideal of femininity, which only menstrual products are capable of restoring (Kissling, 2006). Menstrual commercials never show menstrual blood, and rarely mention the word menstruation, reinforcing shame and silence associated with menstruation (Simes & Berg, 2001). They also manipulate a woman's fear of being discovered as menstruating, given such discovery may tarnish a woman's state of femininity, resulting in stigmatisation (Block Coutts & Berg, 1993), being viewed as less likeable and being physically distanced due to disgust (Roberts, Goldenberg, Power, & Pyszczynski, 2002). Menstrual products are designed to absorb blood, hide odours, to be invisible through clothing, and to be disposed of discreetly (Kissling, 2006). In this vein, a woman's menstruating body is hidden from the public eye, and her stigmatising 'condition' remains concealed (Block Coutts & Berg, 1993; Johnston-Robledo & Chrisler, 2013). These cultural representations which position menstruation as shameful and unhygienic, create and reinforce negative attitudes towards menstruation, towards women and their 'unruly' bodies, and often do so in the name of enhancing corporate profits (Bramwell, 2001; Kissling, 2006). They also act to regulate women's lives

more broadly, including the avoidance of sex during menstruation, as it is positioned as "messy" and "gross" (Fahs, 2011a).

Understanding the ways in which menstrual shame impacts on women's experiences of sexual and reproductive health are of significant importance. For instance, in relation to sexual health, menstrual shame has been associated with significantly less sexual assertiveness and sexual risk-taking (Schooler, Ward, Merriwether, & Caruthers, 2005). Menstrual shame has also been linked to embarrassment towards other reproductive functions, including childbirth (Moloney, 2010) and breastfeeding (Bramwell, 2001; Johnston-Robledo, Sheffield, Voigt, & Wilcox-Constantine, 2007). This is because menstruation and breastfeeding interfere with the social construction of women's bodies being objects of (male) desire (Johnston-Robledo et al., 2007).

Menstruation is also closely aligned with a biomedical or pathological discourse, with menstruation and menstrual symptoms being synonymous with illness (Burrows & Johnson, 2005). Constructions move beyond just a physical illness narrative, with pre-menstrual women being positioned as mentally unstable, possessed or out-of-control (Ussher, 2006). These negative constructions of menstruation have led to the increased promotion of menstrual suppression drugs, such as *Seasonale*, which position menstruation as a disorder, bothersome and incapacitating (Johnston-Robledo, Barnack, & Wares, 2006; Mamo & Fosket, 2009). Rather than recommending menstrual suppression for women who suffer severe menstrual cycle problems, such as dysmenorrhoea, popular press promotes menstrual suppression as a matter of convenience, without citing definitive research supporting its safety (Johnston-Robledo et al., 2006).

In many instances, girls most commonly obtain information about menarche and menstruation from their mothers (Beausang & Razor, 2000; Kissling, 1996). How mothers react to their daughter's menarche, and the information they are provided with prior to menarche, significantly affect a girl's experience of, and attitudes towards, menstruation and sexuality (Beausang & Razor, 2000; Costos, Ackerman, & Paradis, 2002; Lee, 1994, 2008). In some instances, a discourse of shame and silencing results in mothers being reluctant to discuss aspects of menstruation and sexuality with their daughters, leading to a lack of knowledge, confusion and inaccurate beliefs for the menarcheal girl (Cooper & Koch, 2007; Costos et al., 2002; Teitelman, 2004). For example, young women may report concerns about disease, danger and sexual victimisation following menarche, particularly where female reproductive capacity is linked to an adult sexuality without appropriate explanation (Teitelman, 2004). Conversely, daughters who describe receiving adequate information prior to menarche and had mothers who were emotionally connected were more likely to report positive experiences (Lee, 2008; Teitelman, 2004). It is also important to note a discourse of secrecy is often reinforced by mothers at menarche through the use of euphemistic language, promoting behavioural restrictions during menses, and by emphasising the need for menstrual concealment, especially towards men (Costos et al., 2002; Lee & Sasser-Coen, 1996). These behaviours reinforce to young women that cultural constructions of ideal womanhood are contingent on women keeping their leaking, bleeding bodies out of the male gaze (Ussher, 2006).

The information girls/young women receive at school has also been described as unhelpful or too late, given they may have begun to menstruate (Cooper & Koch, 2007); this may further contribute to young women feeling unprepared and

dissatisfied with their experiences of menarche. Conversely, girls who are prepared for the physical changes during menarche are better able to process and accept associated bodily changes (Teitelman, 2004). These findings reiterate the importance of adequate menstrual knowledge and learning to avoid negative experiences of menarche and menstruation. Acknowledging this is of particular importance given negative experiences at menarche are associated with ongoing negative constructions of menstrual bleeding, as well as a negative body image (McPherson & Korfine, 2004). Women who view menstruation negatively may also be more vulnerable to biased messages circulating in popular media, which promote menstruation being a messy inconvenience, rather than a normal and healthy biological process (Johnston-Robledo, Ball, Lauta, & Zekoll, 2003), and more likely to support menstrual suppression (Andrist, 2008; Johnston-Robledo et al., 2003).

While this overview may paint a particularly negative view of dominant discourses surrounding menstruation in the West, there is some evidence not all girls experience menarche and menstruation negatively, particularly when girls associate menarche with a positive new identity, belonging and excitement about bodily changes (Lee, 2008). Girls are also more likely to describe pleasurable aspects of menarche when their transition is associated with their wider potential, such as intelligence or creative skill, rather than when sex and reproduction are primarily referenced (Teitelman, 2004). In the West, there is also a changing cultural space in relation to menstruation. In an attempt to support women to feel more open and accepting towards menstruation and their bodies, academics, feminists and activists are increasingly challenging negative cultural representations and practices in relation to menstruation (Bobel, 2010; Bobel & Kissling, 2011; Fahs, 2016). Contemporary menstrual activism encourages reimagining “ways to move

menstruation out of the closet" (Fahs, 2016, p. 105), encouraging collective resistance, confronting the menstrual product industry and challenging age-old taboos through menstrual art, public performance and menstrual zines (Bobel & Kissling, 2011; Fahs, 2016).

Constructions and experiences of menstruation across diverse cultural settings.

Recently, there has been an increase in literature that considers women's experiences of menarche and menstruation across a number of non-Western cultural settings, including countries in Africa (Mason et al., 2013; McMahon et al., 2011; M. Sommer, 2010), South Asia (Behera, Sivakami, & Behera, 2015; Crawford, Menger, & Kaufman, 2014; Garg, Sharma, & Sahay, 2001; Kumar & Srivastava, 2011), Asia (Chang & Lin, 2013) and the Middle East (Al Omari, Abdel Razeq, & Fooladi, 2015; Golchin Nayereh, Hamzehgardeshi, Fakhri, & Hamzehgardeshi, 2012). There have also been a small number of studies where menarche and menstrual experiences of women are considered and compared across a number of different cultural settings (Chrisler & Zittel, 1998; Hoerster, Chrisler, & Rose, 2003; M. Sommer, Ackatia-Armah, et al., 2015; Uskul, 2004). The increased global interest in experiences of menstruation, particularly in low-income countries, is largely in response to the growing recognition of menstruation as a hygiene issue, with ineffective hygiene practices having negative reproductive and social consequences for girls, such as school absenteeism (McMahon et al., 2011; M. Sommer, Ackatia-Armah, et al., 2015; Standing & Parker, 2017).

Across non-Western cultures, as in the west, menarche has been described as a distinct transition from girlhood to womanhood, which has both positive and negative implications for girls and young women. The fact that girls are considered a

'woman' who is able to reproduce, was commonly experienced positively, given the cultural value of motherhood (Chang & Lin, 2013; Secor-Turner, Schmitz, & Benson, 2016; M. Sommer, 2010). However, negative aspects of this transition included apprehension about increased sexualisation, which made young women feel vulnerable to sexual assault (Chang & Lin, 2013; M. Sommer, Ackatia-Armah, et al., 2015). This was reported to result in restrictions on young women's social mobility due to their newly heightened "risk" of having sex and falling pregnant (Behera et al., 2015).

Negative attitudes towards menarche and menstruation are universal in nearly all cultural contexts in which they have been examined. Similar to Western contexts, a cultural taboo surrounding the discussion of menstruation is reported by women in non-Western cultural contexts leading to a distinct lack of information and preparation prior to menarche (Al Omari et al., 2015; Crawford et al., 2014; Golchin Nayereh et al., 2012; M. Sommer, Ackatia-Armah, et al., 2015). This lack of knowledge and support had implications on the way menarche was experienced, with young women describing their menarche with hatred, as fearful, shameful, confusing, or as an illness (Al Omari et al., 2015; Behera et al., 2015; Crawford et al., 2014; Golchin Nayereh et al., 2012; M. Sommer, 2009; Tegegne & Sisay, 2014).

While some girls/women reported receiving information from mothers, sisters, aunts and friends, girls frequently described inadequate parental support prior to and following menarche, contributing to girls' experiences of fear and confusion (M. Sommer, Ackatia-Armah, et al., 2015). Furthermore, some girls/women described how when they did receive information, it was largely surrounding "hygiene" and "body function", with less support in relation to the emotional aspects of menarche and menstruation (Marván, Morales, & Cortés-Iniestra, 2006). In

addition, similar to the West, the education provided to girls at school was often described as inadequate (Secor-Turner et al., 2016; M. Sommer, 2010), with girls reporting it to be "non-personal" or "science-based" (Secor-Turner et al., 2016).

Young women from developing contexts also described additional embarrassment and shame in relation to their ability to manage their menses in private and with dignity. The lack of available resources to manage menstrual bleeding, in conjunction with limited privacy and facilities to change menstrual products at school, contributed significantly to negative experiences and attitudes towards menstruation (McMahon et al., 2011; Secor-Turner et al., 2016; M. Sommer, 2009, 2010; M. Sommer, Ackatia-Armah, et al., 2015; Tegegne & Sisay, 2014).

Menstrual rules, regulation and restriction.

Studies across the globe have identified that women are subjected to a number of different social and cultural myths, which result in exclusion and restrictions associated with menarche and menstruation. For instance, a study in Nepal demonstrated that at menarche girls were required to undergo a ritual of seclusion immediately after their first period, adding to their experience of confusion and discomfort during this time (Crawford et al., 2014). In addition, in some parts of rural Nepal, despite this practice being made illegal, some women are still required to undergo *chhaupadi* while menstruating (Ranabhat et al., 2015). This involves women being banished from the family home to an external hut during menses, which reinforces stigma towards a menstruating woman and puts women at risk of poor reproductive health, sexual abuse and ill health due to exposure (Ranabhat et al., 2015). Similarly, due to the risk of 'contamination' women from rural India have reported that during menses, they are not allowed cook, attend to certain household chores, and need to observe a number of strict rules in relation to touching preserved

food grains, especially rice, stored powdered spices and pickles (Behera et al., 2015; Garg et al., 2001; Kumar & Srivastava, 2011).

In some cultures, women are required to adhere to strict dietary restrictions during menstruation. For example, in parts of India women are expected to avoid sour foods and "cold" foods as they were considered to increase menstrual pain (Garg et al., 2001; Kumar & Srivastava, 2011; Singh, 2006). Similarly, in Taiwan, girls are recommended to avoid cold foods, this is linked to traditional concepts of Chinese medicine where cold foods are considered harmful for the body, potentially increasing menstrual pain (Chang & Lin, 2013). In contrast, girls in Cambodia and Ethiopia are advised not to drink or eat hot foods, such as tea or porridge, as it is said this would increase menstrual flow (M. Sommer, Ackatia-Armah, et al., 2015).

Across cultures, there are varying taboos in relation to menstrual hygiene. For example, African girls from Ghana and Tanzania are told that incorrect disposal of their used menstrual products could lead to infertility or being "cursed" (M. Sommer, Ackatia-Armah, et al., 2015). Tanzanian women disclosed these threats were circulated in order to make sure women followed "hygienic" practices and kept their sanitary products out of sight (M. Sommer, 2009; M. Sommer, Ackatia-Armah, et al., 2015). This expectation was extended to the drying of sanitary cloths, requiring them to be hidden from public view (M. Sommer, 2009; M. Sommer, Ackatia-Armah, et al., 2015). In addition, some Muslim women living in India, as well as women in Ethiopia and Cambodia, reported avoiding taking baths during menstruation (Garg et al., 2001; M. Sommer, Ackatia-Armah, et al., 2015). This was because of the fear bathing would lead to increased menstrual flow or menstrual pain, and the perception bathing would increase the probability of complications during future pregnancies

(Garg et al., 2001; Kumar & Srivastava, 2011; M. Sommer, Ackatia-Armah, et al., 2015; Tegegne & Sisay, 2014).

In most of the world's religions, menstruation is associated with varying degrees of restriction (Dunnavant & Roberts, 2013). Given it is frequently constructed as a sign of impurity and uncleanliness, women are often prohibited from visiting holy places and undertaking religious practices during their menses (Dunnavant & Roberts, 2013; Garg et al., 2001). For example, in India, both Hindu and Muslim women have reported avoiding religious duties, such as visiting the temple or touching holy texts during menstruation (Garg et al., 2001; Kumar & Srivastava, 2011). Across major religions including Orthodox Judaism, Islam and Hinduism women are also religiously prohibited from having sexual intercourse with their husbands, (Dunnavant & Roberts, 2013; Kumar & Srivastava, 2011; Steinberg, 1997), with it being said to be unhygienic and harmful to both men and women (Garg et al., 2001).

These findings illuminate the importance of considering the ways in which cultural or religious constructs intersect to shape women's experiences and practices during menstruation. In addition, the findings of these studies demonstrate similarities and differences in menstrual beliefs and practices across cultural groups. Even within specific countries or cultural groups, variation occurs according to geographical position –including rural verses urban living, socioeconomic status and social status, such as cast, and religion (Kumar & Srivastava, 2011; M. Sommer, 2009). These findings thus highlight the importance of considering women's experiences both within, and across, cultural and religious contexts.

Very few studies have considered women's constructions and experiences of menarche or menstruation where women have migrated from one cultural context to

another. While Uskul (2004) considered experiences of women from 34 different countries, the participants were attending a summer school in Germany, thus the impact of transitioning from one cultural context to another was not relevant, or examined. Similarly, while Orringer and Gahagan (2010) considered women's experiences across ethnic groups in America, focusing on Mexican American and Arab American young women, no detail was provided as to whether participants had migrated to America, and if so, when this happened, and how this may have influenced a woman's menstrual education or menarche experience. This demonstrates the need for further research which considers how new migrant and refugee women negotiate potentially different cultural discourse and practices, in relation to menarche and menstruation, following migration from one cultural context to another. Given the influence that mothers have on their daughter's experience of menarche and menstruation, it is also important to explore how mothers' experiences and constructions may influence the education and practices they carry out with their daughters, following this migratory transition.

Becoming a Sexual Women

Before continuing, it is important to acknowledge the use of the words 'sex' and 'sexuality' throughout this thesis. While I acknowledge that the use of the term 'sex' potentially reinforces the social construction of heterosex as being structured around the coital imperative (McPhillips, Braun, & Gavey, 2001), I have chosen to use this word to refer to coital sex unless otherwise specified. This is because despite being prompted to explore other forms of 'sex' in interviews, women in this study interpreted 'sex' within a framework of the coital imperative. Further, I have used the word 'sexuality' within this thesis as a means to describe women's experiences as

embodied sexual beings, such as their constructions and experiences of sexual pleasure and desire, not in relation to sexual identity.

Premarital sexuality: Restrictions, regulation and the virtue of virginity.

> When the body becomes physiologically sexually mature, we lose the luxury of imagining that the individual is not a sexual entity. This is the point where virginity really begins to count for something. (Blank, 2008, p. 13)

While menstruation is a biological process, it simultaneously plays a central role in body politics, "helping to produce the body and women as cultural entities" (Lee, 1994, p. 343). Within patriarchal and heterosexist societies, menarche concurrently signifies emerging sexual availability and reproductive potential (Lee, 1994). While this does not always mean pregnancy will occur at this time, it is the point in which women start to learn to discipline their bodies in accordance to social and cultural ideals of feminine sexuality.

Historically, in the West, adolescent and unmarried women were required to be virginal until marriage (Blank, 2008). The value placed on chastity had significant implications for romantic and sexual relationships, as well as negative outcomes for those who had premarital sex. The moralistic, and primarily Christian, intolerance toward premarital sex meant that up until the early 1960s, mothers with 'illegitimate' children were shamed, disgraced and treated as sinful outcasts by society, and often by their own family (Thane & Evans, 2012). It wasn't until the 1960s and early 1970s, coinciding with the sexual revolution, access to the contraceptive pill and the improved social status of women, that a transformation in cultural and societal norms occurred in relation to premarital sexuality (Allyn, 2016; Amy, 2008).

With the exception of socially conservative groups and religious institutions, which continue to promote premarital chastity (Blank, 2008), in most countries in the

secular West there is now a widespread cultural acceptance of premarital sex. In countries such as Australia, Canada, and the United Kingdom the large majority of people agree that sex before marriage is normal, an acceptable part of young adulthood, and important for wellbeing (de Visser et al., 2014; Widmer, Treas, & Newcomb, 1998). This is also reflected in the fact that in Canada and Australia, the average age of first sexual intercourse ranges from 16-18 years old (Rissel et al., 2014; Rotermann, 2005). Indeed, premarital sex is so normalised that sexually inexperienced adults report feeling stigmatised due to their lack of sexual intercourse; they are also less likely to be considered as potential partners for committed romantic relationships, if their prospective partner is aware of their virginal status (Gesselman, Webster, & Garcia, 2017).

It is important to note however, that in some parts of the West, premarital sex has not received widespread approval (Fine & McClelland, 2006). This is particularly evident in the United States (U.S) where much of the federally funded sexual health education financially and morally supports abstinence until marriage education programs (Fahs, 2010; Fine & McClelland, 2006). Such an educational approach is deployed through laws, policies and public institutions and advocates the benefits of remaining abstinent, highlights dangers associated with sex outside of marriage, and emphasises the promise of safety within the bounds of heterosexual marriage (Fine & McClelland, 2006). In conjunction with abstinence only sex education programs, an increased fixation on virginity in this context has led to an emergence of chastity clubs, organizations and purity balls, where young girls pledge their chastity to their fathers until marriage (Fahs, 2010; Valenti, 2009). As described by Fahs (2010), a lack of adequate sex education and the public pledging of one's purity has significant negative implications for young women's sexual subjectivity-a

woman's experience of herself as a sexual being, her feeling of entitlement to sexual pleasure and sexual safety, her ability to make active sexual choices, and her identity as a sexual being (Tolman, 2002a). It also has implications for young women's sexual agency-which in this thesis is defined as a woman's ability to act according to her own wishes and to have control over her sexual life (Fahs & McClelland, 2016, p. 396), including the power to initiate sex and communicate sexual desires, as well as being able to resist unwanted sex (Fetterolf & Sanchez, 2015).

Cultural practices, such as virginity pledging, also have significant implications for sexual and reproductive health. For example, Brückner and Bearman (2005) found that 88% of middle and high school students who had pledged their virginity, did eventually have premarital sex. Pledgers were 30% less likely to use contraception when they did have sexual intercourse, and were less likely to use condoms or utilise health care facilities for sexual health testing or treatment (Brückner & Bearman, 2005). While these beliefs and practices in relation to virginity largely do not occur to the same extent in Australia or Canada, they are an exemplar of how different cultural constructions toward the importance of virginity shape material practices and sexual health outcomes.

Despite premarital virginity being less of an imperative in most contemporary societies in the West, young women's sexuality continues to be depicted and regulated in complex and contradictory ways (Fine & McClelland, 2006; Tolman, 2002a, 2016). The enduring sexual double standard acts to regulate young women's sexuality by drawing on traditional discourses of heterosexuality, such as a Madonna/whore binary, whereby women are positioned as either virtuous or promiscuous (Ussher, 1997b). The double standard acts to regulate women's sexuality through reputation (Holland, Ramazanoglu, Sharpe, & Thomson, 1996),

with only “good” or “nice” girls being those who withhold overt sexual feelings of their own, and who exercise restraint towards boys (Tolman, 2016). In contrast, men are seen positively for having many sexual encounters, are called “studs” if they enact sexually promiscuous behaviour and only risk judgement when they do not display an appropriate level of sexual aptitude (S. M. Jackson & Cram, 2003).

Further, representations of girls are becoming more complex, with girls now being fiercely sexualised within popular media (Gill, 2009). Young women are being socialised to be sexy, rather than sexual beings, being depicted as, and learning that they are, objects of another’s desire or there to incite desire, instead of expressing their own sexual desire (Tolman, 2016). In light of these cultural shifts in representations and practice, young women who do not embrace these new expected feminine identities are at risk of being labelled uptight or prudish (Gavey, 2005), while conversely, those who display too much of an open, desirous or active sexuality run the risk of being labelled a ‘slut’ (Farvid, Braun, & Rowney, 2017; Tolman, 2016). These problematic cultural constructions of young women’s sexuality have implications for sexual and reproductive health. For instance, they may impact on sexual safety as young women could be reluctant to carry condoms, or initiate condom use, given they do not want to be negatively judged for being too sexually assertive by their male partner (Mills & Barclay, 2006; Young, Penhollow, & Bailey, 2010).

Women’s premarital sexuality cross-culturally: A focus on virginity.

Western contexts are not the only settings in which young women’s sexuality continues to be regulated. In a number of societies around the world, women’s premarital sexual virginity continues to be highly regarded. In many Muslim and Christian societies, across Asia, Africa, South America and the Middle East, a

woman's premarital virginity is heavily policed through religious mores, traditional practices, and government policy and laws (Espinosa-Hernández, Bissell-Havran, & Nunn, 2015; Hoga, Tibúrcio, Borges, & Reberte, 2010; Wee, 2012; Zuhur, 2016).

Often, the importance of virginity is linked to wider cultural discourse in relation to morality, honour and shame (Akpinar, 2003). In the Middle East for example, it has been argued that while men enact their family honour through aspects of their lives such as hospitality, socioeconomic status and generosity, a woman's honour is restricted to that of her chastity and sexual virtue (Zuhur, 2016). If a woman's pre-marital virginity were to be compromised, it would not only reflect negatively on her, but the honour of her family and that of her wider community. The hymen, in such contexts, becomes the material signifier of virginity, and gives woman a stamp of respectability and virtue (Abu-Odeh, 2010, p. 917).

Such regulation is culturally and/or religiously bound, and is highly political, geopolitical and historically situated. For example, in Iran, sexuality and sexual mores for women have changed dramatically since the 1979 Iranian revolution, which saw the rise of the Islamic Republic (Yaghoobi, 2012). Despite the leaps made in progressing women's rights and access to education, the revolution led to State-sponsored policies which saw the promotion of a gender apartheid society, restrictive dress codes for women and consensual sexual relations outside of marriage being punishable by death (Yaghoobi, 2012). Similarly, in Afghanistan, prior to the Soviet Union invasion in 1979 and the rise of Islamic fundamentalism, girls had attended school, women had participated in the work force and few women wore a *burqa* (garment covering body and face) (Stabile & Kumar, 2005). However, once the Taliban took rule in 1996, policies were implemented that severely restricted women's rights, mobility and participation in society (Stabile & Kumar, 2005). And

in Indonesia, under Islamist influence, in some schools, girl students have been discouraged from singing or speaking in public as their voices were redefined as *aurat* (a private part) (Wee, 2012). Unmarried couples deemed being 'too close' in public risk public humiliation and young unmarried women who are thought to be sexually active may be forced to undergo virginity checks (Wee, 2012).

A small number of studies have been undertaken in Western countries that explore cultural meanings and practices in relation to sexuality with migrant and refugee women when transitioning from countries with strict rules surrounding premarital virginity and sexuality, to culturally different contexts such as Australia and Canada. They found traditional views towards premarital sexuality and virginity largely continue to be upheld following migration, particularly for first generation women (Meldrum, Liamputtong, & Wollersheim, 2014; Ussher et al., 2012; Wray, Ussher, & Perz, 2014). For example, Wray et al. (2014) reported that young Muslim women maintained their ignorance to all things of a sexual nature, as was expected of unmarried women; this included avoiding conversations about sex and social segregation from men. Meldrum et al. (2014) reported that young Muslim women were made to balance meanings and expression of sexuality according to their Islamic religion, the Muslim culture of their community and that of Australian culture, which many found difficult.

The previous discussion emphasises the importance of understanding how discourses and practices may influence unmarried migrant and refugee women's sexual and reproductive health. Firstly, and as stated above, we know there is an underutilisation of sexual health services from migrant and refugee communities, including young people from culturally diverse communities (Botfield et al., 2016). Given premarital virginity remains important across a number of cultural contexts,

young or unmarried women may be prohibited from accessing appropriate sexual health services, as being seen at clinics may jeopardise their personal or family reputation (Beck et al., 2005; Rogers & Earnest, 2015). They may also avoid contraception use as they fear their parents may discover they are sexually active (Watts et al., 2014). Similarly, in culturally diverse communities that promote premarital virginity, preventative measures, such as the HPV vaccine may be seen as inappropriate or not necessary for young and unmarried women, as chastity in itself is seen as a form of protection against disease (Forster et al., 2017; Salad et al., 2015). The vaccine may also be avoided as it is believed vaccination may result in daughters engaging in promiscuous behaviours due to the protection it offers (Mupandawana & Cross, 2016).

It has also been reported that amongst some communities parents may be reluctant to talk about sexual health with their children (Dean et al., 2017; Rawson & Liamputtong, 2010), or discourage their daughters from receiving sexual health education, as it is thought to encourage premarital sexual behaviour (Ussher et al., 2012). Given this possible lack of sexual health education and access to services, young women may be at greater risk of STIs and unplanned pregnancy if they do have sex (Yeung et al., 2017). These findings suggest deeper understanding is needed in relation to how migrant and refugee women negotiate potentially competing constructions and practices in relation to premarital sexuality, and how this may affect unmarried women's sexual health practices and sexual subjectivity.

The materiality of virginity: A closer inspection.

In many cultures, the meaning of virginity for women extends to the material presence of a vaginal hymen (Abboud, Jemmott, & Sommers, 2015; Kaivanara, 2016). A fixation on the materiality of the hymen however, has led to virginity

becoming medicalised. In parts of the world, particularly the Middle East, women may be required to undergo ‘virginity checking’ or are made to obtain ‘virginity certificates’ (Cindoglu, 1997). This involves healthcare providers examining women’s genitalia to determine the presences of an ‘intact’ hymen (Shalhoub-Kevorkian, 2005). Such practice continues despite the fact a visible hymen is not a reliable indicator of past sexual experience due to naturally occurring variability across women, and the fact that women can have altered hymens for reasons other than coital sex (Essén, Blomkvist, Helström, & Johnsdotter, 2010). However, a failure to ‘appear’ virginal at the first act of sexual intercourse following marriage has serious ramifications for women, such as divorce, ostracism and violence (A. Ahmadi, 2016).

The requirement for women to have an intact hymen, signified by bleeding upon first coital sex, has led to the practice of hymenoplasty. This surgical procedure involves suturing existing ‘remnants’ of the hymen to achieve a partial closing of the introitus, or the construction of a ‘new’ hymen through the use of existing skin of the vaginal wall (Renganathan, Cartwright, & Cardozo, 2009, p. 102). This procedure is said to ‘restore’ the corporeal appearance of an intact hymen and is utilised by women who have had premarital sex, or have concerns about not ‘appearing’ virginal due to an absence of blood following first coital sex. A. Ahmadi (2016) argues that such medicalisation of virginity is emancipatory to women, as they can resist the dichotomous positioning of either a deviant woman who has had premarital sex, or a “normal” woman who refrains from premarital sex. Other scholars caution such interpretation arguing that this practice may in fact perpetuate patriarchal control over women’s bodies and continue to fuel the fixation on the materiality of the hymen, and its discursive construction as a marker of virginity (Kaivanara, 2016).

Understanding how migrant and refugee women make sense of the materiality of the hymen in relation to virginity and premarital sex is thus important. Recent research highlights that in European countries that host migrant communities, healthcare professionals are increasingly being asked questions in relation to virginity, to perform hymen reconstructions or provide virginity certificates to culturally diverse young women, many of whom are from migrant or refugee backgrounds (Essén et al., 2010; Juth, Tännsjö, Hansson, & Lynöe, 2013; Tschudin et al., 2013). Despite such a request going against official health policy, healthcare professionals describe being in an ethical dilemma; if they do not carry out such procedures, they are concerned the young woman involved would be subject to honour-related violence (Juth et al., 2013). This suggests further exploration into the ways women discursively construct the materiality of virginity and the hymen in the context of migrating to Australia and Canada is needed.

The extreme value of women's virginity and control over unmarried women's sexuality is also reflected in the harmful cultural practice of female genital mutilation (FGM). It is important to recognize that while there are a number of terms used to describe FGM, such as "female genital cutting" (FGC) or "female circumcision", throughout this thesis, I have chosen to use the terminology FGM as it is the current terminology used by the WHO and UNFPA [United Nations Fund for Population Activities], which describes the practice from a human rights viewpoint (UNFPA, 2015). It is estimated that more than 200 million girls and women alive today have been subjected to FGM, a practice which spans across 29 countries in Africa, Asia and the Middle East (UNFPA, 2015). WHO has identified four types of FGM, including clitoridectomy, excision and/or infibulation of labia, as well as other

harmful practices to the genitalia which have no medical benefits (for example, pricking or nicking the clitoris) (WHO, 2017b).

It is widely recognised that FGM is a major breach of human rights, and a practice that brings serious negative consequences to women's health, including chronic pain (Okonofua, Larsen, Oronsaye, Snow, & Slanger, 2002), vaginal infections (Morison et al., 2001; Okonofua et al., 2002), urinary tract infections (Almroth et al., 2005), poor psychological health (Whitehorn, Ayonrinde, & Maingay, 2002), negative complications with childbirth (WHO, 2006b) and impeded ongoing sexual function (Andersson, Rymer, Joyce, Momoh, & Gayle, 2012; Ismail et al., 2017).

Although FGM is not supported by any religion, at times religion is used as a justification to support the practice (UNFPA, 2015). FGM is also a manifestation of gender inequality, which is connected to entrenched social, economic and political structures (WHO, 2008). For example, reasons given for the perpetuation of this practice surround identity, such as being initiated into womanhood, and/or marriageability and hygiene or aesthetic reasons, whereby the external genitalia of women are thought to be ugly or dirty (Berg & Denison, 2013; Vissandjée, Weinfeld, Dupéré, & Abdool, 2001; WHO, 2018b). Psychosexual beliefs which position a woman's genitalia as being the cause of insatiable sexual desire have also been reported to contribute to the continuation of this practice (Johnsdotter, Moussa, Carlbom, Aregai, & Essén, 2009). In this vein, the removal of the clitoris, which is often thought to incite such desire, and in more severe cases the physical reduction in the size of a woman's vaginal opening, is seen as a necessary procedure to curb sexual desire and ensure virginity before marriage, and martial fidelity thereafter (Johnsdotter et al., 2009; WHO, 2018b).

A number of qualitative research studies, the majority of which have been undertaken in a European context, explore migrant and refugee women's (and families) perspectives of FGM following migration (Gele, Kumar, Hjelde, & Sundby, 2012; Isman, Ekéus, & Berggren, 2013; Johnsdotter et al., 2009). Some suggest FGM is not supported following migration as it has lost its meaning in the women's new countries of resettlement (Johnsdotter et al., 2009). A reduction in social pressures to perform FGM in the new country has also facilitated its discontinuation (Gele, Kumar, et al., 2012; Vissandjée, Kantiébo, Levine, & N'Dejuru, 2003). However, other studies suggest ambivalent attitudes towards FGM, with participants acknowledging its negative effects on health, but also positioning it as a positive cultural practice (Isman et al., 2013). A quantitative study in Norway with Somali migrants found that 30% of participants still supported the practice of FGM, with recent migrants being more likely to support its continuation (Gele, Johansen, & Sundby, 2012). Upvall, Mohammed, and Dodge (2009) also found some mothers were concerned about their daughters' desires towards men and marriageability as uncircumcised women. Given the fact migrant and refugee women are transitioning from countries where FGM is prevalent to live in Australia and Canada, exploring women's constructions and experiences of FGM in relation to broader cultural discourses of premarital sexuality is of significant importance.

Marriage: Bridging the asexual and the sexual.

A woman's relational context significantly influences her sexual and reproductive health (Dudgeon & Inhorn, 2004; Sarkar, 2008). In this vein, given marriage is the only legitimate space in which many migrant and refugee women are allowed to be sexual, understanding how such women enter into marriage and the implications this may have on a woman's construction and experiences of her

sexuality is important. Understanding the historical and sociocultural contexts of marriage helps facilitate this.

In the West, for most of history, the purpose of marriage has primarily been centred on accumulating resources, social status and the consolidation of wealth, a political or economic transaction or investment, and for the purposes of procreation (Bernstein, 2011; Coontz, 2005). Given the economic and political gains marriage could provide, a match typically occurred as a negotiation between multiple people, including family, neighbours, priests and government officials (Coontz, 2005). During this time, marriage played a key role in the organisation of society; it was central in defining gendered roles for the division of labour and the inheritance of property (Bernstein, 2011; Coontz, 2005). Marriage also dictated personal rights and obligations, including sexual relations, which were traditionally prohibited until marriage (Coontz, 2005). Given procreation was a central goal of marriage and an economic necessity, women's sexual pleasure was not prioritised. Rather, women often endured sexual intercourse for the primary function of reproducing legitimate children and heirs for her husband (Coontz, 2005).

It wasn't until the 19th century that companionship, friendship, romantic love and sexual attraction became fundamental in marriage, and love-based marriages emerged (Cherlin, 2005; Coontz, 2005). Today, to 'be in love' or to 'fall in love' is widely accepted as the norm, with most people 'dating' and having sex, cohabiting and even having children together prior to marriage (Cherlin, 2005). Despite changes in the way people enter into relationships and marriage, in Western societies coupling (and childbearing) remain valued and prioritised organisational features of society (Pickens & Braun, 2018; Reynolds & Wetherell, 2003), with heterosexuality

promoted as both the norm and preferred sexual orientation (Frohlick & Migliardi, 2011; Tolman, 2006).

As the meanings surrounding love and marriage have differed across time, so too are they experienced differently across sociocultural contexts (Levine, Sato, Hashimoto, & Verma, 2004). For example, whereas romantic love is generally seen as an important facet of partnership for marriage in individualistic cultures, such as those in Australia, U.K and U.S, it may be less important to those from collectivist cultures, such as India, Bangladesh and Pakistan (Levine et al., 2004). Cultures with strong kinship networks, or family ties, are less likely to value romantic love, and may even see it as a threat to tradition and the constitution of marriage (Levine et al., 2004). While there is also a changing acceptance for companionate marriage in many non-Western countries, that have traditionally practised arranged marriages (Abeyasekera, 2016; Fuller & Narasimhan, 2008), in many contexts, family arranged endogamous marriage continues to be the preference and the norm (Mody, 2008). In these cultural contexts, marriage for many women is not only constructed as an imperative, but a principal source of fulfilment, and the only legitimate space in which women are allowed to express their sexuality or experience motherhood (Abeyasekera, 2017). By default, it also enacts 'compulsory heterosexuality' because a marriage always takes place between a man and a woman (Rich, 1980).

The timing of marriage and partner choice is also a human rights issue (UNFPA, 2012), with the "right to marry… and enter into marriage with the free and full consent of the intending spouses" being considered central to a person's sexual rights (WHO, 2006a). Currently around the world, girls and women are disproportionally not granted this right, being denied agency over who and when they marry (UNFPA, 2012). For example, in developing countries, it is estimated one

in every four girls is married before reaching age 18, and one in nine are married under the age of 15 years (UNFPA, 2012). Forced marriages, which imply there is no consent by one or both individuals in the partnership (Chantler, 2014), and child marriage, which is marriage before the age of 18 (UNFPA, 2012), is said to occur for a number of reasons. These include traditional gender norms that devalue girls and women, a safeguard against premarital sex, poverty, and a desire to secure social, economic, or political alliances (Raj, Gomez, & Silverman, 2014; UNFPA, 2012).

Migrant and refugee women in Canada and Australia, often arrive from countries where marriage norms are significantly different. National estimates in Sudan, for example, suggest 46% of women are married before the age of 18 years old (Abdel Aziem, Ibrahim, Abdelgbar, & Elgessim, 2014). High estimates of child marriage have also been found in Somalia (45%), Afghanistan (35%) and Iraq (24%) (UNICEF [United Nations International Children's Emergency Fund], 2018). Some qualitative literature on migrant and refugee women's experiences of marriage and husband choice following migration to Western countries (Gopalkrishnan & Babacan, 2007; Pande, 2015; Samuel, 2010), undertaken predominantly with South Asian women, found traditions around marriage are an important part of migrant identity (Samuel, 2010) with a 'spectrum of arranged marriages' continuing (Pande, 2016). However, there is an absence of research that considers how issues of agency in partner choice may impact on a woman's embodied sexual trajectory, and how women's constructions and experiences surrounding husband choice may be influenced when transitioning to countries with different cultural practices in relation to partner choice and marriage.

Sex in marriage: Cultural scripts in the bedroom.

While sex can, and does, happen outside of a heterosexual marriage this section on 'sex in marriage' is labelled as such to align with the previous sections of this literature review, which demonstrate that for many women around the globe, including migrant and refugee women, marriage is the only legitimate space in which sexual intimacy is permitted to occur. I start this section with an overview of dominant discourses in relation to women's sexuality in the West. This is because this is the context women are migrating to and because it also demonstrates sex and sexuality are complex acts for many women, regardless of cultural context. I then detail what is known about sex and sexuality across differing cultural contexts, and what is known about migrant and refugee women's sexuality.

Sexuality is recognised as an important aspect of people's lives, with the expression of sexuality and intimacy playing a significant role in developing and maintaining a person's sense of self, their psychological wellbeing and quality of life (Daker-White & Donovan, 2002; WHO, 2009). As previously stated, sexuality and reproduction is also a rights based issue as sexual health requires a positive and respectful approach to sexuality, and the possibility of pleasurable and safe sexual experiences (Corrêa et al., 2008; WHO, 2006a). Some argue however, that sex is 'not a natural act' (Tiefer, 2004, p. 3) which can be understood solely as a biological need, but instead, is a social, cultural, political practice (Braun, Gavey, & McPhillips, 2003; Tolman et al., 2014). In other words, the meanings attributed to sex, that is what constitutes 'sex', where, when, and with whom are socially and culturally prescribed (Braun et al., 2003).

In the West, normative feminine sexuality has traditionally been understood in relation to heteronormative discourses that dictate norms and ideologies in relation

to expected sexual behaviour of women. Much of this early pioneering work can be attributed to Hollway (1984, 1989), who proposed three dominant discourses in relation to heterosexual relations; the male sexual drive discourse, the have/hold discourse and the permissive discourse. The 'male sexual drive' discourse (Hollway, 1984) suggests men's sexuality is biologically driven, that men 'need' coital sex, and are always wanting or ready to have intercourse. While men are constructed as needing and wanting sex, women's sexuality is viewed as being absent, passive and responsive to men's sexual needs (Fine, 1988; Gavey & McPhillips, 1999). The have/hold discourse suggests sex should take place in the framework of a secure ongoing heterosexual relationship (Hollway, 1989). The male sex drive discourse interlinks with the have/hold discourse (Hollway, 1989) as it conventionally positions women as being asexual, and thus sex for women is merely a means to secure such a heterosexual relationship and children. The permissive discourse, which came about in the 1960s in response to a cultural change towards sexuality, suggests equal and free sexual expression between men and women, with a focus on pleasure not reproduction (Hollway, 1989). The 'coital imperative' is another robust discourse of heterosexual sex in the West. The coital imperative prioritises penis-vaginal intercourse as being the dominant form of heterosex, with other non-coital sexual activities positioned as a 'precursor' to 'real' sex (McPhillips et al., 2001), this is despite the fact that coital sex is not necessarily the most pleasurable form of sex for heterosexual women (Nicolson & Burr, 2003; Richters, de Visser, Rissel, & Smith, 2006).

These discursive constructions of sex remain influential in contemporary women's constructions and experiences of sex in the West and have implications for women's sexual embodiment, subjectivity and health. For example, in a

representative sample of Australian women, one in five had reported enduring sex despite experiencing pain for at least a month in the year prior to being interviewed (Richters et al., 2006). This finding is also reflected in a number of qualitative studies that highlight even where women do not desire penetrative sex, or are experiencing sexual pain, they continue to engage in sexual intercourse to please their male partner (Ayling & Ussher, 2008; Elmerstig, Wijma, & Berterö, 2008; Hayfield & Clarke, 2012). Indeed, studies have shown women will often define their sexual satisfaction according to their partner's satisfaction, rather than their own (McClelland, 2011; Nicolson & Burr, 2003).

Women's experiences of embodiment in relation to sexuality are shaped by more than just discursive constructions of heterosex however, with a number of material factors shaping women's experiences. As women's bodies change in the context of menopause (Ussher, 2008; Ussher, Perz, & Parton, 2015), and with illness (Gilbert, Ussher, & Perz, 2011), they are more likely to experience material changes to the body; these include changes in sexual desire and vaginal lubrication that can lead to a reduction in coital sex due to pain and disinterest. Intrapsychic and relational contexts also play a significant role in how sex is experienced, with people who experience psychological distress reporting disruptions to their sexual lives (Perz, Ussher, & Gilbert, 2014).

While the above discussion brings light to dominant discourses surrounding heterosex in the West, further research in relation to migrant and refugee women's constructions and experiences of sex is needed for a number of reasons. Firstly, there is a paucity of research that considers the factors that shape migrant and refugee women's experiences of sex and sexuality. Furthermore, healthcare professionals working with migrant and refugee women have stated that a lack of understanding in

relation to migrant and refugee women's attitudes towards sexual health, including sexual pleasure and sexual practices, inhibits their ability to discuss such issues with women in practice (Mengesha et al., 2018). Recognition of women's negotiation of sexual relationships is also critical to understanding and preventing sexual coercive behaviour (Gavey, 2005). This is important as sexual coercion has broader material and intrapsychic implications for women's sexual and reproductive health, such as women being more likely to experience an unintended pregnancy (Rowe et al., 2017).

Research that considers the constructions and experiences of sex for migrant and refugee women is extremely limited. Previous qualitative research in this sphere has found that meanings of sexuality for migrant and refugee women are strongly shaped by culture and religion (Dune, 2015; Farahani, 2018; Ussher et al., 2012). Amongst some Iranian migrant women, sexual obedience is reported to be a religious duty that is symbolic of idealised Muslim femininity, and an indicator of modesty or self-respect (Khoei, Whelan, & Cohen, 2008). Similarly, a study with migrant Assyrian women found that coital sex was positioned as a marital duty in which they have no right to refuse, even if they experience pain during sex. A study by Connor et al. (2016) found that Muslim Somali migrant women generally had the right to refuse unwanted sexual encounters, particularly those which are religiously prohibited, such as oral or anal sex, and that within Islam married women had the right to seek sexual satisfaction from their husbands. Migration to Western contexts was also found to challenge traditional patriarchal norms of sexuality, resulting in Iranian women demanding sexual satisfaction for themselves (Ahmadi, 2003). These contrasting findings in relation to women's sexual agency in marital relationships, and the fact that there is extremely little research in this sphere, suggest that further

exploration into how migrant and refugee women negotiate their sexuality within their marital relationship is warranted.

Becoming a Mother: Fertility and Fertility Control

The motherhood mandate.

Motherhood is privileged in all societies around the world. This is evident in Western societies, where women who choose to be voluntarily childless are denigrated, labelled deviant and selfish (Gillespie, 2000). The motherhood imperative is also reflected in women's feelings of inadequacy when faced with infertility (Dryden, Ussher, & Perz, 2014; Loftus & Andriot, 2012). However, in the West, many women have alternative identity positions or social roles available to them (Batool & de Visser, 2016) and voluntarily child free women are increasingly disclosing positive feminine identities that are separate to that of motherhood (Gillespie, 2003).

In contrast, many migrant and refugee women come from cultural backgrounds where women position having children as one of "life's riches" and children are deemed important for their future economic security (Kolak, Jensen, & Johansson, 2017, p. 103). A number of migrant and refugee communities living in both Canada and Australia have greater parity compared to native-born women (Family Planning New South Wales, 2013; Prey, Talavlikar, Mangat, Freiheit, & Drummond, 2014). For example, women from North Africa and the Middle East living in Australia, have a total fertility rate of 3 children per woman (Family Planning New South Wales, 2013), which stands in contrast to the national average of 1.8 children (ABS, 2017). Research on migrant and refugee women from the Sahel African countries and the Middle East suggests that the expectation to have large families continues following migration, as it is linked to a sense of belonging

and security in their new environments (Allotey et al., 2004). This sense of security has been constructed as being more important to women than material challenges, such as accessing affordable housing or acquiring the resources needed to support a large family (Allotey et al., 2004). Somali migrant women report that procreation is the meaning of marriage, and thus childbearing is an expected duty and role of all married women (Degni, Koivusilta, & Ojanlatva, 2006). The value of motherhood is also reflected in young African women's narratives of teen pregnancy. Despite the struggles associated with unintended pregnancy, given the cultural value of motherhood, and the status that comes with being a mother, teen pregnancy was not always positioned negatively (Watts, McMichael, & Liamputtong, 2015). Understanding the meaning of motherhood in a cross-cultural context, as well as the implications of such constructions on other reproductive practices, such as the use of contraception for fertility control, is an under-examined aspect of migrant and refugee women's sexual and reproductive health.

Contraception for fertility control.

The ability for women and girls to access information and services in relation to fertility and fertility control is recognised internationally as a human right (WHO, 2014). Ensuring that women have access to high quality contraception information and methods, in absence of coercion and discrimination, is vital to achieve gender equality and facilitates women's full participation as members of society (UNFPA, 2013). Being able to control fertility through contraception use is central to women's health, facilitates young women to complete their education, and allows women greater earning potential, thereby improving the economic security of both women, and their families (UNFPA, 2013).

In a Western context, the development and the release of the contraceptive pill in the 1960s was a significant breakthrough for the emancipation of women, through increased reproductive control (Watkins, 2011). Prior to its development, women had limited access to dependable means of contraception, relying on natural methods, such as withdrawal and the rhythm method, as well as condoms (Watkins, 2011). Today in industrialised Western countries, including Australia and Canada, women have access to, and utilise a number of reversible contraceptive methods including, IUD's, subdermal implants, vaginal rings, injectables and a variety of oral contraceptive pills. In Australia and Canada, many of these methods are available to women at low cost through government subsidy programs.

Most women of reproductive age in Australia and Canada report using some form of contraception (Black et al., 2009; Freilich et al., 2017; Richters et al., 2016). Despite this, in both contexts, rates of unintended pregnancy remain high (Oulman, Kim, Yunis, & Tamim, 2015; Rowe et al., 2016). This, in part, could reflect feared or experienced side-effects of more effective hormonal methods of contraception such as the contraceptive pill, IUD or subdermal implants, leading to discontinuation or non-consistent use (Dixon, Herbert, Loxton, & Lucke, 2014; Mills & Barclay, 2006). Common side effects women report that contribute to contraception discontinuation include changes to mental health, such as depression, anxiety and mood swings, as well as physical side effects such as weight gain, headaches, changes to bleeding patterns or libido (Dixon et al., 2014; Kelly et al., 2017; Mills & Barclay, 2006; Wigginton, Harris, Loxton, Herbert, & Lucke, 2015). These experiences, or fears of side effects, may also, in part, explain the high utilisation of less effective methods of contraception such as withdrawal in both Australia and Canada (Black et al., 2009; Rowe et al., 2017). Women in Australia also report a lack of information in relation

to contraception options and their potential side effects (Dixon et al., 2014; Philipson, Wakefield, & Kasparian, 2011; Wigginton et al., 2015), which may further contribute to women's contraception non-use or discontinuation.

Dominant cultural constructions of heterosexuality also produce discourses which shape the acceptability of certain contraceptive methods (Kelly et al., 2017). For example, imbedded within a heterosex discourse, where sexual pleasure is prioritised, the use of contraceptive methods, such as condoms, may be seen as unacceptable due to their potential to reduce experiences of (predominantly male) sexual pleasure (Braun, 2013; Kelly et al., 2017). While women commonly disclose the negative impact of contraception on their male partner's sexual pleasure, this is seldom found in reverse, with men rarely commenting on the effect that contraception may have on their female partner's pleasure (Higgins, Hirsch, & Trussell, 2008). Women have also disclosed feeling reluctant to initiate condom use as they are concerned about being accused of having an STI or that doing so might signify that they have been "sleeping around" (Kirkman, Rosenthal, & Smith, 1998 p. 359).

In Australia, Canada and other industrialised Western countries, migrant and refugee women are less likely to use any form of contraception compared to native-born populations (Family Planning New South Wales, 2013; Omland et al., 2014; Wiebe, 2013). In Australia, they are also more likely to report using less effective methods of contraception, such as condoms, withdrawal and the rhythm method, compared to native-born women (Family Planning New South Wales, 2013; Richters et al., 2016). A Canadian study estimated the rate of contraceptive unmet need was nearly 27% amongst refugee women, which is higher than the reported global

estimation, as well as the unmet need reported in Canada as a whole (Aptekman, Rashid, Wright, & Dunn, 2014).

Research in a number of European countries which host migrant and refugee women report higher rates of abortion in migrant women compared to native-born women (Goosen, Uitenbroek, Wijsen, & Stronks, 2009; Rodriguez-Alvarez, Borrell, González-Rábago, Martín, & Lanborena, 2016; Vangen, Eskild, & Forsen, 2008). While a Canadian study by Fisher et al. (2005) found that migrant women did not have a higher rate of abortion compared to Canadian-born women, they did have a higher prevalence of repeat abortions. Unintended pregnancies among migrant and refugee youth are also of increasing concern in Australia, suggesting that mainstream youth sexual and reproductive health services may not be meeting the needs of newly arrived young migrants and refugees (Gifford, Sampson, & Correa-Velez, 2009).

An Australian study by Mazza et al. (2012), found women who spoke a language other than English were 50% less likely to have contraceptive consultations with a general practitioner compared to English-speaking households. This finding was similarly mirrored in the Netherlands, where migrant and refugee women had significantly fewer general practitioner consultations where contraception was discussed or prescribed, compared to native-born women (Raben & van den Muijsenbergh, 2018). Migrant and refugee women also reported a lack of cultural competency and ineffective communication with healthcare professionals when they have attended health services for family planning advice (Allotey et al., 2004; Degni et al., 2006; Rogers & Earnest, 2014), which may contribute to their reluctance to return. Within some communities, such as Sri Lankan migrants in Australia, women (and men) are less likely to have heard of more effective means of contraception, and

are more likely to disclose having difficulty in accessing helpful contraception advice, compared to Australian born men and women (Ellawela et al., 2017).

Past qualitative research with migrant and refugee women has highlighted that women often arrive in their host countries with limited knowledge surrounding contraception and the reproductive body (Quelopana & Alcalde, 2014; Watts et al., 2014). One reason migrant women describe as contributing to their lack of sexual and reproductive health knowledge is that talking about sex is viewed as sinful or inappropriate and thus is avoided in the family context (Quelopana & Alcalde, 2014). While women may have learnt about contraception following migration, their knowledge often remains sparse (Rogers & Earnest, 2014; Watts et al., 2014). This may be related to inadequate access to appropriate contraceptive information, both in relation to the range of methods available and their side effects, as reported by migrant and refugee women (Allotey et al., 2004).

While some migrant and refugee women are aware of contraception options, this does not mean they are always utilised (Watts et al., 2014). Fear about contraception side effects, efficacy and negative experiences of use shape women's willingness to use hormonal methods of fertility control (Degni et al., 2006; Kolak et al., 2017; Rogers & Earnest, 2014), as described above within a Western context. For example, even where young women are having unprotected sex and risk pregnancy, contraception is avoided as it is feared it may render them infertile (Watts et al., 2014). Other fears and misconceptions associated with contraception use include weight gain, irregular cycles, cancer and the irreversibility of specific contraception methods (Watts et al., 2014). Such fears contribute to women avoiding advice in relation to effective or continuous use of contraception, resulting in unplanned pregnancies (Watts et al., 2014).

Gender dynamics also influence the acceptability of contraception use amongst women from migrant and refugee communities (Degni et al., 2006; Kolak et al., 2017; Rogers & Earnest, 2014; Watts, McMichael, et al., 2015). Healthcare professionals observe even where migrant and refugee women may be knowledgeable about their contraceptive options, their husbands do not always consent for its use (Kolak et al., 2017; Mengesha et al., 2017; Newbold & Willinsky, 2009). Migrant women have also described experiences of forced sex, pregnancy coercion and control over the use of contraception, severely restricting their reproductive autonomy (Quelopana & Alcalde, 2014). The use of contraception by women in some migrant communities has also been positioned as problematic given its association with promiscuity (Drummond, Mizan, & Wright, 2008; Watts et al., 2014; Watts, McMichael, et al., 2015). For example, West African migrant women in Australia have reported that if their partner suggested using a condom, this may indicate he was suspicious about her past sexual behaviour (Drummond et al., 2008). Similarly, young African Australian mothers fear that men in their sexual relationships will see contraceptive use as evidence of sexual experience or the intention to cheat on them (Watts, McMichael, et al., 2015).

A woman's wider family is also seen to impact on women's contraceptive knowledge and behaviours (Watts et al., 2014; Watts, McMichael, et al., 2015). Young African mothers living in Australia have described their parents are often not knowledgeable about contraception, retain strong cultural beliefs surrounding its use and are not comfortable discussing it with their daughters, thereby greatly impeding on their ability to provide informed guidance and support (Rogers & Earnest, 2014; Watts, McMichael, et al., 2015). Traditional cultural values may also mean parents deny their children are sexually active outside of wedlock, and believe that

knowledge of contraception would lead to the initiation of sexual relationships; this reasoning further limits opportunities to learn about contraception within the family environment (Rogers & Earnest, 2014; Watts, McMichael, et al., 2015).

Religion also shapes the acceptability of contraception use for fertility control in a number of migrant and refugee communities (Degni et al., 2006; Rogers & Earnest, 2014). Some migrant and refugee women have stated that under Islam, women are not permitted to control their family size (Allotey et al., 2004) with contraception being associated with "killing" and "punishment" from God if they were to use it (Degni et al., 2006, p. 195). Young Latina women living in the U.S, who predominantly follow Christianity, have also described being influenced by their family's religious beliefs, where birth control is prohibited, stigmatised and looked down upon (Gilliam, Warden, & Tapia, 2004). While religion is seen as an important factor in contraception decision-making within a portion of the general population in resettlement countries such as Australia, past research suggests in some migrant communities it is more likely to influence fertility and contraceptive choices, compared to native-born Australians (Ellawela, 2017).

Not all migrant and refugee women have described negative experiences in relation to contraception for fertility control. Some migrant and refugee women have reported positive impacts of contraception use on their health, particularly in relation to birth spacing and the management of heavy menstrual cycles (Rogers & Earnest, 2014). Others have described its acceptability and use to postpone pregnancies as women wanted to continue their education (Degni et al., 2006). Quelopana and Alcalde (2014) have also demonstrated that migration to the U.S facilitated Latina women being able to access information and methods of contraception unavailable in

their home countries, which made women feel more empowered about their reproductive choices.

While exploration of women's constructions and experiences of fertility and fertility control has been somewhat identified in previous literature, it largely focuses on fertility control in the context of unmarried women, particularly those who have experienced an unplanned pregnancy (McMichael, 2013; Watts et al., 2014; Watts, McMichael, et al., 2015). These findings highlight that in some populations a lower use of contraception use may be due to limited knowledge about contraception, fear of side effects, lack of access to methods or cultural and religious reasons. However, few studies have explored the factors that shape migrant and refugee women's agency in decision making surrounding fertility control and constructions and experiences across a number of cultural and religious contexts, particularly in relation to married women. Further research is needed to understand these factors across different communities of migrant and refugee women.

Summary of Literature Review Findings

In this review, I have provided exemplars of dominant discourses and practices both within Western and cross-cultural contexts. This is important for a number of reasons; the West is the context in which women migrate to and demonstrates cross-cultural heterogeneity. It also illustrates women's sexual and reproductive health is a complex issue across the globe, and Australia, Canada or other Western contexts alike are not without restrictive discourses and practice towards women.

Overall, this literature review has also illuminated gaps in the literature in relation to the ways migrant and refugee women experience and construct menarche and menstruation, premarital sexuality, sexual agency in marriage and fertility and

fertility control. Past research that considers migrant and refugee women's sexual and reproductive health is often homogenous, focusing on singular cultural groups meaning similarities and differences within and between cultural contexts are difficult to differentiate. Existing sexual and reproductive health research often examines women's experiences from singular religious groups, with a dominance of Muslim women's experiences (Khoei et al., 2008; Matin & LeBaron, 2004; McMichael, 2013; Meldrum et al., 2014; Meldrum, Liamputtong, & Wollersheim, 2016; Salad et al., 2015; Wray et al., 2014); this means perspectives from women from other religions are underexplored. Further, research in this sphere frequently focuses on second generation women (Manderson, Kelaher, Woelz-Stirling, Kaplan, & Greene, 2002; Rawson & Liamputtong, 2009; Rawson & Liamputtong, 2010) and on young or unmarried migrant and refugee women (McMichael & Gifford, 2009; Meldrum et al., 2014, 2016; Wray et al., 2014) meaning the views and experiences of older, partnered women, and women who are mothers are poorly represented in the existing literature. These factors highlight the need for research that explores migrant and refugee women's constructions and experiences of sexual and reproductive health, across a number of cultural and religious groups, and the need for research which captures both married and unmarried women's perspectives. This research is thus timely given first, the increasing numbers of refugee and migrant populations transitioning to countries with cultural values that are often different from their own. And second, the imperative for host countries to be are aware of, and able to address, the specific healthcare beliefs and needs of new members of society (Benson et al., 2010; Henderson & Kendall, 2011).

Structure of the Thesis

This thesis is presented in the following way. In Chapter Two I detail the methodology of the study. This includes the design, recruitment, study procedures, and processes of data collection and analysis. I begin this section by discussing the relationship between my PhD research and the broader Australian Research Council Linkage project. Within this chapter I also provide further detail and justification for the theoretical framework adopted in this thesis. In concluding the chapter, I reflect on the research process from the position of being a white Western woman and my experience of being involved on the project as a PhD candidate

Chapters Three, Four, Five and Six present the thesis findings and analysis, presented as four journal articles. Chapter Three considers women's constructions and experiences surrounding menarche and menstruation, this being the beginning of a woman's reproductive life. Chapter Four considers women's negotiation of their sexuality as unmarried women and Chapter Five progresses this theme to explore women's constructions and experiences of sex in the context of marital relationships. Chapter Six explores women's constructions of motherhood and the implications this has on women's fertility control, as well as women's sociocultural meanings, experiences and practices in relation to contraception use.

Finally, in Chapter Seven I review the research aims and methods and examine the overall findings of the study within the theoretical framework utilised in this thesis. I then highlight the implications of these findings in relation to women's sexual and reproductive health and embodiment, as well as health education and health promotion, service provision and health policy. To conclude, I address the research limitations and propose avenues of future research to further these findings.

Chapter Two: Methodological Framework

In this chapter, I firstly situate this research by describing my role as a PhD student embedded within a larger Australian Research Council (ARC) funded research project. I then describe what reflexivity is, its importance in qualitative research and relevance to this thesis. Following this, I outline the research design and provide details of the theoretical paradigm adopted in this study, the participants, recruitment procedure and the data collection process. I then elucidate how data was analysed, including details of the transcription process and method of data analysis, including coding and identifying discourse within participant data. Lastly, I reflect on my experience of researching alongside migrant and refugee women.

Situating the Thesis within the Broader Research Project

The research presented in this thesis is part of a larger ARC Linkage (LP130100087) funded project entitled; 'Sexual health of migrant women from culturally and linguistically diverse (CALD) groups: An international comparison'. Funding for this project was also contributed by our project partner organisations; Family Planning New South Wales (FPNSW), The Community Migrant Resource Centre (CMRC) and Centre for the Study of Gender, Social Inequities and Mental Health, Simon Fraser University, Vancouver, Canada. This project, which explores migrant and refugee women's sexual and reproductive health, originated in response to a call for help from FPNSW, who has an established research relationship with Western Sydney University. This non-for-profit organisation, that provides state wide reproductive and sexual health services to the community, including priority populations such as migrant and refugee women, had observed women from certain migrant or refugee communities were not accessing sexual and reproductive health

services. As a leading sexual and reproductive health service provider, and a low-cost public service, they were concerned as to why these communities were not accessing the available services, but were unsure as to why. Consequently, in collaboration with the Western Sydney University, the research team undertook a literature review in order to establish possible explanations for this absence. It was evident early in the review process there was a significant lack of research in this sphere, and thus further research was needed. At this point two pilot research projects were undertaken to explore cultural constructions and experiences of sexual and reproductive health amongst Karen and Assyrian migrant and refugee women (Ussher et al., 2012), as well as young migrant Muslim women living in Australia (Wray et al., 2014). Funding to complete a larger project to explore sexual and reproductive health with women across a number of differing cultural groups was then acquired through the ARC Linkage grant, as detailed above. As outlined at the beginning of the introduction, Canada and Australia were selected as the geographical site for the research as they are similar geographically, economically and politically and have similar migrant and refugee populations.

As a PhD student embedded within this project, I have been heavily involved with all facets of the research from the start of my candidature. While I did not have a role in establishing the design of the project or acquiring ethics approval, I did contribute to the refinement of the interview schedule, recruitment of participants and community interviewers, data collection, coding, analysis and dissemination of our research findings to both academic and non-academic audiences. While bilingual community interviewers interviewed women who did not speak English, I conducted 29 individual interviews and five focus groups (n = 16), with women in Australia who had conversational English or who did not want to be interviewed by a member

of their community. In addition, at the end of the data collection phase, I interviewed community interviewers, in both Australia and Canada, in relation to their experiences of being involved on the project (n = 10). Although this latter data is not presented in this thesis, it has informed my analysis, and my reflexive understanding of the interview process. I integrity checked all data I had collected and supported the project's research officer to complete integrity checking of the data collected by the community interviewers. In conjunction with the research officer, I developed the overall coding framework to code the data, which was later refined by the whole research team. I then coded approximately half of all the data collected for the project, and took the lead in summarising the whole data set into a coding summary document (explained further on). Following this, I distinguished areas of the research project I believed would contribute to filling an identified gap in the literature, but also told a narrative of women's sexual and reproductive health across aspects of their reproductive lifespan. The areas were menarche and menstruation, premarital sexuality, and sexual agency within marriage, as well as fertility and fertility control. I individually analysed and wrote up the data in relation to these topics. My supervisors, Professor Jane Ussher and Professor Janette Perz made critical comments on my written analyses, presented as four academic manuscripts to form the results sections of this thesis (Chapters Three to Six).

Reflexivity in the Research Process

Increasingly in qualitative research, researchers are seeking to acknowledge the situated nature of their research through a process of reflexivity (Berger, 2015; Finlay & Gough, 2003). Reflectivity requires critical self-reflection, or self-awareness, into the ways in which a researcher's social background, assumptions, positioning and behaviour may shape the research process as a whole (Finlay &

Gough, 2003; R. Shaw, 2010). It also includes transparency in decision making at a number of levels: the personal, methodological, theoretical, ethical and political (Engward & Davis, 2015). The process of being reflexive is also interlinked with the intersectional theoretical framework drawn on in this study. Central to intersectionality, which is described below, is consideration for how our own intersectional identities as researchers relate to other team members, as well as how our own perspectives and positions may shape aspects of the research process (N. Clark et al., 2009).

There are a number of contrasting perspectives and contested terrains in relation to how reflexivity is mobilized and defined (Pillow, 2015). While feminist qualitative research values reflexivity and emphasises the need to be reflexive, some researchers are critiquing the way in which it is being carried out (Pillow, 2003 & Gill, 1995). For example, Pillow (2003) states that reflexivity is often positioned as a means to solve problems of voice, power and representation of the researcher and the researched, a method to get more 'valid' data. The way I have aimed to use reflexivity in my research is not to validate my analysis or findings, but an approach to acknowledge and be accountable for the research methods and data analysis employed in this study. Threaded throughout this thesis, I consider the ways in which my own subjectivity, as outlined in the Preface (e.g. White/Anglo, Western, educated, middle-class woman), may have shaped the research process and analysis of data. Where relevant, I also describe reflexive processes that occurred between my supervisory panel and me, and the broader research team.

Establishing the Research Team, Refining the Project Design, Aims and Methodology

The wider research team consisted of White women, and women of colour; women who had migrated and those born in Australia and Canada. It included academic researchers and women from our community partners (FPNSW and CMRC), who work with migrant and refugee women. The bilingual community interviewers and multicultural community members working at CMRC also became an integral part of the research team. This diverse team was established prior to data collection to gain input on the development of the research proposal, research design and methodology, to seek guidance surrounding the interview schedule and to gain cultural insights into the possible barriers and facilitators to research with recent migrant and refugee women.

This process of close collaboration was undertaken as academics on the team reflected on the limitations of designing and rolling out a research program without members of the multicultural community or those in close contact with migrant and refugee women. For example, although members of the research team were migrants, our paths to migration were by choice, many are also Anglo/Caucasian and English speaking. Hankivsky et al. (2010) argue intersectional scholars need to work alongside a variety of stakeholders to undertake research that results in social change. Such an approach is essential to ensure the direction of the project reflects the needs of newly arrived migrant and refugee women and facilitates research that is inclusive, culturally appropriate and undertaken in a respectful manner. It is also a vital step in ensuring the possibility of knowledge translation (Graham et al., 2006), with meaningful outcomes for migrant and refugee women, as well as health care professionals or other community members working in this sphere.

Research Design

A qualitative research design, using semi-structured interviews and focus groups, was utilised to examine constructions and experiences of sexual and reproductive health amongst recent migrant and refugee women living in Australia and Canada. Seventy-eight individual interviews and 15 focus groups (n =82) were conducted between July 2014 to November 2015 in Sydney, Australia and Vancouver, Canada.

Given the sensitive nature of the research topics selected for this project, individual interviews offered participants the opportunity to elicit personal information about their thoughts, feelings and experiences, which they may have felt uncomfortable disclosing in a group environment (Liamputtong, 2007). To complement the interviews, focus groups provided a synergistic group environment in which insights into cultural and community norms could be explored (Creswell, 2009). Focus groups have also been utilised in cross-cultural research to cover sensitive topics including suicide (Colucci, 2008) and refugee women's reproductive health (Allotey et al., 2004).

Theoretical Paradigm: Critical Realism and a Material-Discursive-Intrapsychic Framework

This thesis draws on a material-discursive-intrapsychic analytical framework (Ussher, 2000, 2008), situated within a critical realist epistemological approach (Bhaskar, 2011). A critical realist approach recognises the materiality of somatic, psychological, and social experience, but conceptualises such materiality as being mediated by culture, language, and politics (Bhaskar, 2011). Critical realism falls between the opposing ontological positions of realism and constructionism (Bhaskar, 2011), collapsing the dichotomy in the social sciences between realism and relativist

discursive forms of knowledge (Parker, 2002). In other words, materiality is not reducible to discourse, or without meaning unless interpreted discursively; rather, "material practices are given an ontological status that is independent of, but in relation with, discursive practices" (Sims-Schouten, Riley, & Willig, 2007, p. 102).

Given critical realism accepts there is a material dimension to our lives, which is at least partially non-discursive (Sims-Schouten et al., 2007), within this thesis I draw on this approach to acknowledge material factors of women's bodies and lives such as menstruation or experiences of sexual pain. However, I acknowledge and explore how women negotiate and make sense of such materiality in the context of the discursive constructions of femininity, sexuality, and the reproductive body, located in their particular social, cultural and relational milieus (Ussher, 2010). While critical realism is arguably flexible across a number of different research methodologies, including qualitative and mixed-methods research, this epistemology aligns well with the research aim to understand women's constructions and experiences of sexual and reproductive health within a qualitative research design.

In these next sections, I first discuss what is meant by discourse. I then provide further detail on the material-discursive-intrapsychic theoretical framework and how it is utilised in this thesis. Finally, I discuss intersectionality and how this framework will be drawn on throughout the data analysis.

A closer examination of language and discourse.

It is through language that different meanings to any one event, person, action or thought are communicated (Burr, 2015). In other words, through what is being said, written, or otherwise represented, we are able to 'construct' the phenomena of our world for us (Burr, 2015). In this thesis, 'discourse' refers to these differing ways

of representing the world and denotes a set of meanings, representations or statements that shape a specific version of events (Burr, 2015). Discourses are not fixed however, rather they are historically and culturally specific as well as constantly changing (Foucault, 1972). Discourses are intimately linked to institutional and social practices and thus have significant implications on how we live our lives, shaping what we can do, and what we should do (Burr, 2015, p. 87). For example, dominant discourses of femininity commonly construct women as empathetic, caring, as nurturers and emotional, these qualities are thus frequently associated with 'expected' feminine behaviour. Discourses are often multiple, and may offer competing, contradictory ways of giving meaning to the world (Gavey, 1989). However, each discourse offers different 'subject positions' that a person may take up, shaping the 'possibilities' of constituting subjectivity – one's identities, behaviours, and understandings of the world (Davies & Harré, 1990; Gavey, 1989, p. 464).

The work of theorists such as Michel Foucault has been influential in how we view discourse, subjectivity and power (Foucault, 1972). For example, Foucault argues that 'disciplinary power' regulates human life by controlling individual subjectivity and everyday practices (Foucault, 1975). Such regulation comes from institutions, but also from the individual, through means such as self-observation, measurement, reward, and punishment if one does not conform (Gavey, 2005). It is also argued that while dominant discourses do constrain human behaviour in certain ways, individuals are not passive subjects situated within discourse (Foucault, 1976; Gavey, 1989), but that "discourse can both be an instrument and effect of power…a hindrance, a stumbling-block, a point of resistance and a starting point for an

opposing strategy" (Foucault, 1976, p. 101). In light of this, people can take up, resist, reject or challenge discursive constructions of any phenomena (Gavey, 1989).

In view of these concepts, to understand how women construct and experience their sexual and reproductive health, this thesis explores the discursive constructions that migrant and refugee women draw on to make sense of their sexual and reproductive health. In this thesis I consider the ways migrant and refugee women negotiate certain subject positions in relation to discourses, including how they may variably take up, resist or put-upon others certain subject positions made available through discourse; and the consequences of such positioning on women's sexual and reproductive health and subjectivity.

A material-discursive-intrapsychic analytical approach.

The material-discursive-intrapsychic analytical framework (Ussher, 2000) was developed in response to a call for greater recognition of the 'extra-discursive' aspects of experience within constructionist research (Burr, 1999; Ussher, 1997a). Material-discursive-intrapsychic and material-discursive approaches align with critical realism by moving away from the mind-body binary divide (Yardley, 1999) and considering the material, discursive and intrapsychic aspects of an experience to be equal and interrelated (Ussher, 2008).

Within a material-discursive-intrapsychic theoretical approach, materiality encompasses "…factors that exist at a corporeal, societal, or institutional level factors that are traditionally at the centre of biomedical or sociological accounts" (Ussher, 2000, p. 219). Within this thesis, this includes acknowledging the materiality of the bleeding body at menstruation, and women's embodied experience of sexual pain or infertility. Exploring the discursive aspects of women's sexual and reproductive health thus involves understanding the "…social and linguistic

domains" (Ussher, 2000, p. 219) of women's talk. Acknowledging the discursive aspects of women's talk then involves exploring the way women construct aspects of their sexual and reproductive health, and their gendered subjectivity. This could include examining the cultural and social meanings associated with menarche and menstrual blood, infertility, or the role of wife. For example, what does it mean for a woman within her cultural context to have a menstruating body at menarche? Or what does it mean to be a 'good wife' in terms of sexual relationships? The intrapsychic factors of this theoretical framework are those that "…operate at the level of the individual and the psychological" (Ussher, 2000). For this thesis, this could include examining the impact of menarche and menstruation on how women feel about their reproductive bodies, the negotiation of menstrual shame, anxiety or embarrassment, how women feel about communicating about sex, and the psychological consequences of experiencing sexual pain, unintended pregnancy or infertility.

While each level of analysis can be described separately, a material-discursive-intrapsychic theoretical approach provides a framework to explore each 'level' of analysis, their interrelatedness, as well as their resulting possibilities or restraints for women's subjective experiences (Ussher, 2000). This framework is thus well suited to this research and has been drawn on in other research areas that examine women's health including: experiences of sexuality after cancer (Gilbert et al., 2011), experiences of depression (Ussher, 2011), maternal experiences (Winstanley, 2005), premenstrual syndrome (King & Ussher, 2013; Ussher & Perz, 2013) and women's health interventions (Erskine et al., 2003).

Intersectionality

Throughout this thesis, I also draw on an intersectional framework. Intersectionality is compatible with critical realism and a material-discursive-intrapsychic approach as it recognises the materiality of intersecting social identities, such as social class, gender or age, and acknowledges that how they are made sense of, or experienced, is dependent on the way in which they are constructed within a specific cultural and historical context. The theory of intersectionality emerged as a consequence of the black feminist movement in the 1980's (P. Collins, 1999). The term, originally created by Kimberlé Crenshaw, challenged the notion of a universal gendered experience for Black women during this period (Crenshaw, 1989). More recent developments of intersectionality focus on the interaction and mutually constitutive nature of gender, race, religion, age, and other categories of difference in individual lives and social practices (Davis, 2008, p. 68).

Intersectionality can be applied to feminist and non-feminist based research, having been employed to analyse a range of complex social processes including classism, ageism, ableism and xenophobia (Carbado, 2013). It has also recently been applied to quantitative research. For example, Swank and Fahs (2013) used logistic regression to examine how race, gender and other key factors, such as experiences of hate crime, inspired activist movements amongst gay and lesbian people from the U.S. It is argued that intersectionality can be used across both quantitative and qualitative methodologies, as both methods can benefit from understanding how responses from individuals reflect the identities that form them (Grzanka, 2018 p.98).

An intersectional perspective argues that theorists must consider the impact of more than a single identity or typical category of analysis (e.g. gender) in women's experiences to identify how the collective impact of simultaneous social

identities (e.g. culture, race, sexual identity, gender) effect oppression and domination (Hankivsky, Cormier, & De Merich, 2009; Varcoe et al., 2007). Thus, intersectionality moves away from an additive approach of single variables to form an experience that can be grouped or labelled and considers an experience or identity in the light of multiple influential factors continuously interacting (Bowleg, 2008). Intersectionality recognises that analyses of single determinants independently are insufficient as these social positions are experienced simultaneously (Viruell-Fuentes, Miranda, & Abdulrahim, 2012).

As argued by Carbado (2013) however, intersectionality is not an effort to identify an "exhaustive list of intersectional social categories" that are added up to determine "the different intersectional configurations those categories can form" (p.815). Similar sentiments are expressed by Salem (2016) who warns that despite intersectionality having roots imbedded in Black and Third World feminism, it's adoption in mainstream feminism today has resulted in it becoming watered-down and a 'catch-all' for diversity. She calls for analysis that not only considers the intersection of identities, but also examination of structural inequalities and power relations, as these are the contexts in which such social identities are constituted (Salem 2016 p. 12).

There is increasing recognition of the complex and multidimensional factors associated with social identities and how they intersect to impact on the health of migrant and refugee women (Guruge & Khanlou, 2004; Pittaway & Bartolomei, 2001). For example, intersectionality has been drawn on to explore how mental illness among poor Latina migrant women affects their relationships and likelihood of engaging in high risk sexual behaviour (P. Y. Collins, von Unger, & Armbrister, 2008). Exploring different domains of migrant women's lives through the adoption

of an intersectional framework has also facilitated in contextualising low uptake of HPV vaccination among young Somali migrant women (Salad et al., 2015), as well as deeper understandings into young African migrant women's experiences of teenage pregnancy following migration to Australia (Watts, Liamputtong, & McMichael, 2015). In this thesis, intersectionality is drawn upon as a framework to explore differences across varying domains of women's lives such as cultural or religious groups without minimising shared values, beliefs and experiences (Guruge & Khanlou, 2004). Drawing on such a lens is more likely to facilitate understanding into the interlocking factors that affect women's experiences of sexual and reproductive health and give rise to knowledge that can be translated into meaningful healthcare outcomes for women's sexual and reproductive health and wellbeing (Varcoe et al., 2007)

To summarise my theoretical approach; a material-discursive-intrapsychic theoretical model aligns with a critical realism epistemology and will be utilised to capture women's experiences without privileging the discursive over the material or intrapsychic aspects of women's experience. Within this epistemological and theoretical paradigm, to acknowledge women's homogeneity, an intersectional approach will facilitate understanding into the way that differing sociocultural backgrounds and identities shape women's subjective experiences of sexual and reproductive health.

Participants

A total of 160 women took part in the study. Participants were women between the ages of 18-70 years old, with a mean age of 35 years. Participants were recent migrant or refugee women who were born in and had migrated from Afghanistan, Iraq, Somalia and Sudan. Sri Lankan (Tamil) and South Sudanese

women were included in the Australian context and South America (Latina) women in Canada. The term Latina is often used to described women with roots from Latin America. In this study Latina participants came from a number of different countries including Mexico, Columbia, Puerto Rico, El Salvador, Peru, Cuba and Chile. An additional group of women from India (Punjabi) were interviewed as part of the wider research project, however as this data had not been collected when I started analysis, this data is not included within my thesis. The average time since migration to Australia or Canada was seven years.

With the exception of one Latina woman who disclosed being in a same sex relationship, all participants identified as being heterosexual. Most participants were currently married, or had been married (n =123), 37 women were single at the time of the interview. A Western definition was used to define marriage and assumed a legal or formally recognised union between two individuals. Participants predominantly followed Islam (n = 112), Christianity (n = 33) and Hinduism (n = 7). One participant was Buddhist and seven described not practising any religion, the majority of which were Latina women (n = 6). Most participants had received at least some primary school education, with six participants stating that they had received no formal education at all.

Specific cultural backgrounds examined in this study were chosen in consultation with our community partners, organisations who provide sexual and reproductive health and migration support to migrant and refugee populations. The cultural groups selected were identified as being absent within existing sexual and reproductive health services, despite making up a significant proportion of newly arrived migrant and refugee women. Further, groups selected were underrepresented in prior sexual and reproductive health research, which in Australia has focused on

South East Asian women (P. W. Garrett, Dickson, Whelan, & Whyte, 2010). Given Western Sydney University aims to conduct research that services communities in this area, participants in Australia were selected from Western Sydney, a major region of Sydney, New South Wales, which is made up of nine local government authorities. This region is typically of lower socio-economic status compared to greater Sydney (ABS, 2018) and has suburbs with a high density of migrant populations (ABS, 2014). As a whole, Vancouver is a very culturally diverse city with migrants representing 40.8% of the total population (Statistics Canada, 2017). Participants in Vancouver were largely recruited from organisations located in East Vancouver and Greater Vancouver; areas known for their cultural diversity.

Although route of migration was not explicitly collected, due to the political sensitivity of the topic, most participants arrived in Australia and Canada on humanitarian visas. This information was noted during interviews where women discussed transnational migration through countries that frequently host refugees (for example, Kenya and Jordan), periods in refugee camps or detention centres, and experiencing war or severe hardship prior to migration. Table 1 below provides further breakdown of demographic information according to participant's cultural background.

Recruitment: Accessing Migrant and Refugee Women

We recruited for migrant and refugee women 18 years and over who had settled in Australia or Canada in the last 10 years from Afghanistan, Iraq, Somalia, Sudan, South Sudanese, Sri Lanka and Latin America. Our strategy for recruiting women between 18-45 years old was based on the assumption that these women were more likely to need to access sexual and reproductive health services, although we did not

Table 1

Sample sociodemographic characteristics

Variable/Group	**Afghani**	**Iraqi**	**Latina**	**Somali**	**South Sudanese**	**Sudanese**	**Tamil**
	(n=35)	*(n=27)*	*(n=17)*	*(n=38)*	*(n=11)*	*(n=20)*	*(n=12)*
	M(SD)	***M(SD)***	***M(SD)***	***M(SD)***	***M(SD)***	***M(SD)***	***M(SD)***
Age	31.4 (9.1)	38.7 (12.5)	37.1 (5.6)	31.9 (10.4)	36.6 (6.2)	38.7 (7.5)	36.8 (7.3)
Years since migration	5.1 (4.1)	4.3 (2.1)	8.3 (4.9)	5.4 (3.1)	10.8 (2.1)	8.9 (3.4)	5.1 (2.5)
Number of children	3.3 (1.3)	2.7 (1.2)	1.5 (0.7)	3.7 (2.0)	4.5 (2.2)	2.9 (1.1)	2.1 (0.5)
	n (%)	***n (%)***	***n (%)***	***n (%)***	***n (%)***	***n (%)***	***n (%)***
Have children							
Yes/pregnant	20 (57.1)	20 (74.1)	11(73.3)	23(60.5)	11 (100.0)	19 (95.0)	11(91.7)
No	15 (42.9)	7 (25.9)	4 (26.7)	15(39.5)	-	1 (5.0)	1 (8.3)
Religion							
Islamic	35 (100.0)	23 (85.2)	-	38(100.0)	-	16 (80.0)	-
Christian	-	3 (11.1)	10 (58.8)	-	11(100.0)	4 (20.0)	5 (41.7)
Buddhist	-	-	1 (5.9)	-	-	-	-
Hindu	-	-	-	-	-	-	7 (58.3)
Non-practising	-	1 (3.7)	6 (35.3)	-	-	-	-
Education							
Primary	7(20.0)	6(22.2)	-	8(21.1)	3(27.3)	4(20.0)	-
Secondary	15(42.9)	3(11.1)	2(11.8)	3(7.9)	2(18.2)	5(25.0)	7(58.3)
Tertiary	6(17.1)	18(66.7)	10(58.8)	3(7.9)	2(18.2)	10(50.0)	5(41.7)
Nil	2(5.7)	-	-	1(2.6)	2(18.2)	1(5.0)	-
Other	1(2.9)	-	-	2(5.3)	2(18.2)	-	-
No response	4(11.4)	-	5(29.4)	21(55.3)	-	-	-
Relationship status							
Married/de-facto	17 (48.6)	14 (51.9)	13 (76.5)	13(34.2)	6 (54.5)	13 (65.0)	12(100.0)
Single	12 (34.3)	7 (25.9)	2(11.8)	14 (36.8)	1 (9.1)	1 (5.0)	-
Divorced/separated	2 (5.7)	5(18.5)	2(11.8)	8 (21.1)	4 (36.4)	6 (30.0)	-
Widowed	4 (11.4)	1 (3.7)	-	3 (7.9)	-	-	-

exclude women who responded to a study invitation or volunteered for an interview or focus group, based on their age.

Given the increasing number of migrant and refugee women arriving in Australia and Canada, we focused on new migrant and refugee women as they are more likely to be influenced by norms, beliefs and practices from their countries of origin, compared to women who may have migrated many years prior to the research. As discussed in the introduction, new migrant and refugee women are also less likely to access health services and have poorer health outcomes.

Women were recruited to participate in this study through a variety of methods. Firstly, flyers for the research (in English and the first languages of participants) were displayed in migrant community centres, sexual health clinics and at one university campus in Sydney (See Appendix A for English version). These methods garnered minimal interest to participate in the research. This was not surprising as although the flyers had been translated into participant languages, they detailed the study was interested in discussing sexual and reproductive health. Given the sensitive nature of this topic, publicly viewing the advertisement may have been seen as inappropriate, let alone taking down details of the study and willingly contacting the researchers. Following the poor response to the advertisement flyers, our recruitment strategies changed direction.

As previous research recommended (Watts & Liamputtong, 2013), the research officer and I engaged with our partner organisations and community interviewers and requested assistance with recruitment. We provided community support workers, who were employed by the migrant resource centres and the community interviewers, with flyers and participant information sheets for the research, and asked them to distribute them throughout their client/peer networks. We also asked community interviewers if they knew of any women in their community who would be willing to participate. Following this, we requested that

should a client or member of their community be interested in participating in an interview or focus group, that they take note of their contact details and gain permission for them to be contacted by either the research officer or me. This method proved the most fruitful and reflects the important nature of connecting with community members or “cultural brokers" for effective recruitment (Eide & Allen, 2005). It also suggests potential research participants want to identify a common person who they themselves know, and who is familiar with the researchers, as a means to check the researcher’s credibility and trustworthiness (Liamputtong, 2008).

In addition to this, I visited an existing migrant community group that meet on a regular basis. I used this as an opportunity to introduce myself and talk to potential participants about what was involved in the study. This was also an opportunity to provide written information including research flyers and participant information sheets. I returned the following weeks to undertake interviews with the women who were willing to participate. I also engaged with community contacts I had made through volunteering at an organisation that provides literacy support for refugee women. They facilitated the distribution of study materials and obtaining details of women who were interested in participation. Once I started to complete interviews, a snowball method also facilitated recruitment (Braun & Clark, 2013). This occurred by me asking participants who had completed an interview if they had any friends or family members who might feel comfortable undertaking a similar interview. If they said they did, I asked them to contact this person, pass on information about the study, ask if they were interested in participation and gain permission for their details to be passed on to me to contact them. Such method is often used in sensitive research with migrant women, as it allows researchers to recruit women who are traditionally from ‘hard-to-reach’ communities

(Liamputtong, 2013). However, to maintain confidentiality participants were not asked to disclose their involvement in the study to potential participants. We continued recruitment until saturation was reached; whereby we could identify replication of key themes across each cultural group in relation to the research questions, and where few original contributions were arising from data (Charmaz, 2006).

Research Procedure

Overarching ethics approval to conduct this study was granted from The University of Western Sydney (H10352 13/011669). Please see Appendix B for letter of approval. Simon Fraser University (2013s0602) and Family Planning NSW (R2014-01) provided reciprocal approval.

Community Interviewers

In cross-cultural research, the use of bilingual interviewers is described as 'critical' (Hennink, 2008). Bicultural researchers were utilised in this study as a means to overcome potential language barriers as they spoke the language of participants and shared social and cultural similarities with participants (Liamputtong, 2013). It has been argued that community interviewers are in a better position than monolingual researchers working with interpreters to conduct cross-cultural research as they have deeper knowledge of the people, and the issues that may be present in their community (Shklarov, 2007). The utilisation of community interviewers, also meant there was less likely to be a distortion in the data which may occur as a consequence of language difficulties (Shklarov, 2007), such as that which often occurs with the use of interpreters. This methodology has also been successful in past qualitative health research with migrant women (Morrow, Smith, Lai, & Jaswal, 2008).

The community interviewers were recruited specifically for this project, through our partner organisations and community networks. All were women and all were migrants or prior refugee women themselves, who had high school or a tertiary education. While no community interviewers had previous experience in undertaking qualitative research, many had experience working as professional translators. As recommended (Liamputtong, 2013), prior to commencing data collection, in both Canada and Australia, the women received a one-day interview-training workshop facilitated by the chief investigators on the project (Professor Jane Ussher and Professor Janette Perz). During this workshop, which I attended and participated in (Australia), we discussed the interview schedule to be used in this research, how to conduct conversational interviews, such as the importance or probing and follow-up questioning, and how to transcribe data. We also practised individual interviewing techniques with the women and simulated a focus group discussion. Community interviewers were also given information in relation to ethical conduct of research and how to be responsive to the needs of their participants.

Each community interviewer conducted approximately five interviews and for most, one or two focus groups. In a small number of focus groups in Australia, while I ran the group, the community interviewer was present to translate any concepts that may not have been clear in English. The community interviewers were provided with ongoing support and advice from the research team throughout the data collection process. This included frequent contact or 'checking-in' from the research officer and I in relation to how women were progressing with their interviews. Professor Jane Ussher also reviewed and commented on the early transcripts from the interviewers, giving them further advice in respect to where questions could be better followed up, or ideas expanded on. The frequent contact

and team environment fostered a warm and helpful setting that facilitated positive experiences for the women involved in the project data collection.

It is important to acknowledge however, the community interviewers themselves were women of migrant/refugee backgrounds, some of who had large families of their own to support as well as juggling fulltime work while assisting with the project. Therefore, during the research period, providing flexibility for community interviewers was critical. For example, consideration was made for women who returned to their home countries to visit family, where women had unexpected changes in housing situations requiring more time to conduct interviews, and where religious events such as Ramadan made talking about sex inappropriate during the data collection period.

The Interview Procedure

The majority of participants (n =115) were interviewed in their first languages by trained community interviewers, which were women of the same ethnic background (n = 9), or who spoke the same languages as participants (n = 3). As described earlier, I completed the remaining interviews. While all community interviewers completed their interviews face-to-face with participants, I gave my interviewees the option of completing interviews either face-to-face (n =20) or via the phone (n = 9).

There is some research literature that considers interactional differences between semi-structured qualitative interviews conducted by telephone or face-to-face (Irvine, Drew, & Sainsbury, 2013; Sturges & Hanrahan, 2004). Similar to past research however (Sturges & Hanrahan, 2004), no discernible difference in the content of the interviews undertaken either by phone or face-to-face was noted. While the content did not differ, I found the face-to-face interviews more appropriate

in instances where women had difficult accents as I could draw on other forms of visual communication such as eye contact, facial expressions and body language to make sense of the context. In face-to-face interviews, women, at times, would also show me objects related to the discussion such as photos or traditional incense used in ceremonies. Being present face-to-face also enabled me to build rapport with the women more quickly and this may have facilitated greater comfort in discussing topics that are more sensitive. It also allowed for flexibility in the interviewing style. For example, we could stop and address the needs of children, or women could breastfeed during an interview if needed.

For individual interviews, to help reduce the power dynamic between participants and me as a researcher, I asked participants to elect an appropriate venue to carry out the interview, which were most commonly participant's homes and libraries. Focus groups took place at a convenient location all participants were able to travel to, these included quiet rooms for hire at community centres, migrant resource centres and local libraries.

Prior to the interviews, I would often talk to participants on the telephone, two or three times to organise a time and date, confirm the interview the day before it occurred and to reschedule if a participant couldn't make the original time or date. This gave me the opportunity to chat and get to know women somewhat prior to the interview. Sometimes I had to reschedule interviews a number of times due to a change in participant's parental circumstances or work shifts and I feel these opportunities to communicate prior to the interview facilitated a greater level of comfort and trust leading into the actual interview.

Before commencing the interviews, I reiterated to participants the structure of the interview, the topics being covered and described the interview process as being

more of a discussion than a 'survey'. At this point I also reassured participants if they came across a question which they did not want to answer to "just tell me I don't want to answer this question, let's move on." Only in two instances, once in a focus group and once during an interview did participants state that a topic was "too sensitive" or "private", in which case we promptly moved on to the next question. This did not appear to make the participants uncomfortable and was disclosed in a light-hearted manner; it also did not seem to impact on the data collected following this point. Both were in relation to sexual intimacy with their husbands, and thus, given the taboo nature of sex talk, reported in Chapter Five, it was not surprising. I also advised participants if they did not feel comfortable talking about their own personal experiences they could draw on broader cultural practices and understandings as an alternative. I then reminded participants they could withdraw from the study at any time without providing a reason. This did not occur in any of the interviews I conducted. In one instance however, after completing an interview with a community interviewer, a participant requested to have her interview recording deleted as she no longer wanted to be involved in the study. The interview data was immediately revoked.

Before the commencement of each interview or focus group, participants received a participation information statement (PIS) (Appendix C and D) and a consent form (Appendix E). In a small number of cases, where it was inappropriate to send documents relating to a study on sexual and reproductive health to women's houses or emails, this information was given verbally. Given the PIS and consent form were in English, prior to beginning the interviews I discussed each point on the consent form with participants, and the content in the PIS statement, giving an in-depth description about what was involved in the study. I described the study

purpose and aims, topics to be covered, what consenting to the study involved, reassurance of confidentiality, and answered any questions participants may have had about the study. This took up to 20 minutes at times, and was a process I never rushed as I deemed it very important to women's understanding of what participation involved; it also facilitated in establishing a two-way communication channel which I feel helped to establish an open and honest relationship with participants (Liamputtong, 2008). Written informed consent or verbal consent (which was digitally audio-recorded) was gained from all participants. Consent was also given by all participants to audio-record interviews and focus groups, with the exception of one interview where the participant declined to be audio recorded; in this instance I took extensive notes instead.

Interviews and focus groups lasted on average 90 minutes. The interview schedule (See Appendix F) was piloted with women who were members of the participant's community who worked at CMRC. While they acknowledged the sensitive nature of the topics in the schedule, they felt it was appropriate and important to include all questions. It was also piloted with four interviews and refined to enhance the relevance and accessibility of questions. While the interview schedule remained relatively consistent across interviews and focus groups, there was some personalisation of questions asked, based on factors such as marital status, and whether or not FGM was practised within that participant's community, for example. The interviews began with asking demographic questions including: country of birth, age, marital status, religion, number of children, countries of residence prior to migration and educational history. Following this, the first topic of conversation was surrounding menarche and menstruation. We intentionally placed this topic first, to build rapport and comfort with participants surrounding the

discussion of sexual and reproductive health issues, as menstruation is a topic more easily discussed compared to topics surrounding sexual relationships, which were to follow. Subsequent questions were on fertility, relationships, sexual pleasure, sexual pain and desire, sexual health; including STIs and cervical cancer, FGM, changes in sexual and reproductive health in relation to migration, experiences of accessing sexual and reproductive health care and recommendations for sexual and reproductive health service delivery. The extensive interview schedule reflected the requests for topics to be covered from project stakeholders, in addition to addressing gaps in the existing literature that were identified by the research team.

Throughout the interview process, the line of questioning was not always unilateral. At times participants had questions about my cultural background, whether or not I practised certain rituals surrounding menstruation, for example. Given questions were not sensitive in nature, I felt comfortable answering them and felt that it was appropriate to do so. A few participants also had questions surrounding problems they were having, or specific concerns they had in relation to their sexual and reproductive health. If these were going to lead to more lengthy discussions, I asked participants if they felt comfortable completing the interview and addressing their concerns at the end of the interview. At the end of the interviews and focus groups, I would then address questions that had previously been brought up, however, when providing advice to participants I would always remind them I was not a health professional and provide them with details about where to access resources. For questions I could not answer, such as how to get assistance with employment, where possible, the research officer and I would find resources and get back to the women.

At the end of each interview or focus group, I would often debrief with participants, asking them how they felt, what they thought of the interview and whether they had any further questions. Community interviewers were provided with written pamphlets and resources, covering a broad range of topics to provide for women if requested or deemed appropriate. Each participant was gifted a $25AUD/CAD supermarket voucher as a token of appreciation for participating in the research and to compensate for any travel costs to get to the interview.

Analysis of Interviews and Focus Groups

The data for this thesis was analysed using a process of thematic decomposition, drawing on a material-discursive-intrapsychic and intersectional analytical theoretical framework, situated within a critical realist epistemology. As a part of analysis, the interview and focus group data first required transcription and integrity checking. Data was then organised through a process of coding to facilitate thematic decomposition analysis. I now provide details of these processes in the following sections.

Translation and transcription.

Community interviewers transcribed and translated interview and focus group audio-recordings that were conducted in the participant's first language. Interviewers in Canada orally translated their interviews, which were then sent for professional transcription. Community interviewers in Sydney found it easier to listen to the audio-recordings and then translate them straight into written English. Transcripts translated by the community interviewers were reviewed for minor spelling or grammatical errors, but were otherwise left unedited. Most interviews and focus groups conducted by me in English were professionally transcribed verbatim. However, the first four interviews I transcribed myself, as a means to connect with

the data and start to recognise opportunities where greater follow-up could have occurred. These transcripts were also reviewed by my primary supervisor who provided critical feedback prior to continuing with data collection.

One of the major issues of professional transcription was that they came back with multiple miss-transcribed sentences, missing words and large sections labelled 'inaudible'. This was because many of the women I interviewed had strong accents, and at times spoke very quickly. For longer interviews which were around 50-60 pages it took me two to three days to complete integrity checking each interview; stopping, rewinding, listening, amending, re-starting. Although this process was extremely time-consuming, this was an important step to make sure I captured women's accounts as accurately as possible. I also felt that it aided in me becoming very close to the data set as I used it as an opportunity to get familiar with women's accounts, by taking notes and writing memos surrounding interesting sections of data. These notes and reflections helped to later inform my initial analysis of the data.

Thematic decomposition

Data was analysed using thematic decomposition (Stenner, 1993; Stenner, McFarquhar, & Bowling, 2011). This form of discourse analysis identifies themes—that is, commonality in patterns or stories across the data—and then considers discourses and subjectivity in participants' accounts associated with such themes (Braun & Clarke, 2006). As stated by Stenner (1993), in thematic decomposition we look at how individuals "draw upon numerous, often contradictory and competing stories, within which they position themselves" (p. 131). This analytical approach first required the data be coded and organised according to themes or patterns within data. Following this, a second level of analysis occurred in which discourses and

participant subject positions were explored, as well as their implications for subjectivity and sexual and reproductive health practice. Below I provide a detailed outline of the steps involved in the first and second level of analysis.

The 'first level' of analysis: The coding framework and development of themes.

Halfway through the process of data collection, the initial stages of analysis began. To begin the process of becoming familiar with or immersed with the data (Braun & Clark, 2013), a random subset of participant transcripts were individually read and re-read by the research officer and I. Following an initial reading of the transcript, as recommended (Bazeley, 2013; Braun & Clark, 2013), transcripts were then re-read line-by-line in close detail, with hand written notes added to capture relevant concepts or 'codes' coming from the data. Given we were undertaking inductive analysis, whereby the development of the themes is driven by the data and less by existing theory, research, or hypothesis (Braun & Clarke, 2006), this process was comprehensive and inclusive. Known as semantic codes, these first order codes were mostly descriptive and reflected the semantic content of the data (Braun & Clarke, 2006). Examples of first order codes are concepts such as "menstrual learning from mother", "communicating sexual pleasure", "inability to say 'no' to sex" and "fear of contraceptive side effects".

The research officer and I then came together again to resolve any differences across our allocation of first order codes. For example, where I may have defined a section of text in relation to contraception education as "learning about contraception at school", the research officer defined this as "formal contraception learning". Through a process of discussion and decision-making with the research team, we then grouped first order concepts where commonalities occurred, making a smaller

number of more distinct categories. We also added concise overarching or higher order codes, such as “menstrual knowledge” or “sexual pleasure and desire”, under which first order codes sat. This process of discussion and collation allowed for both the refining of codes, and definition of what data should be included within each code to ensure consistency. The parallel process of data collection and coding also allowed us to distinguish when we had reached data saturation. Having formulated the coding framework, transcripts were then imported into NVivo (Version 11), a software program that facilitates the electronic organisation of qualitative data into the relevant codes. After applying the coding framework to nearly half of the data set, we made minor changes to the framework, whereby a small number of codes were further collapsed due to an overlap in concepts when coding the data.

Coding the whole data set was an ongoing and continuous process of discussion and refinement. If the research officer or I were unsure about where to code a certain section of data, we would consult with one another, as well as with my supervisor, who oversaw this process and checked transcripts and the coding framework for consistency. The overall project-coding framework can be found in Appendix G. Table 2 below depicts the coding framework I extracted to facilitate my data analysis.

Once coding of all data was complete, each of the coded sections was summarised within a coding summary. Developing the coding summaries first involved reading the transcripts line by line and extracting brief statements or small snippets of quotes that identified what had been said. This information was then put into a table noting what had been said by which participant/s or focus group, and marking the participant with the most illustrative quotes with an asterisk.

Table 2

Coding framework

Menarche and Menstruation	Construction and meaning of menarche	*Becoming a woman*
		Developing bodies
	Menarche experience	*Experiences of first period*
		Celebration and rituals
	Menstrual knowledge	*Menstrual learning (e.g. how and what was learnt)*
		Daughters(e.g. communication)
		Link to reproduction (e.g. knowledge of fertility)
	Changes after menarche	*Socialisation and activities*
		Presentation and clothing
	Changes during menstruation	*Socialisation and activities following menarche*
		Physical presentation and clothing
		Food
		Hygiene
		Sexual relations
		Religious changes and restrictions
		Experiences of menstruating (e.g. heavy bleeding, pain)
	Premenstrual changes	*Construction and meaning*
		Physical and psychological changes
Fertility/Contraception	Contraception experience	*General experiences of use*
	Contraception choice	*Personal choice*
		Partner influence

		Cultural and religious influence
		Other factors
	Contraception knowledge	*Formal education (e.g. school, doctor)*
		Informal education (e.g. friends, family)
		General knowledge
	Contraception misconceptions and worries (e.g. physical or psychological)	
	Cultural construction of fertility and motherhood	*Pressure to reproduce*
		Experiences of motherhood
Relationships	Marriage	*Partner choice*
		Arranged marriage
		Choosing your husband
		Daughters and marriage (e.g preferred pathways to partner choice)
		Dowry
		Multiple wives
	Divorce (e.g. acceptability of relationships after divorce, community reactions to divorce)	
	Relationships before marriage (e.g. acceptability)	
	Same sex relationships (e.g. attitudes, acceptability)	
Sexuality	Sex before marriage	*Virginity (e.g. meaning, significance)*
		Preferences for daughters (e.g. importance of virginity)
		Consequences of sex out of marriage

		Attitudes towards sex before marriage
	Sexual pleasure and desire	*Sex initiation*
		Sex consent
		Sexual enjoyment and desire
		Talking about sex
		The wedding night
Female Genital Cutting/Circumcision/ Mutilation (FGM)	Constructions of FGM	
	Experiences of FGM	
	Impacts of FGM on health and sexuality	

For example, under the broad code *'Becoming a woman'*, participants generally discussed how menarche signified a) readiness for marriage b) the ability to have children and c) that it marked a transition from girlhood to womanhood. Thus, this process further helped to refine commonalities across the data set. To allow for cultural and geographic comparisons, participants' accounts in coding summaries were color-coded to represent women from differing cultural backgrounds, and accounts from Canadian women were bolded to identify differences between Australian and Canadian women. Below, Figure 1 is an illustrative section of a coding summary for the code *'Becoming a woman'* under the topic of menarche and menstruation.

The process of coding, re-reading the coded data, collating and summarising the data played a major role in facilitating the identification of themes. By this stage, I had become very familiar with the data and began to make notes about central concepts coming out of each of the four topic areas I had selected to explore.

Colour coding Key **Latina - Vancouver only** Sudanese - Sydney; **Sudanese – Vancouver** Somali - Sydney; **Somali – Vancouver** Iraqi - Sydney; **Iraqi - Vancouver** Afghani - Sydney; **Afghani – Vancouver** Tamil - Sydney only Punjabi - Sydney only S Sudanese (South Sudanese) - Sydney only		
Menstruation		
Construction of menstruation	**Becoming a woman**	**Marriage:** • The onset of menarche means readiness for marriage-"So you become a woman, and you are a wife." -FG_MIX_SUD_ISL_SYD and "I was scared because I knew that they are going to be forcing me to get married."Akoi*, FG_S_IRQ_ISL_SYD, **FG_S_SOM_ISL_VAN**, FG_MIX_SOM_ISL_SYD, Minoo*, Arliyo, Hasina, Suz, Eira/Kamila, Hido • Marriage at menarche to prevent sex/pregnancy outside of marriage "They are afraid for their honour on your own"-FG_S_IRQ_ISL_SYD-P1 and "She will be more safe with her husband…he's going to take care of all these sexual things, so she is not going to look outside." FG_S_IRQ_ISL_SYD-P3, FG_MIX_SUD_ISL_SYD • Prioritisation of education over marriage-FG_S_IRQ_ISL_SYD-P1 • Marriage at menarche is geographically dependant-FG_S_IRQ_ISL_SYD **Childbearing:** • Menarche marks being able to have babies-**FG 1_MIX_LAT_MIX_VAN**, FG_S_IRQ_ISL_SYD, FG_MIX_SOM_ISL_SYD, Suhaira, Hasina, Akoi, Lokoya, Suz, Eira/Kamila, **Amran** • A celebration of the possibility of motherhood-**FG 1_MIX_LAT_MIX_VAN** • Some women did not associate menarche with getting married and wanting to have children despite it being a dominant culture-**FG 1_MIX_LAT_MIX_VAN**, Hasina, **Mariana**, **Sofia** **Growing up/being a woman:** • Menarche marks adulthood/growing-up/girl to woman transition/no longer a child-**FG 1_MIX_LAT_MIX_VAN**, **FG_M_IRQ_ISL_VAN**, **FG_M_SUD_ISL_VAN**, **FG_S_IRQ_ISL_VAN**, **FG_S_SOM_ISL_VAN**, Suhaira, Asilah, Najiba, Nasira, Raana, Saadia, Shima, Arliyo, Hasina, Naqo, Akoi*, Suz, Eira/Kamila, **Amaal**, **Amran**, **Hani**, FG_M_S SUD_CH_SYD • Menarche is too young to be considered a woman-Arliyo, Akoi • "I didn't know what a woman was; I didn't know the meaning of these words."-**FG 1_MIX_LAT_MIX_VAN**, Suz, **Mariana** • Those who don't menstruate are not female "Because it didn't come to be early, they said I was a boy"-**FG_M_SUD_ISL_VAN**, Hido, Samira

Figure 1. Exemplar of coding summary

The development of themes from the coded data was an active process which involved reviewing the codes and collating the codes according to similarities in concepts (Braun & Clark, 2013). For example, through coding and summarising the

menarche and menstruation data, a central concept of shame was exceedingly evident. This formed the overarching theme for my analysis presented in Chapter Three.

Another core concept, as mentioned earlier, was menarche marked a transition from girlhood to womanhood. Although *'Becoming a woman'* was a code in itself, it later became a discursive theme beneath the overarching theme of '*Cycles of shame'*. Similarly, several codes related to the concept of menarche and menstruation being silenced and concealed due to shame, and thus, *'The unspeakable'* became the second discursive theme under '*Cycles of shame*'. Where necessary, subthemes were then developed for each of these core themes to capture specific aspects of these dominant themes (Braun & Clark, 2013).

For each results chapter presented in this thesis I continuously referred to the coding summaries, collated codes and drew on multiple codes within and across topic areas for each theme. For example, specific sections from the coded relationships data were relevant to the chapter on premarital sexuality, as well as women's negotiation of sexual agency. This process of clustering and comparing codes enabled me to identify salient patterns that were relevant to my research questions, and aided in the initial formation of thematic outlines or maps for each of the results chapters presented in this thesis.

As discussed by Braun and Clark (2013), to develop my analysis further, I then went back to the coded data set and extracted data relevant to each of the themes and subthemes highlighted in my outline. This process helped me double-check I had appropriate data that fitted into the themes and supported the argument of each chapter. Theme refinement was an ongoing process however, and at times, it was not

until I had begun writing the analysis that I recognised themes needed further tweaking and refinement.

The 'second level' of analysis: Exploring discourse and participant subjectivity

Following the thematic organisation of the data, I examined the data discursively (Ussher & Perz, 2014; Willig, 2001). An underlying premise of discourse analysis is that discourses shape and produce subjectivity and are central to the construction of social reality (Ussher & Perz, 2014). In other words, discourse analysis allows for the exploration of available subject positions in relation to discourse, and examines the implications of such positions on the possibilities of selfhood, and subjective experience (Willig, 2000, p. 549). To examine the discontinuities and contradictory subject positions women took up, I also drew on positioning theory (Davies & Harré, 1990).

In this vein, I began my discursive analysis by identifying dominant discourses presented in the thematically coded data and examining the subject positions these opened up or disallowed participants to take up (Ussher & Perz, 2014). To facilitate this process, I asked myself a series of theoretically informed questions such as; How are women talking about and making sense of their sexual and reproductive health (e.g. experience of menarche, virginity, sex)? How are women positioning themselves in relation to such discourses? What do these constructions achieve for women, men or their wider communities? When might women be able to resist, ignore, or take up these subject positions? What are the implications of taking up, or resisting such subject position? In many instances, the themes themselves represented dominant discourses within the data. For example, nearly all women interviewed described premarital sex as being 'forbidden', 'a

mistake', a 'sin' and 'wrong' in their cultural context (See Chapter Four). Thus, the discursive theme became *"The virginity imperative"*.

I then examined the varying ways in which women positioned themselves in relation to this discourse or theme and the implications this had on women's subjectivity and practice. For instance, some women drew on a religious discourse to validate the need for women to be virgins at marriage, others stated this was an unfair expectation on women but remained virginal until marriage; and in a few instances, women resisted this cultural expectation and engaged in premarital sex. Consistent with a material-discursive-intrapsychic theoretical framework, while examining the discursive constructions of women's sexuality and reproductive health, I was also equally exploring the material and intrapsychic aspects of women's accounts, particularly in relation to these discourses. For example, the need to be virginal at marriage had material implications on women's access to knowledge about sex and experiences of first sex. It also had intrapsychic implications for women who did have premarital sex, such as the negotiation of feelings of guilt and ongoing negativity towards their sexuality (elaborated in Chapter Four).

As a part of this inductive process, I also considered how the discourses in participants' talk related to broader cultural discourse, such a 'woman as abject discourse', 'patriarchal discourse', 'male sex drive discourse', 'coital imperative discourse' and a 'heteronormative discourse'. This was done through a close examination into the ways in which participants were describing experiences and constructions. In the context of the coital imperative discourse for example, women spoke about other forms of sex, such as masturbation or oral sex, as being "dirty", "wrong" or "undesirable". Similarly, where participants spoke about how women were prohibited from initiating sex or expressing sexual desire, this was suggestive

of a ‘heteronormative discourse’, whereby women are passive and receptive in relation to men.

Through discursively analysing the women’s talk it became evident culture, religion and gender were dominant intersecting domains significant in shaping their experiences and constructions. Where relevant I also considered other identities, such as age, being a migrant or a mother, however these were less frequently drawn on by women. Similarly, while we did not seek to exclude women who identified as being same sex attracted for example, the majority of women who volunteered were heterosexual.

As described by Willig and Rogers (2017), our analyses and interpretations of collected data are always mediated by us, the researchers, and thus we cannot pretend we are simply ‘uncovering’ meaning (p.7). Being aware of this, my primary supervisor and I were reflexive about the ways in which we may have influenced the process of data analysis. We had many conversations about our own cultural backgrounds and how they may have shaped our assumptions and interpretation of data. We discussed at length practices in relation to premarital sex, sex, love, marriage and fertility that existed in our cultural contexts and how this may impact on how we view other cultures, particularly where practices are vastly different. These discussions were extremely important in challenging my own preconceptions surrounding migrant and refugee women and their sexual and reproductive health. They also demonstrated to me the multiple interpretations open to any one piece of data, and how my interpretations were shaped by my identity, experiences and beliefs.

Being more aware of this, I made great effort to consider the ‘whole picture’ as much as possible in the women’s stories. I was conscious to pay attention to, and

explore, accounts of women's agency and resistance rather than focusing solely on accounts where women were negatively influenced by cultural or religious discourse. I did this through close examination of accounts, looking for statements and actions, that suggested women were questioning or 'pushing back' against dominant cultural and religious discourse. In an attempt to capture women's voices more accurately, I also paid particular attention to the ways in which the women positioned themselves in relation to dominant discourses and experiences, rather than placing them within discursive boundaries I deemed appropriate.

Evaluation and Dissemination of the Research Findings

Research findings are typically written up and published within refereed academic journals (Liamputtong, 2007). However, as argued by R. Sommer (1999), this dissemination model is somewhat deficient as the general public, health service providers and people working in the community with migrant and refugee women may not have access to research findings through this modality. Similarly, when research output contains academic jargon or is heavily theoretical it may be difficult to follow for readers who do not work in the field, discouraging service providers from reading them (Liamputtong, 2007). Consequently, it is suggested research outputs be produced in a form accessible to the general public and community alike; this could include reports, public forums or newspaper articles for example (Marshall & Batten, 2004; Paradis, 2000). Returning to communities to share research findings is also important in gaining trust and respect, as well as facilitating future research collaborations that may empower migrant and refugee communities (Watts & Liamputtong, 2013).

The research team on this project agreed that it was ethically important to develop a report documenting the research findings, in addition to academic journal

articles. I contributed to the report created to support healthcare providers and community workers who assist migrant and refugee women with sexual and reproductive health. This document was developed as a means of disseminating our research background, overall findings and subsequent recommendations in an accessible, simple English, non-academic format. A Stakeholder Forum was held at the Community Migrant Resource Centre in Sydney on October 11th 2016, where 61 participants, made up of healthcare providers including doctors and nurses, health promotion officers, representatives from governmental departments (for example, New South Wales Refugee Health) and community workers and interviewers, provided feedback on the initial draft report and presentation of the findings. Their feedback and suggestions in relation to the findings, including how to disseminate the research outcomes, were systematically noted and used to refine the final version of the document (See Appendix H). In conjunction with our stakeholders, the report was then released at a further research launch on the 1st of May 2017 and is now publicly available online (Ussher, Metusela, et al., 2017).

Reflecting on the Intricacies of Interviewing Women from Migrant and Refugee Background

Procedural experiences.

Given I am not from the cultural backgrounds of women I interviewed, I would like to reflect on some of my observations and experiences. Firstly, I found that data collection was not always straightforward. It often took place after a number of re-scheduling attempts, over the geographical spread of Western Sydney and, at times, in unusual locations, one being a hairdressing salon. In addition, one interview would often take a whole day. Prior to, or following interviews, I would frequently be involved in participants' routines of family life, such as helping prepare

lunch for children or being taken along to school pick-ups. Other times I would arrive at the woman's house and she would need a hand with household duties, such as unloading the groceries, before being able to get started on the interview. I was happy to help out with such activities as I believe it is an important aspect of reciprocity in research. Younger children who did not attend school were often at home during the interview, and women would need to attend to them at times as we spoke. I did not find this distracting, but saw these occasional stops and starts as being a part of the research process, pausing the recorder or taking a break when needed.

Once the interview was over, I was often offered lunch or traditional foods, sweets and tea, which the women were excited to share with me. I would always accept their offers, welcoming the opportunity to interact more casually; I also felt this was important in establishing rapport with the women as I was not simply turning up, collecting my data, and leaving. These nuanced aspects of researching with women from diverse cultural backgrounds did not come as a surprise to me given my years of volunteer experience working alongside refugee communities in Western Sydney, where I grew to understand that cultural practices, such as sharing food, were customary for all guests. This experience also made me aware of the busy lives of the women, whereby they usually juggle multiple household activities and children all at once, frequently with little support from their husband. Given this knowledge, I was not surprised that women at times would need to reschedule interviews or locations at the last minute. I just saw this as a part of working with such communities and was as flexible and accommodating as possible.

In relation to participant comfort discussing aspects of their sexual and reproductive health, it is evident, in both the data collected by the community

interviewers and me, there was a reluctance by some participants to discuss more intimate details of their sexuality. While women rarely stated this verbally, there were 'silences' in women's responses to these topics, compared to the rest of the interview schedule. This is not surprising given some participants disclosed the interview was "the first time they had spoken to somebody about this topic" and many women spoke extensively of the shame associated with talking about sex. While there were no major differences between the data collected by interviews and focus groups when covering the majority of topics surrounding women's sexual and reproductive health (e.g. menstruation and contraception), again, less talk about women's intimate sexual lives was evident in the group discussions. At times I was surprised however, by the intimate stories women were willing to share in a focus group setting that were not directly related to sex, such as women's experiences of dysfunctional relationships or experiences of abortion with minimal or no prompting.

Lastly, with a number of participants, I felt they enjoyed the opportunity to talk about their lives and experiences with somebody who was non-judgemental and willing to listen in a confidential setting. This was particularly the case for women who disclosed being isolated from their friends and families (who were back in their home country). I also perceived some participants wanted to use the interview to voice their frustrations surrounding injustices faced by women in their communities; for example, with respect to the work distribution between husband and wife for a married woman, and gender inequalities in relation to premarital sexuality.

Insider/outsider positioning.

We cannot escape being both insider and outsiders. We can only ask, instead, how we have used these positions, and how we could use them, ethically and

> reflexively, to generate knowledge about-and to transform the social world (Wilkinson & Kitzinger, 2013, p. 254)

It is also important to note, that while I do not share the cultural backgrounds of women interviewed, nor experiences of, or reasons for migration, I am not a complete 'outsider'. Although I was the researcher, and understand that this comes with a power differential between participants and me, I am also a woman. I too have a menstruating body. I have experienced menstrual related shame and silencing, distress in relation to finding an appropriate contraceptive method and pressure to reproduce as a woman in her early thirties. In these ways I am then an 'insider'.

It is important to emphasise I am in no way attempting to devalue women's experiences or compare my life trajectories to that of refugee and migrant women who may have experienced trauma. I do believe however, having these shared experiences increased my ability to empathise with the women's accounts and sensitively negotiate listening, prompting, supporting and following-up during interviews. I feel being a woman also influenced the ways the women shared their stories and enhanced the researcher-interviewer connection, this was particularly evident in their willingness to disclose more intimate details of their personal lives. Also reflecting on my insider/outsider positioning, it is relevant to share I have been in a long-term relationship with a first generation migrant who is from a cultural and linguistic background vastly different to mine. In this respect, I have a certain level of understanding in relation to cultural sensitivities around topics such as sexual and reproductive health.

Further, the fact that I was not a member of their community, an 'outsider', may have meant the women felt more comfortable sharing intimate details with someone they are unlikely to see within their social circles. As has been reported

amongst other cross-cultural researchers (Colucci, 2008), this may have given me room to question beliefs and practices in more depth given the women's beliefs and practices are not taken for granted knowledge within my cultural setting. I have experience interviewing people about sensitive issues, and come from a cultural background where communication about reproduction and sexuality is normalised. In this sense, I did not feel uncomfortable talking about sex, or asking questions in relation to sex. In contrast, it was evident when reading the community interviewers' transcripts that there was a level of discomfort in addressing some of the questions in the interview schedule. For example, one community interviewer stated, "I apologise for treading on this topic" prior to asking about other forms of non-coital sex the participants may have engaged in. Other interviewers utilised proxy words or statements when referring to coital sex, such as "what you do to have children" or "intimate relations". While this may have been a strategy that community interviewers drew on to ensure a level of cultural sensitivity towards the participants they interviewed, it arguably may have also acted as a means of reinforcing the taboo or 'unspeakable' nature of sexuality. Consequently, participants may have been reluctant to discuss the more intimate details of their sexual and reproductive health.

Prior to the interviewing process, one community worker at CMRC disclosed that married women may feel uncomfortable talking to an unmarried woman about issues relating to sexuality. However, I did not find this to be an issue when undertaking individual interviews. If participants asked, I felt comfortable saying I was not married. This usually ended in a humorous conversation, such as being told I would be "worth many cows" in Sudan because of my height. Following the disclosure of my marital status, women used this knowledge as an opportunity to impart advice to me, such as having "my eyes wide open when choosing a husband."

In reflection, I felt that because I was outsider to the communities I was interviewing, the exchange of personal information in relation to sex was not seen as inappropriate, despite being unmarried. Perhaps this was also related to my age: I am evidently not 'young' and in many instances a similar age to my participants. Given these factors, in conjunction with the community interviewers, my position as an insider/woman and outsider/Anglo researcher may have also helped enrich the research process.

Analysis Outline

The following chapters present the results of the analyses I conducted. Each chapter is presented as an academic journal article. While each chapter has been re-formatted, the content remains the same as the published/submitted manuscripts, following the journals requirements; this includes spelling (U.S) and the use of pseudonyms or participant demographics, which were discouraged in the first paper presented.

The first chapter, Chapter Three, considers women's constructions and experiences of menarche and menstruation, the beginning of a woman's reproductive cycle. I then consider women's constructions and experiences of sexuality prior to marriage, presented in Chapter 4. The following Chapter 5 examines women's experiences of sexuality within marriage. In the final results chapter, Chapter 6, I explore the meanings and value of motherhood, as well as women's constructions and experiences of contraception use for fertility control.

Chapter Three: Experiences and Constructions of Menarche and Menstruation Among Migrant and Refugee Women

In this chapter, I begin the analysis of this thesis by starting at the beginning of a woman's reproductive life cycle, menarche and menstruation. I explore the ways in which women construct and experience menarche, and cultural and religious discourses and practices in relation to menstruation. The analysis presented in this chapter is in the form of an academic journal article, accepted in *Qualitative Health Research*. Appendix I presents the published manuscript.

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Abstract

Experiences and constructions of menarche and menstruation are shaped by the sociocultural environment in which women are embedded. We explored experiences and constructions of menarche and menstruation among migrant and refugee women resettled in Sydney, Australia, and Vancouver, Canada. Seventy-eight semistructured individual interviews and 15 focus groups comprised of 82 participants were undertaken with women from Afghanistan, Iraq, Somalia, South Sudan, Sudan, Sri Lanka, and varying South American countries. We analyzed the data using thematic decomposition, identifying the overall theme "cycles of shame" and two core themes. In "becoming a woman," participants constructed menarche as a marker of womanhood, closely linked to marriage and childbearing. In "the unspeakable," women conveyed negative constructions of menstruation, positioning it as shameful, something to be concealed, and polluting. Identifying migrant and refugee women's experiences and constructions of menarche and menstruation is essential for culturally safe medical practice, health promotion, and health education.

Keywords: focus groups; health care, transcultural; health promotion; interviews, semistructured; refugees; reproduction; research cross-language; research, qualitative; sexuality/sexual health; women's health; thematic decomposition; qualitative; Australia; Canada

Introduction

Despite menstruation being an internal bodily process, the way in which women experience and construct menarche and menstruation is influenced by the wider sociocultural milieu in which they live. Understanding how cultural, societal, religious, and other intersections of difference might influence a woman's experience in this sphere is essential, given the prevalence of negative attitudes and representations of menarche and menstruation (Rembeck, Möller, & Gunnarsson, 2006; Ussher, 2006). Within a Western context, dominant cultural discourses portray menstruation as a "hygienic crisis" that needs to be managed and concealed, as well as a bodily function loaded with shame and embarrassment (Beausang & Razor, 2000; T. E. Jackson & Falmagne, 2013). Consequently, women are required to conform to rules and regulations associated with menstrual management, reinforced through mainstream media and menstrual education (Erchull et al., 2002; Kissling, 2002). In contrast, menstrual activists, artists, and poets have challenged negative representations of menstruation, to contest derogatory discourse and empower menstruating women (Bobel, 2010). Menstruation is also positioned positively when it is associated with privileges of adulthood, or where the focus of the menarcheal transition is not solely on sex and reproduction (Lee, 2009; Teitelman, 2004).

Menstruation in many non-Western contexts, however, is strongly associated with dirt, taboos, and restrictions (Garg et al., 2001; M. Sommer, Ackatia-Armah, et al., 2015). These representations are often shaped by major religions such as Judaism, Hinduism, and Islam where we see strict prescriptions and prohibitions which menstruating women must adhere to (Crawford et al., 2014; Dunnavant & Roberts, 2013; Guterman, 2008), such as the exclusion of women from religious ceremonies because they are considered polluting, dirty, or impure. Such ideologies

position the menstruating body as unclean and a source of pollution (Ussher, 2006), contributing to stigma and women feeling ashamed of their reproductive bodies (Chrisler, 2011; Johnston-Robledo & Chrisler, 2013). This has implications for women's health. For example, women who have negative attitudes toward menstruation are more likely to support suppression of menstruation through long-term oral contraception use (Andrist, 2008; Johnston-Robledo et al., 2003). Furthermore, menstrual shame has been linked to increased sexual risk-taking (Schooler et al., 2005) and embarrassment toward other reproductive functions, such as breastfeeding (Bramwell, 2001; Johnston-Robledo et al., 2007) and childbirth (Moloney, 2010). Mother's attitudes toward menstruation also shape the menstrual education girls receive, which might negatively affect their experiences of menarche and ongoing perspectives toward menstruation and sexuality (Beausang & Razor, 2000; Cooper & Koch, 2007; Costos et al., 2002).

The majority of research studies that have examined the impact of cultural constructions of menstruation have focused on experiences of girls and women within a White Western context (Beausang & Razor, 2000; Burrows & Johnson, 2005; Lee, 2009). There have been a small number of studies that consider cross-cultural experiences of women currently residing in the West (Chrisler & Zittel, 1998; Orringer & Gahagan, 2010; Uskul, 2004). However, such studies were predominantly undertaken in the United States, conducted with university students, and required spoken or written English for participation, considerably limiting those who can be involved. There is a growing body of research considering the experiences of menarche and menstruation of women within a range of non-Western cultural settings, such as Middle Eastern, Asian, and African countries (e.g.,Crawford et al., 2014; do Amaral, Hardy, & Hebling, 2011; Liu, Chen, & Peng,

2012; Mason et al., 2013; M. Sommer, 2010; M. Sommer, Ackatia-Armah, et al., 2015). These studies highlight that although there are many similarities in the way menarche and menstruation are experienced across cultures, such as lack of menarche preparation and difficulty managing menstruation from a hygiene perspective, there are also a number of differences, including specific beliefs and practices (M. Sommer, Ackatia-Armah, et al., 2015) and restrictions placed on women during menses (Crawford et al., 2014). This suggests that researchers need to pay attention to commonalities and differences across cultures when examining the sociocultural meaning and construction of menstruation.

Despite the importance of menarche and menstruation in women's wider sexual and reproductive health, few studies have considered the experiences and constructions of menarche and menstruation in culturally and linguistically diverse (CALD) migrant and refugee women[1] settled in their new countries of residence. Understanding migrant and refugee women's experiences and constructions of menarche and menstruation are important given women have transitioned between two differing cultures and might need to negotiate conflicting cultural ideals associated with reproductive health (Salad et al., 2015; Ussher et al., 2012).

Acculturation in Western contexts has been found to affect women's sexual and reproductive health, such as increased reporting of premenstrual stress (Pilver, Kasl, Desai, & Levy, 2011) and engagement with sexual risk taking behaviours. To date, migrant and refugee women's attitudes and experiences of menarche and menstruation have largely been ignored despite being intimately linked to fertility,

[1] The term "culturally and linguistically diverse" (CALD) is used in Australia to describe people who have a cultural heritage different from the dominant Anglo Australian culture (Department of Health, 2016a), replacing the previously used term of people from a "non-English-speaking background" (NESB). As this term is not used in Canada, where many of our participants reside, we are defining our sample as "migrant and refugee women."

sexual health, and a woman's identity (Brantelid et al., 2014; M. Sommer, Sutherland, & Chandra-Mouli, 2015; Teitelman, 2004). The focus of past research on migrant and refugee women's reproductive health has predominantly been on pregnancy outcomes, childbirth, postpartum experiences (Tran, Young, Phung, Hillman, & Willcocks, 2001; Tsianakas & Liamputtong, 2002), or sexual health (Ussher et al., 2012; Wray et al., 2014). Furthermore, past research either has conceptualized migrants as a homogeneous population, which negates variations which occur within and between cultures (Beiser, 2005; Rawson & Liamputtong, 2010), or has been focused on migrant women's experiences from predominantly Vietnamese or South-East Asian backgrounds (Gagnon et al., 2002; P. W. Garrett et al., 2010). Identifying how menarche and menstruation is experienced and constructed by migrant and refugee women is essential for the provision of culturally safe reproductive health care, health promotion activities, school-based education, and is important for the development of wider sexual and reproductive health education for women who have newly migrated (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003; WHO, 2010).

The aim of the present article is to address these significant gaps in the research literature by examining constructions and experiences of menarche and menstruation among women who had recently migrated or arrived as refugees in Australia or Canada, across a range of cultural groups. The research questions were as follows: how do migrant and refugee women construct and experience menarche and menstruation? What are the implications of these constructions and experiences for the broader sexual and reproductive health of migrant and refugee women?

Methods

Research design.

This article is part of a larger program of research examining the sexual and reproductive health of migrant and refugee women who were currently living in Australia and Canada. Although the broader project covers topics of menstruation, fertility, contraception, sexuality, sexual health, and access to health services (Ussher, Perz, et al., 2017), the current article will only present on data relevant to menarche and menstruation. Seventy-eight individual interviews and 15 focus groups with 82 participants were conducted primarily by community interviewers in Sydney, Australia, and Vancouver, Canada. To enhance data richness, individual interviews were used to elicit personal in-depth accounts that might not be disclosed in a group setting, while focus groups provided a synergistic setting to gather insight into cultural and community norms (Creswell, 2009). Participants originated from multiple countries, including Afghanistan, Iraq, Somalia, and Sudan. Sri-Lankan (Tamil) and South Sudanese women were included in the Australian sample and women from varying South American countries (Latina) in the Canadian sample. Migrant groups were chosen through a process of consultation with the project advisory committee established with major stakeholder groups whose roles included migratory support to new migrant and refugee populations, as well as agencies who provide sexual and reproductive health care to women. Women from the countries selected for this study were recognized as being underrepresented in previous research, and were identified by stakeholder groups as being absent or poorly served within current sexual and reproductive health services, despite making up a substantial proportion of recent arrivals to both countries. Australia and Canada were chosen for this research as both countries are similar geographically and have

comparable migrant populations. Data were collected from July 2014 to November 2015.

Participants.

Participants were women who had migrated in the last 10 years, with the average time since migration being 7 years. Women identified as practicing a range of religions, including Christianity, Hinduism, and Islam. Interviewees and focus group participants included women with varying migratory experience, including humanitarian, family reunion, refugee, and women seeking asylum. Participants ranged from 18 to 70 years old, with a mean age of 35. Except for one Latina woman who identified as being in a same sex relationship, all identified as being heterosexual. Table 1 (See Chapter 2) provides the socio-demographic information for each cultural group.

Procedure.

At the onset of this project, the advisory committee was contacted to provide cultural guidance, establish appropriate research methodologies, refine the research aims of the study, and provide guidance on the research interview schedule. Following this, women were recruited through the distribution of flyers by community support staff working at migrant resource centers and the community interviewers themselves. Furthermore, women were invited to participate through visits to preexisting cultural community groups, through flyers displayed in health centers for migrant women, and snowballing. Before taking part in the interview or focus groups, women were informed participation would involve discussion of sexual and reproductive health. Consent forms were provided in English; however, any queries about participation were addressed verbally in their first language with a

community interviewer to ensure understanding. Informed consent was gained from all participants.

Community interviewers, who received training by members of the research team (JU and JP), in how to conduct interviews and focus groups, conducted the majority of the interviews, a method that has been successfully adopted in previous sexual and reproductive health research with non-English speaking women (Go et al., 2002; Morrow et al., 2008). In most instances, interviewers were of the same ethnic background to the women they interviewed; however, in three cases, the interviewers spoke the participant's first language but identified as having a differing ethnic background. Each community interviewer was responsible for conducting approximately five interviews and one or two focus groups. Focus groups were either conducted in participants' first language, or in some instances facilitated in English, with the option of interpretation through the presence of the trained community interviewer. Members of the research team (AH and CM) conducted the remaining interviews and focus groups with women who preferred to speak English or wanted to be interviewed by someone who was not a community member. Interviews and focus groups took place at venues elected by participants, including their home, local libraries, or community centers; child care was provided when necessary. The interviews and focus groups were semistructured and lasted on average 90 minutes. With the exception of one individual interview, where the participant declined to be audio-recorded and extensive notes were taken, all interviews and focus groups were audio-recorded with permission from participants. The interview schedule included the open-ended questions: Did you know about menstruation before it first happened to you? When did you first find out anything about bleeding? Did things change for you after you started bleeding, for example, celebrations or prohibitions? Is anything

different in your life now when you bleed? How have you/will you address menarche with your daughters? The same interview schedule was utilized in individual interviews and focus groups across all cultural groups; however, the wording and formatting of questions was used flexibly to suit the specific context of the participants. This research was approved by the Western Sydney University Human Research Ethics Committee, and by the ethics committees of community stakeholder organizations.

Analysis.

Audio-recordings of non-English interviews were either translated verbally into English and then transcribed, or transcribed directly into written English by the bilingual community interviewers. This process involved a systematic approach by which a small segment of data were listened to multiple times and then translated. Translation was conducted in a manner that was as close as possible to the participant's accounts while taking into consideration the subtleties of language. Interviews and focus groups in English or with English spoken sections were professionally transcribed verbatim, and then integrity was checked by listening to the audio- recording and reading written text to ensure authenticity and accuracy. To improve readability filler words such as "um" and "ah" were removed. Participants' names were replaced with pseudonyms.

Our epistemological standpoint was critical realism, which recognizes the materiality of somatic, psychological, and social experience, but conceptualizes such materiality as being mediated by culture, language, and politics (Bhaskar, 2011). In this light, to both acknowledge the biological materiality of menarche and menstruation, and recognize women's constructs and subjective experience of these events, we adopted a material-discursive theoretical framework (Ussher, 2008). Our

analysis also drew on intersectionality, a concept which examines how mutually constitutive categories of difference, such as gender, culture, and religion, shape individual lives, social practices, and cultural ideologies (Davis, 2008). Intersectionality moves away from an additive approach of single variables, to consider experience in the light of multiple influential factors that are continuously interacting (Bowleg, 2008).

Participant's transcripts were analyzed using a process of thematic decomposition, a form of analysis which identifies participant subjectivity or discourses across themes within data (Parton et al., 2016; Stenner, 1993). Analysis was inductive, whereby the development of the themes was driven by the data and less by existing theory, research, or hypothesis. A subset of interviews and focus groups were read and reread independently by two members of the research team who were experienced qualitative researchers. First order concepts or codes, such as "menarche celebration," "link to reproduction," and "menstrual rules," were identified. Following this, the entire data set was then coded utilizing the computer software NVivo, a program to facilitate in the organization and coding of qualitative data. Codes were then grouped through a process of continuous and vigilant decision making, creating a smaller number of more distinct categories as the process continued. Subsequently, each coded set of data was summarized with reference to specific accounts from individual participants or focus groups. Participant accounts in the coded summaries were then color coded to represent women from differing cultural groups and accounts from Canada were bolded to allow for a crosscountry analysis. Through the process of coding, summarizing, and highlighting, we were able to identify commonalities across women's accounts, between individual interviews and focus groups, as well as unique stories specific to women or their

cultural group. This process was important to identify how women discursively experience and construct menarche and menstruation in respect to their wider sociocultural contexts. Any discrepancies with coding data or data analysis were resolved through consultation and discussion with the wider research team.

Across all cultural groups, the positioning of menarche and menstruation as shameful was central to women's accounts. The majority of participants retrospectively described being immersed in cultural discourses of shame shaping both their experiences of menarche, and ongoing behaviors toward menstruation. Through our analysis, we observed how women resist and negotiate discourses of shame toward menstruation, in their own experiences, and with their daughters today. Thus, "cycles of shame" became the overarching theme of this article. "Becoming a woman" and "the unspeakable" are the two core themes that fell beneath the central idea of shame. See Figure 1 for full thematic map.

Within participants quotes presented in this article " ..." are used to identify sections of discussion that were not relevant to the analytical context and "[ ]" signifies text that have been added by the authors to improve readability and retain meaning of the verbal passage. Quotes are substantiated by ethnic background to enable comparisons within and between cultural groups. Through our analysis, no significant difference was found between the accounts of women from Australia or Canada, or individual interviews and focus groups. Consequently, there is no distinction made with regard to these variables when presenting participant accounts.

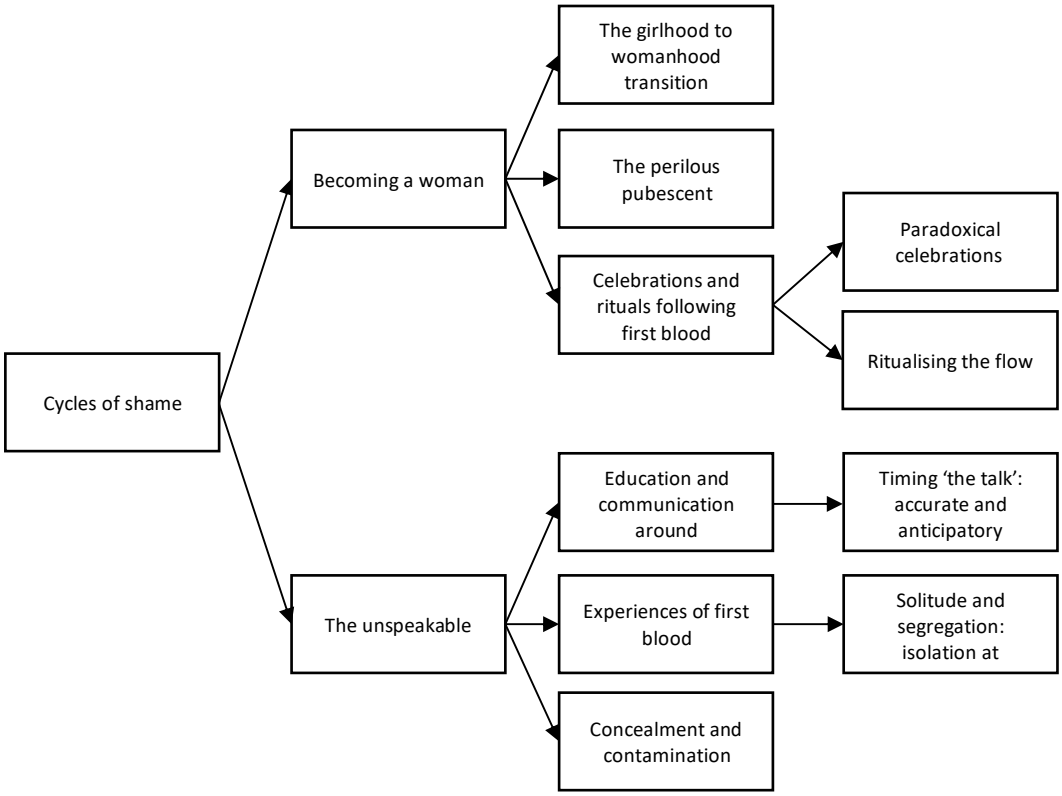

Figure 1. Thematic map

Results

Cycles of shame: Becoming a woman.

The discursive theme "becoming a woman" explores women's constructions of menarche and the implications this developmental milestone has on women within the context of their wider cultural milieu. Three subthemes were identified under this theme: "The girlhood to womanhood transition," "the perilous pubescent," and "celebrations and rituals at first blood."

"Yesterday you were a girl, but today you're a woman": The girlhood to womanhood transition.

A majority of women across all cultural groups described the sudden onset of bleeding as being a distinct point at which they transitioned into womanhood. For example, participants told us, "you start bleeding and you become a woman" (Somali), "the day when the period comes, like she becomes a woman" (Iraqi). This

transition affected the gender identity position participants adopted, as one woman commented, “I thought I was a boy, when I got my period…I became a woman” (Somali). A number of participants positioned this as a positive transition they had been waiting for, with one woman saying, “finally I am a woman” (Afghani). Others positioned menarche positively as it signified fertility:

> When I started bleeding, I kind of felt happy…I was really waiting because it kind of lessened my anxiety because I was asking myself, oh my goodness, I’m not going to have children…it was kind of a relief. (Somali)

In another account, a participant said, “[When] the period, it come to me, I was very happy, now [I] was thinking I’m going to have kids because I have period” (Sudanese). For many participants, however, the putative status of “womanhood” following menarche was rejected:

> When you get your period…[You’re] not running around anymore, just being like a woman, act[ing] like a woman. Actually you are not…because, when you are 11 like my age when I got period, 11 is not woman it’s just a young girl, but you act as you are a woman. (Somali)

This account suggests that although menarche might mark the materiality of achievement of a woman’s reproductive body, it can occur at a time when a girl still discursively positions herself as a child and wants to engage in childlike behavior, such as “running around.” As such, it was common for women to describe feeling resentment toward their newly ascribed adult positioning. For example, participants told us, “I don’t want to be…a big girl, I want[ed] to stay as a child…you need to change your manner, the way of sitting…you can’t play outside with your friends”

(Iraqi) and "you can't play around like a child again…I didn't like having to grow up" (South Sudanese).

When further questioned about what being a woman meant, a number of participants disclosed constructions centered on marriageability and childbearing: "when the girls get their period they can be married to a man" (Somali):

> In South Sudan, when the girl has the first period, that means you are considered as a woman…it's associated with marriage…you're going to get married and you are going to have babies. (South Sudanese)

Consequently, for a number of women, a direct outcome of menarche was immediate marriage and childbearing. As one woman told us,

> I remember my uncle's wife told my dad [that I had my first period] and that is how I got engaged and married by 14. Before knowing anything I was already a mother…I didn't get a chance to know when I was a girl, when I was a woman and when I was a mother. (Afghani)

As is evident in the above account, the majority of women did not position cultural norms of early marriage and childbirth positively. One participant reported that it caused her great anxiety: "I was scared because I knew that they are going to be forcing me to get married, and I wasn't prepared for it, I was scared to be a mum" (South Sudanese). Early marriage and childbearing also had consequences in the formation of a woman's identity and the opportunities available to her. The above participant went on to say, "I had my first one [child] when I was 17…you spend your time looking after the children, nothing else, [it's] not about you" (South Sudanese). Similarly another woman said,

> I got married so young that I feel like all my opportunities were really taken away from me. I wanted to be a dentist for example…but then the moment I got married, I got pregnant and I had kids…I could have been a person, and instead I'm just a mother and a wife. (Afghani)

The perilous pubescent.

"Becoming a woman" was aligned with women's nascent sexuality, and fear of pregnancy in those who were not married. Participants repeatedly disclosed being warned to "avoid boys," "be more careful," and "watch your steps" after menarche. Such cautionary advice was predominantly delivered by mothers and was frequently at the forefront of girls' menstrual education, as one participant said,

> My mum always told me...when you get the period, don't come closer to the men, don't sit with the men...if you sit with the men or talk closer to the men, you're going to fall pregnant...once I got it, I was scared of men because my mum always told me these stories. (Sudanese)

When another participant was asked what would happen if you "get closer" to men following menarche, her response was, "men can rape you and you can get pregnant and in my religion a woman is not supposed to get pregnant before she is married" (Somali). The urgency of marriage following menarche was also positioned as a way to maintain family honor: "they are afraid for their honor on your own" (Iraqi); "after I got my period I have to get married because I might get pregnant" (Sudanese). Without the protection of a husband to "take care of sexual things" women were deemed "at risk" of being tempted into premarital sex and falling pregnant, a culturally intolerable act. However, warning messages received by menarcheal girls were often difficult to understand, given absent or incomplete information about the

association between menstruation, sex, and pregnancy, as one woman commented, "they don't give any information ...like any sexual relationship or anything ...they won't tell" (Tamil). For in being told not to "go around with," "do a mistake," or "play with" boys, young women were given the erroneous impression that any contact with men can make you pregnant.

Although women could attempt to conceal their menstruating bodies to avoid pubertal sexualization, breast development is an overtly visual signifier of pubertal womanhood. Across most cultural groups, women reported being self-conscious of their developing breasts and inherently positioned them as something that they must conceal from the public eye, as one woman told us, "I was mainly concerned about my breasts, I was very shy, and I was wearing loose clothes and was careful about that" (Afghani). In societies where women are encouraged to be sexually invisible to men other than their husband, the prospect of their breasts being an object of male desire can be experienced as shameful. This was reflected in accounts of women describing the pubertal growth of their breasts as anxiety provoking. For example, "I used sticky tape, scarves, and other things to tightly wrap my breasts close to my body in order to flatten them; I also used to hunch my back so they don't show" (Iraqi); "I was really embarrassed ...when my breasts was coming, I was very shamed" (South Sudanese). These accounts highlight how participants did not want to be in the sexual gaze of others, particularly men, and consequently went to great lengths to cover their developing reproductive bodies.

Celebrations and rituals following first blood.

Paradoxical celebrations.

Although most women we interviewed reported having experienced menarche as a private and personal affair, menarche celebrations did occur within

some cultural groups, predominantly the Tamil and South Sudanese context. Traditional celebrations practiced included prayer, ceremonies, parties, and animal sacrifice. For example, participants told us, “the 30th day we celebrate and invite our cultural people, relatives and friends” (Tamil); “they call adults and girls like you to come ...they cut a cow or a sheep for people to eat” (South Sudanese);

> When you have the first period, you don’t keep it as private. You have to tell your family ...they celebrate it ...young girls my age will come and you will be treated like you are getting married ...sometimes it can go for seven days [of] celebration. (South Sudanese)

Most participants positioned menstrual celebrations as a public recognition of their entry into womanhood: “just marking that she has become a woman” (South Sudanese); “it’s welcoming to adulthood” (South Sudanese). In other cases, participants disclosed that they “don’t know” the reason for menstrual celebrations or believed their purpose has changed over time:

> Now it’s like they do these things for fun ...before, I think my parents’ time ...they do this sort of celebration to show the other people, I’ve got a girl ...whenever you are ready, you can marry that girl. (Tamil)

Participant’s revealed obvious discomfort in the role that menstrual celebration played in announcing to the wider community that they were now “menstruators.” For example, when asked about their emotional responses during menstrual celebrations, embarrassment was a common response: “I was really shy you know it’s not good when people come over and say oh, she got [her] period, now she’s a big girl” (South Sudanese); “I felt embarrassed ...in our country ...they think she become like a menstrual girl ...[they] look at you in like a different way” (Tamil).

In an Australian or Canadian context, celebrations were largely positioned as being redundant, outdated or inappropriate, with no sense of loss. For example, one participant said, "now, no one actually prays or cares, like, if you don't tell anyone, who cares" (South Sudanese). Other women told us,

> My daughter ...she said, why do you want to have a function for getting a period ...I also realized that it's true. It's the normal process in the body, so why should we have [a] party ...I'm not going to follow it. (Tamil)

"They grow up in Australia and they see it's not [an] appropriate thing to announce" (South Sudanese). In another account, a woman living in Australia said, "they call it a Saree Party here" (Tamil), referring to the "coming of age" party in a Western context where a girl wears a saree for the first time. These findings suggest that for a minority of women, where menstrual celebrations do continue to occur, they might do so in an adapted form.

Ritualizing the flow.

Across most cultural groups, women could describe traditional rituals that took place at menarche and during menstruation. These included ceremonies with leaves, dirt and water, slapping, dietary changes, flour hand dipping, changes to showering, and wearing of new clothing. For example, participants told us, "the mother should put her daughter's hand in the bag of flour. They believe that if I didn't do that ...something bad will happen to me" (Iraqi); "they put some tree leaves around her hand ...to wish the girl luck to get married and have children" (Sudanese); and "they made me sit on a heap of dead leaves and poured water on my head" (Tamil).

Although most participants said the practice of restrictive bathing during menstruation was considered something of the "old days" and of their "grandmothers" era, there were still a small number of Iraqi women in this research who changed hygiene practices during their monthly menstruation. For example, "by three or four days I take a shower. When the bleeding is little I take shower ...it is not good for the back" (Iraqi). In such accounts, women attribute increased menstrual flow and menstrual pain to showering, thus avoiding the practice during menstruation. Similarly, Afghani women described avoidance of cold drinks to prevent menstrual pain: "[avoid] cold water ...if a woman watches out for these things she won't have any bloating, she won't have any cramps" (Afghani). Although some food avoidances continued with monthly bleeding, Tamil women also reported specific dietary changes associated with menarche:

> They don't give any spicy food, no chilli ...first they give us the raw egg, not the boiled, raw egg and the sesame oil. That's what I did with my girls here in Australia . . .[in] our culture they believe there's a wound inside because of the new eggs produced and it [has to] come out, the blood and all that, to heal. This helps the changes to loosen that blood to come out. (Tamil)

This account illustrates the cultural construction of menarche as a time when women have an internal wound that needs healing. Dietary changes were also positioned as a means to strengthen the reproductive system and avoid menstrual pain: "they think that it directly works with the womb you know the reproductive system will get the strength" (Tamil); "I had everything [special foods] because I was told I will have less stomach pain" (Tamil). One participant described continuing to give her daughter raw eggs during menstruation: "here I give my children only one egg a day, over there three eggs a day" (Tamil). However, another stated, "just a fresh egg

...they think it's healthy, but after I came here I know it's bad, because it's not even boiled, it's not good for the health" (Tamil). These accounts highlight how women might continue adapted versions of traditional rituals with their daughters, or dismiss certain rituals on arrival to their new countries of residence.

Cycles of shame: The unspeakable.

"The unspeakable" dually describes women's inability to talk about menarche and menstruation, and its discursive positioning as disgusting and polluting. "Education and communication around menstruation," "experiences of first blood," and "concealing the contamination" are three subthemes beneath the dominant discourse of "the unspeakable."

Silence and secrecy: Education and communication around menstruation.

Throughout the interviews, women commonly described an absence of discussion surrounding menstruation, as evidenced by the following accounts: "nobody tells us, nobody talk about it" (Somali); "we don't really talk about stuff like that" (Afghani). A number of participants stated that the reason menstruation was not discussed was because of shame and wider disapproval from family and friends: "they think it is shameful, it's disrespectful, you don't have respect for yourself" (Afghani); "women's monthly period ...people don't talk about. In Sudanese culture it is shame to talk about it" (Sudanese). In one account, a participant described how those who do choose to discuss menstruation are considered deviant: "if we share these things those girls are like naughty girls, so we never share anything" (Tamil). Women also positioned menarche as something they were "not allowed" to talk about, and in some instances were shocked to learn about it: "it was shameful for me to even listen to this kind of stuff" (Afghani). In this vein,

some women engaged in self-policing to regulate their own reproductive health knowledge:

> When topics like this came up, we would generally keep away from it and not involve ourselves too much in these talks ...it's not very good for women or girls to be focused on this kind of gossip. (Afghani)

For nearly a quarter of women interviewed, school was where they had first learnt about menarche, and for some women, this remained their only source of menstrual education and information:

> I did not have enough information, they taught us at school basic information not in details to understand or learn about bleeding ...information about a woman's body in general, woman body diagram, and how the women bleed every month, it was very simple, at home no one told me about it. (Sudanese)

As illustrated by this account, women commonly disclosed being dissatisfied with the explanation and support they received from school. In the above account, it was described as "very simple," others stated information "wasn't clear," was "very brief," and "corporate." Nearly half of the women interviewed in the present study also received little or no preparatory menstrual education or support from their mothers, in most cases because it was considered too shameful a topic to discuss. For example, "nobody tell me nothing ...it's not only my mother ...all mother[s], they didn't share" (Somali); "our mother's from the old generation so she didn't give me any information about it" (Iraqi). In another example, when one woman questioned her mother about menstruation, her mother's response was, "don't worry about these stuff and never ask me questions like this again, it is not your business" (Afghani). Women were further denied information by being excluded from adult conversations

that might have imparted menstrual knowledge, as one woman told us, "she [mother] said it is shame ...when they speak about pregnancy or menstrual period, she said, go to other room" (Iraqi). When asked the reason for such reluctance on the part of mothers, it was described as a "cultural thing" which could not be challenged, as one woman said,

> They are very secret about this stuff, they don't talk about that to us ...I don't know why it is that belief, but still my mum doesn't talk about that, yeah, about periods or childbirth or anything, we don't talk openly. Maybe it's a cultural thing. (Tamil)

At the same time, many women described having felt discomfort in approaching their mothers with regard to information about menstruation: "I would be very embarrassed to talk with my mum" (South Sudanese); "out of shame I couldn't, [I] didn't know how to approach her about it" (Afghani). Consequently, a number of women did not seek information about menstruation at all: "No, I did not ask anyone. I decided to deal with it myself, I was shy to ask, I feel shame" (Somali). Other participants described accessing information from other women family members, such as sisters or aunts, or close girlfriends: "I couldn't talk to my mum ...that was a very hard topic ...but I can talk to my friends" (Sudanese); "my older sister was more playing the role of a mother" (Latina).

Timing "the talk": Accurate and anticipatory guidance.

When information about menstruation was provided, it predominantly occurred at the time of menarche, when such conversation was unavoidable. A small number of participants did report turning to their mothers for support following menarche and described having had sufficient information. However, a large

majority reported having felt disappointed or inadequately informed. For example, one woman told us, “my mother is an educated woman, she is a dentist, yet she summed the whole subject in 5 minutes and did not mention it again. She was shy to speak about such subject” (Iraqi). Many women described topics covered by their mothers as being messages of warning, the need for concealment, and practical management, with an absence of the physical and emotional care women needed. For example, “I remember she didn’t even give me a cuddle or comfort me. She just quietly put a very ugly and scary fabric inside my legs and told me to not tell anyone about it” (Afghani); “she did not tell me anything about changing feelings, she told me very little and did not talk about it much” (Iraqi). In other instances, the information that participants described receiving and relaying to their daughters was incorrect, or women were unsure of its meaning. For example, one participant’s mother told her “not to sit anywhere dirty during our period because ...everything is sort of open and you can get all kinds of infections” (Afghani). In another account, a participant described telling her daughter who began menstruating in Australia:

> I said ok if you want my advice when you got your period ...you can’t let the boy touch you ...I told my daughter, she do it now ...I don’t know whether it is good or bad, I don’t know. (South Sudanese)

The absence of education from mothers and at school meant that at the time of menarche many women reported they had poor knowledge about the function of menstruation in relation to reproduction. For some, it was not until well into their menstruating years that they became aware of the role menstruation had in childbearing: “I just know when we grew up aged 20 years, that’s when I know this makes this” (Somali); “I really I didn’t know until I became pregnant with my first son” (Iraqi). As a consequence of receiving little or no menstrual education

themselves, many women disclosed being more open or wanting to be more open with their own daughters during menarche. For example, “I treat my daughters not like my mother treated me ...I don’t want them to be shocked, like I was” (Iraqi); “I want to avoid what happened to me when no one told me, so I told my daughter she already knows” (Sudanese). However, some of the mothers interviewed disclosed being “shy” to talk in depth with their daughters or “unsure” when the right time was to address menstruation:

> We were raised...we’re shy from those matters and even I can’t talk to my daughter frankly and tell her what happened ...I tell her about the period, and I tell her about the baby, but not the long procedure ...I think I felt embarrassed. (Iraqi)

In another account, a woman described wanting to discuss menstruation with her 11-year-old daughter, but not knowing when or how: “until now I haven’t said anything to her about it ...I don’t want her to experience the same as what I had ...but I don’t know when, and where and how” (Iraqi). As a result of the same concerns, another participant described attending a women’s health course where she was provided with the appropriate information to support her daughter:

> I was scared and shy to talk about this topic ...I went to a migrant resource center and there was a lady ...she talked about the periods and how to tell their daughters. I learnt from that session and it encouraged me to tell my daughter. (Sudanese)

In another example, a participant disclosed wanting to talk to their daughters in the future but only when they are “old enough” by cultural standards: “I will explain to my daughters ...at an age of you know, nine, ten. No younger than that because I

think I'm still following the culture" (Afghani). These accounts highlight that although many mothers would like to educate and support their daughters through menarche, given their own poor experiences of menstrual education, they might lack the knowledge and confidence to do so at an appropriate time.

"When I got my period, my heart kind of broke": Experiences of first blood.

In line with the finding that nearly half of all participants received very little or no preparatory menstrual education, most described having experienced negative emotions toward their first menses. Participants used strong emotive language such as "shocked," "scared," and "shame" when recalling these experiences: "I didn't know anything about bleeding ...I was shocked" (Somali); "I felt ashamed, I felt scared, and I thought something abnormal happened to me" (Sudanese). Women without menstrual education were also more likely to construct their first menstrual blood as being an injury, illness, feces, or urine. For example, "I thought I might have had an accident and peed my pants" (Afghani); "I had no idea what menstruation meant ...I was kind of horrified that something was wrong with me or I might have hurt myself" (Afghani). Other women positioned their first menses as a form of punishment: "I thought I had done a sin or something really bad" (Afghani); "I was thinking it might be something that I have done and I might be in trouble" (Afghani). These accounts demonstrate how menstrual blood can be constructed as evil and corrupting in the absence of information about its natural biological function. The internalization of such constructs not only positions women's reproductive corporeal bodies in a negative light but also might add to fear and feelings of shame.

However, not all experiences of menarche were negative. Women who were provided with adequate menstrual information prior to menarche described their first

menstruation more positively. For example, “I want to have it, it was okay because my mum used to explain for me. I used to see my aunties, yeah, it wasn’t that bad” (Somali); “I knew about it before ...I have a sister she is older than me and that’s why, she told me, I didn’t get surprised by that because I knew” (Iraqi). These accounts reiterate how menarche experiences are shaped through the provision of menstrual education and familial support girls receive prior to and during menarche.

Solitude and segregation: Isolation at menarche.

For a number of Tamil women, the menarche celebrations described above occurred following a period of seclusion, reflecting a complex cultural construction of menstruation: “I was made to stay in the room for one month until they had the ceremony” (Tamil); “she moved me to a smaller room in the house and asked me to stay there and not to come out ...I was locked up in the small room ...for 11 days” (Tamil). Although some participants who had experienced menstrual seclusion positioned it as being “natural” and something that happens to every woman, others found seclusion challenging: “you can’t go outside that was tough” (Tamil). Interviewees provided few explanations for menstrual seclusion; however, one participant described it in terms of the need for recuperation, drawing again on the concept of an internal wound: “there is some wound inside and the wound has to be healed, that’s why they keep the girls in the room” (Tamil). Another participant commented, “because I was only nine years old, my parents thought I’m not ready to go to school because of the body changes ...so they kept me nearly 4 months” (Tamil).

In addition to enforced isolation, many participants reported self-isolation, positioning menarche as something they were unable to communicate about with others. For example, women told us, “when I first got my period I went away and

cried, nobody knew I was crying, I hide it, I cry, I still remember" (Somali); "there was a little dark room, and I would go there and I would lay out a mattress ...and I would just sit there and cry" (Afghani). A number of participants also described not disclosing to mothers and family that they had begun menstruation, as they felt "ashamed" or "shy." As a consequence, some participants described menarche as being a lonely time: "it was a very sad situation because I was very, very lonely" (Latina), and positioned their menarche experience in a negative light, "I never wanted to remember this day again and I kept praying, oh god never ever let this happen to me again" (Afghani). In combination, these accounts suggest that associations between menstruation and shame or secrecy might be reinforced by menstrual seclusion, whether it is a cultural practice or self-enforced.

"When I got the period I always wear dark clothes": Concealment and contamination.

Throughout women's accounts, menstrual blood was nearly always constructed negatively. Participants repeatedly positioned blood as "disgusting," "dirty," "awful," and "not clean." One participant said,

> It was disgusting ...because it's blood ...you can smell there is something different ...I found in my bed some blood, so I tell my family, I can't sleep on this bed. They wash it, and I said ...you have to change it, so they change the whole bed because of that ...because the blood has come from the vagina, so I think it's dirty. (Iraqi)

This account captures the disgust a woman reportedly had about her own fecund body, resulting in her positioning menstrual blood and her vagina as abject. One of the consequences of menstruation being constructed as polluting and contaminating

was women's desire to conceal their menstruating bodies from the wider world: "I started to wear dark colors when I get my period. I do not wear whites at all ...it will look disgusting when it stains" (Iraqi); "my mother told me to wear more black when I get my period" (Afghani). Many women described feelings of self-consciousness and greatly feared leakages, resulting in frequent visits to the bathroom:

> I was cautious or conscious of getting my dress dirty so I would go more frequently to the wash-room. I was afraid of my dress getting stained. It is a big problem, how can you get out of school? It was like a shame. But it wasn't only me; all the girls felt this way. (Sudanese)

It is likely that the fear of leaking is further accentuated given the intolerance of visible menstrual blood and the threat of humiliation if this occurs: "my mum told me ...make sure that it doesn't spoil your clothes, because people will laugh at you ...they will scald you" (Somali). Not only did women have to wear dark clothes to counteract the possibility of leakage but also loose clothes were essential to hide any evidence of menstrual products: "they told me that when I have menstruation, try to avoid wearing tight clothes in order to avoid the pads to appear from your tight clothes" (Iraqi).

The onset of menses was also found to introduce restrictions into girls and women's domestic lives. For example, three Sudanese women described the inability to enter the kitchen and carry out normal household duties while menstruating, even following migration: "you can't cook, you can't wash dishes, you can't clean the house for one week until you are clean" (Sudanese). Although such restrictions might reinforce the notion of menstruation being dirty, one Sudanese woman viewed such restraint in a positive light given it meant she had a break from her usually demanding household activities: "seriously for me, it's good, because I can relax"

(Sudanese). Such examples were unique to Sudanese women and demonstrated how some women can position menstrual restrictions positively.

Nearly all women described sex during menstruation as strictly prohibited. Reasons for such restrictions on sexual activities included sex being "unhealthy," "harmful," and "dirty" when a woman is bleeding, and sexual abstinence being religiously sanctioned. For example, one woman said, "when it comes to religion, in Islam a man and a woman should not have sex when a woman is having their period, it is dirty, you are dirtying yourself" (Afghani). Women reported feeling shameful and embarrassed about their menstruating bodies, particularly with regard to the smell of menstrual blood:

> No penetration, this area is dirty and full of microbes during the period. Excuse me, but the smell no one can tolerate it ...we know that our bleeding is dirt inside our body and it's being discharged, yuck. (Iraqi)

In addition, menstrual sex was avoided as women considered it inappropriate for men to witness their menstruation: "I never be near to my husband, this is a type of respect to him as a man. I don't like him to see something not good in me" (Iraqi). In another account, a Latina woman attributed avoidance of menstrual sex to her partners dislike for menstrual blood: "[men] feel disgusted by the smell of the blood ...my husband, he hates the smell of blood ...he's so disgusted and so grossed by our menstruation". These accounts reinforce the construction of menstruation as something that must be concealed from men, given its discursive position as something dirty and unpleasant. Only one participant countered such constructions, and positioned menstrual sex as acceptable, despite acknowledging common discourses of such practice being unhealthy: "both of us did not mind intercourse

during the period despite the fact that it is said to be unhealthy and wrong to have intercourse" (Iraqi).

Many women also described prohibition from religious activities, such as visiting the mosque, temple, or church; praying; touching the Koran; participating in religious ceremonies; and observing Ramadan, when menstruating. For example, "these days we can't go to the temple" (Tamil); "praying is for when you're pure and clean and you're respecting yourself in front of God" (Afghani); "it's totally forbidden when a woman is having her period, she is not supposed to touch the Koran" (Somali). Some Muslim women reported that they were required to undertake a cleansing bath before resuming religious activities, because menstrual blood was polluting. Ritual bathing after the cessation of bleeding was assumed to restore "purity": "when you have your period, before you've cleansed yourself, you're not allowed to pray or read the Koran" (Afghani). Religious prohibitions and the requirement of ritualized bathing thus reinforce the construction of a woman's reproductive body as unclean and polluting, and herself as lacking purity.

Discussion

This article has examined the construction and experience of menarche and menstruation among migrant and refugee women who had recently migrated to Australia and Canada. Although participants were of differing cultural and religious backgrounds, they expressed similar negative constructions of the material event of menarche and menstruation, drawing on broader cultural discourse, positioning it as shameful, something to be concealed, and polluting.

Menarche and Sexuality

Menarche is a time of significant psychological and sociocultural adjustment, potentially leading girls to reconceptualize their identity as women within the

patriarchal societies they live (T. E. Jackson & Falmagne, 2013). It is discursively positioned as a marker of adulthood and reproductive maturity across many sociocultural contexts (Ussher, 1989), as found in the present article. However, as reported in previous research conducted with culturally diverse women (Orringer & Gahagan, 2010; Uskul, 2004), many participants experienced this new adult positioning as overwhelming or unwanted, because of the sudden social and behavioral restrictions and the expectation that they would display hegemonic feminine behaviors. These accounts demonstrate that through a women's fecund body, she is integrated into the social and sexual order (Lee & Sasser-Coen, 1996; Ussher, 1989), which for some resulted in a sense of lost childhood and negative attitudes toward menstruation.

"Becoming a woman" was discursively linked to marriage and childbearing, with being a wife and mother a cultural imperative shared by all participants; for women in this study, menarche signified that girls were now marriageable. For some women, particularly those who originated in Afghanistan, getting married and having children were immediate material outcomes of menarche. As reported in previous research, this was to prevent women from engaging in unlawful practices, such as premarital sex and pregnancy outside of wedlock (Raj et al., 2014; Schuler, Bates, Islam, & Islam, 2006), a potential threat to family honor, and to protect them from unwanted sexual advances of men. In prior research, menarche has similarly been documented as a time in which young women's emerging sexuality is discursively positioned as problematic (Lee, 1994; Teitelman, 2004). However, focusing on warning messages and the avoidance of men following menarche, with no concomitant explanation as to how menstruation is linked to pregnancy, has been found to be confusing for young woman (Costos et al., 2002) and might lead to fears

that any expression of sexuality would lead to pregnancy and thus a loss of reputation (Ussher, 1989). This could have negative implications where young women associate their developing bodies and sexuality with shame, danger, or victimization (Mason et al., 2013; Teitelman, 2004).

Within androcentric societies, pubertal women learn quickly that their developing bodies are objects of the male gaze and a signifier of sexuality (Lee & Sasser-Coen, 1996). As a consequence of such positioning, in line with earlier research with women from non-Western backgrounds (Golchin Nayereh et al., 2012; Mason et al., 2013), participants in this study described being self-conscious of the sexualization of their bodies at menarche, particularly breast development, positioning it as being shameful. Accounts in this research are contrary to those of Western women, where the development of breasts has been reported to be seen as an asset (Lee, 2009), a finding that is likely a reflection of the increasing sexualization of girls and emphasis on breasts in the media among Western cultures (Graff, Murnen, & Krause, 2013). Given many participants in this research did not receive adequate pubertal education from their families or at school, girls might have lacked both the subjective and cognitive knowledge to make sense of their developing bodies and sexuality (Beausang & Razor, 2000; K. A. Martin, 1996), thus resulting in anxiety and body shame. This can have implications for the way these women communicate about sexuality with their own daughters (McMichael & Gifford, 2009).

Celebrations and Rituals

As reported in previous research, among women of varying cultural backgrounds (Chrisler & Zittel, 1998; Uskul, 2004), we found the practice of menarche celebrations uncommon, with the exception of Tamil and some South

Sudanese women. Women who experienced celebrations positioned their purpose as one of "welcoming into womanhood." However, although wider society might value such celebrations, it does not mean the menarcheal girl will view them in the same light. Menarche is generally considered a personal event, and many girls feel anxious about people knowing they are menstruating, thus go to great lengths to conceal it (T. E. Jackson & Falmagne, 2013; Lee, 2009). The discomfort with menarche celebrations reported in our study might therefore be associated with the public sharing of an intimate bodily process and being "viewed differently" among their communities. Even though menarche celebrations might attempt to promote positive messages, such as "welcoming" into womanhood, women are simultaneously receiving stigmatizing messages about the taboo nature of menstruation, a bodily function to be contained and hidden (Johnston-Robledo & Chrisler, 2013).

The discursive positioning of menarche celebrations in this study was shaped through the intersections of culture and migration. Following migration, some women now viewed menarche celebrations as being inappropriate, as they are not practiced in the West, and therefore discontinued such practice with their daughters. Other women, notably in the Tamil community, showed evidence of adapted traditional celebrations, with a focus on having "fun" rather than announcing a woman's marriageability to wider society, as traditionally intended. Such accounts highlight how women are negotiating multiple potentially conflicting discourses and modernization, affecting the cultural practices they choose to carry out with their daughters who enter menarche today.

Menstrual seclusion has previously been described among differing sociocultural environments (Crawford et al., 2014; Mendlinger & Cwikel, 2005). In this research, the material practice of seclusion was predominantly reported among

Tamil women, and only occurred at menarche, primarily for the purposes of "recuperation." Similar to accounts of women in a study by Crawford et al. (2014), seclusion at menarche was described as challenging by some participants in our research. It is possible that in the absence of a coherent explanation of menstruation prior to menarche, menstrual seclusion might be confusing and lead girls to associate their menarche with isolation (Crawford et al., 2014).

As reported previously (Chang, Chen, Hayter, & Lin, 2009; Mendlinger & Cwikel, 2005; M. Sommer, Ackatia-Armah, et al., 2015), this study found culture specific rituals and dietary beliefs surrounding the consumption or avoidance of certain foods and drinks during menstruation. Similarities in rituals were expressed by women within each cultural group, highlighting how traditional knowledge surrounding women's health may be preserved and transmitted generationally (Mendlinger & Cwikel, 2005). These findings also emphasize the importance of considering cultural constructions of health and illness. Although menstrual rituals and practices described in this article might not align with Western views of medicine, changes in diet and hygiene during menstruation were considered key functions for the avoidance of increased menstrual pain and blood flow for a number of women who participated in this research.

Silence, Stigma, and Shame

Silencing menarche and menstruation acts as a reinforcer of the discursive positioning of a woman's bleeding as a source of stigma (Johnston-Robledo & Chrisler, 2013; Ussher, 2006), and denies women the right to learn about the functioning of their reproductive bodies. Although menstrual talk is typically avoided, even in a Western context (Kissling, 1996), the implications of menstrual

stigma are that menstruation is constructed as "unspeakable," as found in the present study across all cultural groups. As Chrisler (2011) argues, "stigma attached to women's bodies can divide women from each other and create conflict between 'good' and 'bad' women" (p. 8). Similar to previous findings (Al Omari et al., 2015), women in this research were positioned as "naughty" or "disrespectful" if they spoke about menstruation in public. Consequently, this created a collective silence among young women to avoid being labelled as "bad" and resulted in women feeling ashamed to ask about their experience of menarche. In addition, in some instances, discussion of menstruation was considered too shameful to listen to, thus women engaged in self-policing (Foucault, 1975) to regulate their own reproductive health knowledge. Findings of self-policing have previously been reported by migrant women in relation to receiving sexual health education (Wray et al., 2014). Self-policing of essential health knowledge, such as menstrual education, might result in women having limited understanding of their own reproductive bodies placing them at risk of poorer sexual and reproductive health.

In contrast to earlier research conducted in a Western cultural context, where mothers are described as "emotional anchors" during menarche (Koff & Rierdan, 1995; Lee, 2008), women interviewed in the present study across all cultural groups received little or no preparatory menstrual education or support from their mothers. Such finding supports that of previous studies with both Western and non-Western women (Al Omari et al., 2015; Cooper & Koch, 2007; Costos et al., 2002), highlighting that across sociocultural settings, menstruation continues to be discursively positioned as a shameful topic for mothers to discuss with their daughters, thus repeating intergenerational cycles of shame and secrecy (C. Bennett & Harden, 2014).

In parallel with previous research (Beausang & Razor, 2000; Uskul, 2004), the ways in which mothers reacted to girls at menarche was reported to have directly influenced a girl's experience. Where mothers did educate their daughters about menstruation, discussions were commonly described as "brief" or "unemotional," with a focus on menstrual rules, which can lead to girls feeling dissatisfied with their menarche experience and resentful toward their mothers (Costos et al., 2002; Uskul, 2004). Through participants retrospective accounts, we were able to see how migrant and refugee women, who experienced hegemonic discourses of shame toward menarche and menstruation, are now choosing to negotiate cultural secrecy and shame through menstrual communication and education with their daughters. As reported previously (Cooper & Koch, 2007; Kissling, 1996), many women who received poor quality or no menstrual support themselves intended to provide their daughters with menstrual education and counseling. At the same time, our finding that a substantial number of mothers wanted to educate their daughters, but were shy, uncertain, or had misunderstandings about how or when to approach menarche, suggests that migrant and refugee women may need support with addressing menarche with their young daughters. Conversely, some mothers passed on cultural beliefs that might reinforce menstrual shame and stigma, such as warning daughters to avoid being touched by boys during menses. This finding emphasizes the need for education sessions for mothers to ensure they have a sound understanding of menarche as a reproductive and emotional transition, as well as providing an opportunity to counter negative discourses of menstruation through positive representations of menarche and menstruation. Education sessions could also promote the discussion of menarche and provide constructive methods to enable mothers to approach daughters about this sensitive topic.

Although menarche is not always a smooth transition to womanhood, girls in the West seldom experience it with a complete absence of knowledge (Kissling, 1996), in contrast to the experience of women in the present study. In conjunction with poor maternal education, participants found menstrual teaching in school was frequently absent, inadequate, lacked practical support, or occurred when girls had already begun menstruating, a finding frequently reported in the literature with Western and non-Western women (Beausang & Razor, 2000; Cooper & Koch, 2007; M. Sommer, Ackatia-Armah, et al., 2015). In the absence of any framework to make sense of menarche, women associated their first menses with excrement, injury, and guilt, similar to those reported in previous literature in a Western context (Cooper & Koch, 2007; Lee, 2009). Negative constructions of menstrual blood lead women to feel humiliated and unclean, and might result in women developing ongoing associations between menstruation and contamination (Lee, 2009). An additional implication of being denied knowledge of their reproductive bodies meant a large portion of women were unaware of how menstruation was related to fertility, putting women potentially at risk of unplanned pregnancy (Koff & Rierdan, 1995). Consequently, it is important to ensure that menstruation is incorporated into sexual and reproductive health education available to all migrant and refugee girls and women. In addition, health care professionals should be aware that some newly arrived migrant and refugee women might not have adequate knowledge of their menstrual cycles in relation to fertility, and could require further explanation and counseling during consultations when discussing topics such as contraception and pregnancy.

Contamination and Concealment

Although there are many cultural representations of blood, ranging from family and kinship, to violence and war, menstrual blood is almost always positioned negatively (Bramwell, 2001). Historically and cross culturally, menstrual blood has been discursively constructed as being poisonous, magical, and polluting (Buckley, 1988; Laws, 1990). One explanation for this is because it exits the body from the vagina, a part of a woman's body commonly represented as being unclean, shameful, and inherently sexual (Bramwell, 2001; Braun & Wilkinson, 2001). Experiences of shame and feelings of "dirtiness" toward menstrual blood are commonly reported in the literature (Donmall, 2013; Lee & Sasser-Coen, 1996) and are thus not unique to participants in this study. Understanding how women retrospectively experience and construct menarche and menstruation is important to recognize across all age groups, as negative experiences of shame could extend to influence how women view and experience ongoing aspects of their sexual and reproductive lives. For example, positioning menstruation as abject might mean women are reluctant to disclose menstrual cycle– related problems to their health care professionals, resulting in delayed diagnosis or treatment (Seear, 2009) and might impact on a woman's ability to discuss abnormal vaginal symptoms when seeking medical advice (Braun & Wilkinson, 2001). To provide culturally sensitive care, it is essential that health care professionals are aware of cultural constructions of both the vagina and menstruation, particularly when considering the wider sexual and reproductive health of women (do Amaral et al., 2011), such as cervical smears.

Etiquettes of concealment, to prevent public knowledge of menstruation, were discussed at length within women's accounts, supporting previous research findings (Beausang & Razor, 2000; Burrows & Johnson, 2005; Uskul, 2004). Self-

surveillance surrounding menstruation is likely to affect a woman's attitude toward her body and is energy consuming (Johnston-Robledo & Chrisler, 2013). In the context of this study, across cultures, participants' self-surveillance resulted in behavior changes during menstruation, such as frequent visits to the bathroom and missing school, a well-recognized consequence of being a menstruating woman in a developing country (M. Sommer, 2010). Menstruation also complicates the social construction of a woman's body as being attractive and objects of desire. Leaking bodies which "smell" do not fit the ideal feminine standards of beauty and thus the corporeality of the women's body must be repressed, contained, kept private, and outside the public gaze (Roberts & Waters, 2004; Ussher, 2006).

Women across cultures and religions are continually receiving paradoxical messages by which they are both demonized for their bleeding bodies, positioning them as unclean and polluting (Dunnavant & Roberts, 2013), but praised for their ability to procreate (Goldenberg & Roberts, 2011). When considering the intersections of gender and religion, the present study was no exception, with many women continuing to avoid activities during menstruation due to religious beliefs, even following migration. Although the prohibition of women from religious activities or places of worship during menses was seen across Hinduism, Christianity, and Islam, some practices were specific to participant's religious and cultural backgrounds. For instance, some Afghani women viewed menstruation as being so contaminating and unclean that only a religious bathing ritual following menses could neutralize such threat. Although similar findings have been found among Orthodox Jewish women who report practicing bathing rituals to restore purity after menses (Guterman, 2008), no other cultural groups in this study reported similar practices.

Although ritual bathing is uncommon in a Western context, the taboo nature of menstrual sex reported in women's accounts has been found in the West (Allen & Goldberg, 2009). Avoidance of menstrual sex is reported for reasons of "mess," negative self-perception, and partner's disgust (Fahs, 2011a). Even though our participants shared some of these concerns, their primary reason for refraining from sex during menstruation was again centered on religion, particularly for women who practiced Islam. The exclusion of women from religious activities and sexual intimacy could be frustrating for women (Guterman, 2008) and might lead women to internalize feelings of shame and inferiority toward their own bodies (Crawford et al., 2014). However, not all exclusions currently practiced by women were experienced or positioned negatively, highlighting how menstrual restrictions occur paradoxically (Dunnavant & Roberts, 2013). In a Western context, the inability to enter the kitchen during menstruation could be positioned as being repressive; yet, for some Sudanese women, in this research, the cultural expectation to refrain from cooking during menses was found to be a welcomed break. In a similar light, women who are banished to menstrual huts during menstruation might position such cultural restriction as an opportune time to socialize with other women and a relief from their busy domestic lives (Mendlinger & Cwikel, 2005).

There are a number of strengths and limitations of this study. Strengths include participants being interviewed in their first language meant women could explore their experiences in depth and were not limited by language. This also allowed for participation of women who were newly arrived to Australia and Canada and might not be fluent in English, and whose experiences are often ignored as a result. Interviewing women from diverse cultural groups made both within and between comparisons possible, an important element for the development of

appropriate heterogeneous health promotion and education activities for migrant and refugee women. Limitations include the fact that researchers could not back-check translated transcripts for accuracy. Furthermore, meanings and discourses about menarche and menstruation may have been lost through the process of English translation given we could not analyze menstrual related terms in participant's first languages. Women were also retrospectively reflecting on their experiences; thus, stories shared in this research might not necessarily be illustrative of girl's experiences of menarche and menstruation in their countries of origin today. Lastly, given we spoke to a small subset of women from each cultural group, experiences and constructions of menstruation might not be representative of their community as a whole.

In conclusion, through the use of a material-discursive theoretical framework, we were able to examine women's constructions and experiences of the materiality of menarche and menstruation, in the context of cultural and religious discourse which provided meaning for such events. The current research demonstrates that there are many commonalities in migrant and refugee women's experiences and constructions of menarche and menstruation, as well as some differences across cultures, reinforcing the importance of considering intersections of gender, culture, religion, and migration in shaping the subject positions women take up in relation to the reproductive body. Our study findings highlight that as a result of menstrual shame and stigma, many women across cultural groups experience menarche with a complete absence of knowledge about their bodies, and within patriarchal societies, particularly those who follow strict religious doctrine, women might be more likely to consider menstruation as shameful and polluting, resulting in negative attitudes toward the corporeality of their bodies. This research has demonstrated that some

migrant and refugee women arrive in host countries with little or no knowledge of menarche and menstruation, highlighting the importance of appropriate menstrual education as a part of sexual and reproductive health education, for young girls and for mothers to transmit to daughters. Our findings reiterate the importance of considering culturally specific experiences and constructions of menarche and menstruation given their possible implications on help seeking health behaviors and the wider sexual and reproductive health of migrant and refugee women.

Chapter Four: Regulation and Resistance: Negotiation of Premarital Sexuality in the Context of Migrant and Refugee Women

As described in the previous chapter, menarche signifies a woman's reproductive potential and emerging sexuality. To build on this, the following chapter considers the ways in which migrant and refugee women experience and construct their sexuality as young women prior to marriage, and as married women reflecting back on this period of their lives. The analysis presented in this chapter is in the form of an academic journal article, accepted in *The Journal of Sex Research*. Appendix J presents the published manuscript.

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Abstract

Constructions of normative sexuality shape the sexual scripts that women are permitted to adopt and the manner in which such sexuality can be expressed. We explored experiences and constructions of premarital sexuality among migrant and refugee women recently resettled in Sydney, Australia, and Vancouver, Canada. A total of 78 semistructured individual interviews and 15 focus groups composed of 82 participants were undertaken with women who had migrated from Afghanistan, Iraq, Somalia, South Sudan, Sudan, Sri Lanka, and South America. We analyzed the data using thematic decomposition. Across all cultural groups, women's premarital sexuality was regulated through cultural and religious discourse and material practice. Such regulation occurred across three main facets of women's lives, shaping the themes presented in this article: (1) regulating premarital sex—the virginity imperative; (2) regulation of relationships with men; and (3) regulation of the sexual body. These themes capture women's reproduction of dominant discourses of premarital sexuality, as well as women's resistance and negotiation of such discourses, both prior to and following migration. Identifying migrant and refugee women's experiences and constructions of premarital sexuality is essential for culturally safe sexual health practice, health promotion, and health education.

Introduction

Across sociocultural settings and epochs, constructions of normative sexuality vary, influencing women's subjective experiences of sexual identity and sexual practices (Ussher, 1997b; Weeks, 2014). Cultural ideologies and social practices are transmitted through language and representations, known as discourses, or discursive practices (Burr, 2015). An exemplar of cultural variance in discursive constructions of sexuality is the contrast between the acceptance and widespread practice of premarital sexual activity among the majority of people in secular countries, such as Australia and Canada, and its condemnation in many religious non-Western cultures globally. For example, in a national survey of Australians, the majority (87%) of men and women reported that they accepted sex prior to marriage as the norm (de Visser et al., 2014). The median age of first sexual intercourse in Australia is 18 for women and 17 for men (Rissel et al., 2014) and the average marriage age is 31 years old (ABS, 2015), suggesting that a high proportion of individuals are engaging in premarital sex. These liberal attitudes toward premarital sex are associated with comprehensive sex education through the mainstream schooling system, which is strongly supported by parents (Berne et al., 2000; McKay, Byers, Voyer, Humphreys, & Markham, 2014), as well as widespread provision of preventive sexual health measures, such as the human papillomavirus (HPV) vaccine, to young people (Markowitz et al., 2012). Access to contraception for unmarried women is also the norm in both countries, reflected in the fact that many young and unmarried women are currently using some form of contraception (Black et al., 2009; Family Planning New South Wales, 2013).

It is important to acknowledge, however, that while Australia and Canada may be fairly tolerant toward premarital sex, this is not the same across all Western

contexts. In the United States, for example, adolescent sexuality is regulated through the influence of conservative Christian institutions, which shape the continued cultural and political value of premarital virginity (J. C. Williams, 2011). This influence has resulted in the majority of state and federal policies supporting abstinence-only sexual health education programs within schools (Fine & McClelland, 2006; Weaver, Smith, & Kippax, 2005). Such lack of comprehensive sex education is thought to contribute to higher rates of teen pregnancy and sexually transmitted infections (STIs) and lower rates of contraception use compared to other developed countries with more pragmatic and sex-positive attitudes toward sexual health education (Weaver et al., 2005).

Among some contemporary Muslim societies in the Middle East, Asia, and Africa, the regulation of women's sexuality is more explicit. The significant value placed on a woman's virginity strongly shapes women's expression of sexuality, romance, marriage, gender relations, and gender equality (Hélie & Hoodfar, 2012; Khan, 2012). Such findings have similarly been found within Hindu cultures (Menger, Kaufman, Harman, Tsang, & Shrestha, 2015; Regmi, van Teijlingen, Simkhada, & Acharya, 2011) and a number of Christian cultures, such as those in South America (Espinosa-Hernández et al., 2015; Hoga et al., 2010). Within these societies, a woman's premarital chastity stands as an important marker of her own honor and that of her family (L. R. Bennett, 2005; Kaivanara, 2016). In some Muslim contexts, governmental policies and practices aim to control women's sexual autonomy and confine any expression of sexuality to the institution of marriage (L. R. Bennett, 2005; Khan, 2012). The existence of moral police authorities, who are employed to reinforce adherence to such regulations, combined with strict sex segregation and the severe surveillance of women and their sexualities, act to control

women's expression of sexuality and sexual agency (Kaivanara, 2016; Yaghoobi, 2012). In these cultures, sexuality is considered a very private matter, closed to discussion, particularly for unmarried women who are culturally and religiously expected to be asexual until married (Ghanim, 2015; Shalhoub-Kevorkian, 1999).

What has not been sufficiently explored is how migrant and refugee women from culturally and linguistically diverse (CALD)[1] backgrounds negotiate competing discursive constructions of premarital sexuality when migrating from cultures where a discourse of sexual agency and acceptance of premarital sex is less prevalent to countries with more liberal attitudes and practices, such as Australia and Canada. This was the aim of the current study. To address this issue, the following research questions were asked: How is sexuality prior to marriage constructed and experienced among recent migrant and refugee women living in Australia and Canada? What are the commonalities and differences across a range of cultural groups? What are the implications of these constructions and experiences for the sexual and reproductive health of migrant and refugee women?

It is important to understand how migrant and refugee women experience and construct premarital sexuality for a number of reasons. Within Australia and Canada, the sexual and reproductive health needs of migrant and refugee women is of growing concern due to their underutilization of sexual health services (Aminisani, Armstrong, & Canfell, 2012; Botfield et al., 2016; Manderson & Allotey, 2003). Past research has identified a number of barriers that shape migrant and refugee women's access to health care services (Botfield et al., 2016; Mengesha et al., 2016). These

[1] The term "culturally and linguistically diverse" (CALD) is used in Australia to describe people who have a cultural heritage different from the dominant Anglo Australian culture (Department of Health, 2016a), replacing the previously used term of people from a "non-English-speaking background" (NESB). As this term is not used in Canada, where many of our participants reside, we are defining our sample as "migrant and refugee women."

barriers include practical challenges, such as the navigation of complex health systems (McMichael & Gifford, 2009), difficulties with language and communication (Riggs et al., 2012; Straus, McEwen, & Hussein, 2009), and the preference for female health care providers (Tsianakas & Liamputtong, 2002). Other barriers include perceived racism or discrimination when accessing services and receiving care (Allotey et al., 2004), such as cultural stereotyping based on ethnic background (Straus et al., 2009). Past literature has also highlighted that health care services may be avoided if the provision of care is considered culturally inappropriate or does not align with cultural constructions of acceptable care (Phillimore, 2015; Woodgate et al., 2017).

The underutilization of sexual and reproductive health services may also be associated with sociocultural beliefs surrounding premarital romantic relationships and sexual behavior. Past research has established that premarital chastity remains extremely important within some migrant and refugee communities (McMichael & Gifford, 2010; Meldrum et al., 2014; Wray et al., 2014). This may inhibit equitable access to sexual and reproductive health services for unmarried women (Meldrum et al., 2016), as such services are deemed inappropriate (Beck et al., 2005; Rogers & Earnest, 2014). A prohibition against accessing services has also been found to extend to preventive health practices, such as HPV vaccination, which are thought to be unnecessary for unmarried women who are presumed to not be sexually active (Salad et al., 2015). Previous research suggests that sexually active unmarried women from diverse cultural backgrounds may avoid accessing sexual and reproductive health services, as their personal reputation and family honor may be jeopardized if community members find out they are engaging in premarital sex (Manderson et al., 2002; Rawson & Liamputtong, 2009).

It has also been found that the taboo nature of sexual and reproductive health discussion for unmarried women among some migrant groups may affect the sexual health education that women receive (Meldrum et al., 2016), thereby reducing their capacity to make informed decisions about their sexual and reproductive health (D. Shaw, 2009). Among many migrant and refugee families, the cultural taboo of talking about sex with unmarried women may leave younger generations with limited sexual health knowledge, resulting in poor sexual health practices, such as the absence of contraception use (Dean et al., 2017; Manderson et al., 2002; Rogers & Earnest, 2014; Ussher et al., 2012). Furthermore, in migrant communities where virginity is prioritized, parents may not support sex education at school for their daughters, as it is believed such learning may encourage premarital sex (Beck et al., 2005; Ussher et al., 2012); this leaves young women vulnerable to unplanned pregnancies and STIs. A lack of sex education may also lead to emotionally negative experiences of first sex, which have been associated with sexual difficulties later in life (Rapsey, 2014; Smith & Shaffer, 2013). Following migration, it has been found that exposure and integration into societies with differing sexual norms may cause intergenerational discord and family conflict, further limiting a woman's ability to discuss sex with parents and adding to acculturative stress (Dean et al., 2017; Manderson et al., 2002). Greater understanding is needed into how migrant and refugee women negotiate competing constructions of premarital sexuality and how this may influence their sexual health practices and sexual subjectivity— their experience of self as a sexual being, entitled to sexual pleasure and safe sex, free to make decisions in relation to sexual choices (Tolman, 2002a).

Among diverse migrant cultures in the West where women's virginity is prioritized, it has been found that the meaning of virginity is often simplified and

symbolically charged. Being a virgin commonly refers to not having had coital sex, with the material presence of a woman's hymen signifying virginal status (Abboud et al., 2015; Cinthio, 2015). More globally, failure to prove virginity on the wedding night, through the presence of hymeneal blood, has been found to result in severe consequences for young women, such as immediate divorce, social stigmatization, and physical violence (R. J. Cook & Dickens, 2009; Eich, 2010). This has led to the medicalization of virginity, such as virginity checks and hymen reconstruction or "hymenoplasty," a procedure to artificially repair or restore the hymen to mimic expected bleeding at first coitus (A. Ahmadi, 2016; Amy, 2008; Kaivanara, 2016). It has been found that health care professionals in the West are increasingly being faced with questions from young migrant and refugee women surrounding issues such as hymenoplasty, which many feel ill-equipped to deal with, if they do not understand the sexual norms associated with premarital sex to which these women are adhering (Essén et al., 2010; Loeber, 2015).

Physical regulation of women's premarital sexual bodies also extends to the practice of female genital mutilation (FGM)[2]. An estimated 200 million women and girls alive today have undergone FGM (UNICEF, 2016), a tradition carried out in both Christian and Muslim communities (Mathews, 2011). It is practiced across 30 countries in Africa, the Middle East, and some isolated Southeast Asian contexts (UNICEF, 2016). FGM refers to "all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons" (WHO, 2016). While the motives for FGM vary across cultural and

[2] The terminology used for this procedure is complex and has undergone various changes. We have chosen to use the terminology "female genital mutilation" (FGM) as opposed to "female genital cutting" (FGC) or "female circumcision," as FGM is the current terminology used by the WHO and United Nations Population Fund (UNFPA), which describes the practice from a human rights viewpoint (UNFPA, 2015).

geographical settings, the primary function is to mitigate a woman's sexual desire, ensuring virginity until marriage, and thus maintaining her family's reputation and honor (Fahmy, El-Mouelhy, & Ragab, 2010). FGM is widely considered a major breach of human rights, as it denies women's bodily integrity and has significant physical and psychological sequelae, including extensive pain and bleeding, complications with childbirth, recurrent urinary tract infections, and even death (WHO, 2016). Given that Australia and Canada are destinations for migrant and refugee women from countries where this practice occurs, understanding how women discursively construct FGM, in the context of constructions and practices associated with premarital sexuality, is important for health care professionals and educators.

Experiences and constructions of women's sexuality are not static; they are subject to change and transformation according to the social and historical context in which one is embedded (N. Ahmadi, 2003b). For example, urbanization and the influence of the Internet has meant that in some traditionally patriarchal contexts, such as Iran women are demanding sexual intimacy and romantic love prior to marriage, which is slowly leading to societal shifts in constructions of normative heterosexuality, potentially allowing women more freedom (Afary, 2009; Kaivanara, 2016; Mahdavi, 2009). Many Muslim women are also demonstrating resistance to policing of their sexuality in the public sphere by challenging dress codes and talking to nonrelated males in public—actions which are traditionally prohibited politically and culturally (Hoodfar & Ghoreishian, 2012). These examples highlight how women are not always passively situated within prevailing discourses but can reposition, resist, variably adopt, and negotiate dominant discourses to achieve a desired sexual subjectivity (Day, Johnson, Milnes, & Rickett, 2010, p. 238). This has

been described as the adoption of counter-narratives or counter-discourses to facilitate the position of sexuality in more agentic ways (McKenzie-Mohr & Lafrance, 2014a). Little is known about the ways in which migrant and refugee women, after migrating to Australia or Canada, may adopt counter-discourses in relation to premarital sex, which is the context of the present study.

While a small number of studies have considered migrant and refugee women's experiences and constructions of premarital sexuality, there are a number of gaps in existing research, which the present study aims to address. Qualitative research that has been undertaken on migrant women's sexual health commonly considers the perspectives of women who are from the same cultural or religious background (Manderson et al., 2002; Meldrum et al., 2016; Wray et al., 2014), limiting the ability to acknowledge commonalities and differences across multiple social structuring factors, such as religion, cultural background, or geographical location (Martinez & Phillips, 2008). Even where diverse cultural backgrounds have been considered, study sample sizes are small, making generalizations to the wider community difficult (Meldrum et al., 2016; Rogers & Earnest, 2014). Past research on migrant women's sexual health also often considers the perspectives of second-generation women (Rawson & Liamputtong, 2009) or the perspectives of unmarried women only (Manderson et al., 2002; Rawson & Liamputtong, 2009; Wray et al., 2014), leading to a call for research on adult women and those who are parents (Keygnaert, Vettenburg, Roelens, & Temmerman, 2014; McMichael & Gifford, 2009). These gaps in the research literature need to be addressed to implement effective sexual and reproductive health policies, services, and education, and to better understand the specific challenges facing migrant women from different sociocultural and religious backgrounds (P. W. Garrett et al., 2010).

Method

Research design.

A qualitative research design was utilized to examine constructions and experiences of premarital sex among recent migrant and refugee women living in Australia and Canada. The findings presented in this article are drawn from a larger program of research examining migrant and refugee women's sexual and reproductive health in Sydney, Australia, and Vancouver, Canada (Hawkey, Ussher, Perz, & Metusela, 2017; Ussher, Metusela, et al., 2017). A total of 78 individual interviews and 15 focus groups, with 82 participants, were conducted (total n = 160 women) from July 2014 to November 2015. Focus group participant numbers ranged from three women to 10 women within each group. Participants were women who were born in and migrated from other countries, including Afghanistan, Iraq, Somalia, and Sudan. Sri Lankan (Tamil) and South Sudanese women were included in the Australian sample, and women from South America (Latina) were present in the Canadian sample. Table 1 (See Chapter 2) provides further demographic information for participants in each cultural group.

Participants and procedure.

Participants were women ranging from 18 to 70 years old, with a mean age of 35. All women, except for one Latina participant who identified as being in a same-sex relationship, identified as being heterosexual. Participants were women who had migrated in approximately the last 10 years, with the average time since migration being seven years. Women identified as practicing a range of religions, including Christianity, Islam, and Hinduism. The majority of participants migrated as humanitarian refugees, in which a visa is given to those who are fleeing their home country in fear of persecution or those who are suffering substantial discrimination

and human rights abuses in their country of origin (Department of Immigration and Border Protection, 2017).

Community stakeholders involved in the provision of sexual and reproductive health care and support of migrant and refugee women, such as community migrant resource centers and family-planning clinics, partnered with the research team to establish an advisory committee. Meetings with community stakeholders were held to determine the most appropriate methodologies of research, to develop interview schedules, and to refine project aims. Participants' countries of origin were selected because they were recognized as being underrepresented in previous research literature in this sphere, which in Australia has focused on Southeast Asian women (P. W. Garrett et al., 2010). In addition, community stakeholders identified selected cultural groups as being those who were not attending sexual and reproductive health services, despite contributing to a significant proportion of recent arrivals to both countries. Australia and Canada were chosen for this research study as they are comparable geographically, economically, and politically, and they host similar migrant populations. This project was also a part of an ongoing collaboration between researchers in Australia and Canada.

The majority of participants (72%, n = 115) were interviewed in their first language by trained community interviewers, women of the same cultural background or who spoke the same language as the interviewees. Members of the research team JU and JP, who are academics in the fields of women's health and sexuality, trained community interviewers in qualitative methods at a one-day workshop, which covered how to conduct conversational interviews and focus groups and how to transcribe data. In five focus groups (n = 16) and 29 one-to-one interviews, women who preferred to speak English, or who spoke English but wanted

to be interviewed by a non–community member, were interviewed by a member of the research team. Such methodology has effectively been adopted in prior research with migrant women (Morrow et al., 2008).

Individual interviews were utilized to facilitate the collection of in-depth information, which may not be disclosed in a group setting due to its sensitive nature, while focus groups were used to provide insight into cultural or community norms (Creswell, 2009). The integration of focus group and individual interview data allowed for enhanced trustworthiness of our findings through elaboration and clarification across the two methods (Lambert & Loiselle, 2008). As recommended by Krueger and Casey (2014), focus groups were homogenous, in that women were of the same cultural group, and married and single women were interviewed independently where possible.

Participants were recruited through the distribution of study advertisement flyers by community support workers, preexisting community cultural groups, the trained community interviewers, flyers displayed in women's health centers, and snowball recruitment (i.e., where women passed information about the study onto other women). All interviews and focus groups took place in participant-selected locations, including local libraries, community centers, or participants' homes. Participants were offered a $25 (AUD/CAN) supermarket voucher in appreciation of their time and travel costs to attend the interview. Interviews and focus groups were audiorecorded with participant permission. The interviews and focus groups were semistructured and lasted on average 90 minutes. The interview schedule contained broad open-ended questions about women's sexual and reproductive health, including experiences of menarche and menstruation, sexual health, and sexual health screening and support. The specific questions and prompts associated with

premarital sexuality, the focus of this study, included the following: tell me about sex before marriage in your culture; what does being a virgin mean? Are certain things okay in your culture, such as touching each other intimately, kissing, or oral sex, when you are not married? What happens to women who are not virgins at marriage? If a woman did have sex before marriage, is there anything she could do to regain her virginity? How do you feel about being in an Australian/ Canadian culture where women often have sex before marriage?

Allowances to the interview schedule were made to accommodate each participant, for example, questions asked differed slightly according to whether a participant was married or unmarried. Informed consent was gained from all participants. This research was approved by the Western Sydney University Ethics Committee and the Simon Fraser University Ethics Committee, and by one of our stakeholder ethics committees.

Analysis.

Interviews and focus groups that were not carried out in spoken English were translated and transcribed into English by the bilingual community interviewers. Translation was undertaken to retain as much original meaning as possible, while taking into consideration the subtleties of the English language. For example, community interviewers would at times translate statements such as “this is shame,” which in English would be described as being “shameful.” English spoken interviews were professionally transcribed verbatim and integrity checked to ensure accuracy. Filler words such as “um” and “ah” were removed for the purposes of readability. All participant names were replaced with pseudonyms, and identifying information was removed from transcripts.

Our epistemological standpoint was critical realism, which recognizes the materiality of somatic, psychological, and social experience, but conceptualizes such materiality as being mediated by culture, language, and politics (Bhaskar, 2011). In this light, to acknowledge the materiality of women's premarital sexuality (e.g., the hymen, female genital mutilation), as well as the discursive construction of sexuality (e.g., being a virgin at marriage is essential), we adopted a material-discursive theoretical framework (Ussher, 2008). This approach moves away from the mind–body binary divide (Yardley, 1999) and considers the material and discursive aspects of sexuality to be equal and interrelated (Ussher, 1997a).

Participants' transcripts were analyzed using thematic decomposition (Stenner, 1993). This form of discourse analysis identifies themes—that is, commonality in patterns or stories across the data—and then considers discourses and subjectivity of participants' accounts associated with such themes (Braun & Clarke, 2006). To begin analysis, a subset of participant manuscripts was independently read and reread by the authors and research officer on the project. During this process, potential first-order concepts and codes were noted; these included "meaning of virginity," "premarital sex is forbidden," and "premarital relationships boundaries." The entire data set was then coded by the first author and the research officer under these first-order codes, using the computer software NVivo, a program to aid in the organization of qualitative data. The second author continually checked for variability and consistency across codes. Codes were then collapsed into a fewer number of categories through discussion and vigilant decision making with all authors. Data within codes was read again by the first author and research officer and summarized to facilitate the identification of themes across codes. To allow for cultural and geographic comparisons, participants' accounts in

coding summaries were color-coded to represent women from differing cultural backgrounds, and accounts from Canadian women were bolded. Any discrepancies, such as where coded data would fit best into themes and how to best collapse codes into themes, were brought up at project meetings and discussed until agreement was reached. The broader research team was made up of White women and women of color who either had migrated to or were born in Australia or Canada. Team members were academic researchers and those working with migrant women in the community.

Through the process of coding, summarizing, and highlighting, commonalities were identified across participants' accounts, as well as concepts or experiences unique to participants or women in specific cultural groups. Following coding, one core concept was identified across the data: women's sexuality prior to marriage was strongly regulated. Such regulation occurred across three major domains of women's lives forming the three discursive themes presented in this paper: regulating premarital sex—the virginity imperative; regulation of relationships with men; and regulation of the sexual body. While many women's premarital sexuality was controlled through dominant cultural and religious discourses and material practices, there were also accounts of resistance, both prior to and following migration. Adoption of and resistance to cultural and religious discourses was not binary, however. A number of women interviewed gave accounts of both accepting cultural and religious beliefs and practices associated with sexuality at the same time as they resisted such beliefs and practices. This suggests that women were engaged in active negotiation of their sexual subjectivity to gain a degree of sexual agency.

In the presentation of participants' quotes, the following transcription annotation was used: Ellipses (i.e., "…") are used to identify discussion sections

where text was removed when it was not pertinent to the analytical context. Brackets (i.e., "[]") indicate text that has been included by authors to improve readability and preserve meaning of the verbal passage. Quotes are substantiated with a participant's pseudonym (or the use of "FG" in the case of a focus group), age, relational status, and ethnic background. For individual interviews, "Married" denotes participants who are currently married or have been previously married to men. For further breakdown of current relational context, see Table 1 (See Chapter 2). "Mixed" describes focus groups where participants were of differing marital status. In our analysis, no differences were identified between accounts by women in Australia or Canada; thus, country of origin has been excluded.

Results

Regulating premarital sex: The virginity imperative.

Premarital sex was discursively positioned as being "unacceptable," "forbidden," or "a mistake" by nearly all participants interviewed across the cultural contexts. For example, Hoodo (29, married, Somali) said, "It is not something that we take lightly … it's not permissible at all." A married Iraqi focus group participant told us, "It is a sin and it is a major mistake." Similarly, women across the cultural contexts described premarital sex as simply not a part of their culture: "It is wrong … it is not our culture!" (Nita, 27, married, Tamil); "That thing is forbidden… . Sex before marriage is not in our culture" (FG, married, Somali). Other participants, especially Christian and Muslim women, drew heavily on both religion and culture to reiterate the compulsory nature of being virginal until marriage: "We are Christian, we have our rule … our girls, they have to be virgins" (Nyandeng, 34, married, South Sudanese); "It's not in our religion, and also it's not in our culture. It is forbidden" (FG, married, Somali). Exceptions to this finding were predominantly from accounts

with Latina women, who had migrated from countries such as Cuba which were perceived to be more tolerant of premarital sex. As a Latina focus group member stated, “Having sexual relationships before marriage is okay… . People see it as normal and healthy.” However, despite now living in countries with more liberal ideologies toward premarital sex, the virginity imperative was described as being adhered to post-migration by the majority of women interviewed. Crossculturally, participants told us: “I still believe in our culture, so I don’t agree having sex before marriage is right” (Andrea, 26, married, Tamil); “The Sudanese culture does not agree with what happens here” (Nafisa, 36, married, Sudanese); and “I would love for my son to marry a virgin… . I realize that this is one of the cultural residuals that is left in me” (Nasima, 43, married, Iraqi). This was further evidenced in the fact that no young or unmarried participants disclosed having had sex, suggesting the virginity imperative may continue to regulate young new migrant women’s premarital sexual practice even following migration.

Regulation through the virginity imperative was a gendered practice, with many women describing a sexual double standard in their communities, wherein premarital sex was permitted for men but forbidden for women. For example, women said: “My parents didn’t mind them [brothers] to have relations, but for me I wasn’t allowed” (FG, mixed, Iraqi); and “They have all these ridiculous sort of openended chances for men to redeem themselves … for a girl, they don’t give you these concessions at all” (Homa, 40, married, Afghani). The double standard was partly attributed to there being no physical test to prove male virginity, in contrast to women, where the presence or absence of a hymen was considered material verification of a woman’s prior sexual experience. For instance, Eira (26, married, Sudanese) said, “Boys, even if they play, there is no change … but for us, it’s going

to be a bit different." These accounts highlight the patriarchal ideologies that may govern unmarried women's sexuality, with the sexual double standard being a mechanism of control that denies women the right to choose if or when they would like to engage in premarital sex or intimacy.

Across all cultural contexts, women's transgression of the virginity imperative put them at risk of severe material consequences, such as family exclusion, a loss of reputation, stigmatization, and violence. Participants told us, "Nobody will respect her in society" (Suz, 42, married, South Sudanese) and "If a woman had sex before marriage, there is a very negative stigma that will follow her around… . She is 'cheap'; she is 'not worth it'" (Fahmo, 23, single, Somali). This stigmatization was said to result in women becoming "unmarriageable" or being "sent back" to their family home: "People start saying, 'She is a used woman, so I am not going to marry her into my family'" (Homa, 40, married, Afghani); "We knew a few girls that didn't bleed and they were sent back" (FG, married, Afghani); "They kill them; families kill their daughters if they cause such a bad name to the family honor" (FG, married, Afghani). These accounts suggest that the consequences of transgression may act as a deterrent for women's premarital sexual exploration, highlighting how cultural and religious discourse can regulate unmarried women's sexual agency and sexual subjectivity.

As a consequence of premarital sex being discursively constructed as culturally and religiously forbidden, some unmarried Afghan participants described a process of self-regulation to maintain sexual innocence, such as refraining from thinking about sex. For example, a member of an Afghani focus group disclosed, "Oh, my God, it's bad [to think about sex]… . We don't think like that. We follow our religion, so our thinking or ideas are all religious." A further account by Ara (34,

single, Afghani) demonstrates the framework she adopts to govern her sexuality as an unmarried woman:

> We never think sex before marriage. That's automatically with Muslim girls… It's not an important part of your life. As long as you think that you'll meet someone, that person is nice, that's it. I've never thought about that [sex] more than that.

These excerpts suggest that some unmarried women may engage in self-policing of their sexual thoughts and desires to adhere to the cultural ideals of a virgin woman, one who is chaste and naive about sex.

In line with findings reported in Ussher, Perz, et al. (2017), across cultural groups the discussion of sex was also discursively positioned as "shameful" and "not allowed," particularly for unmarried women. This had material consequences in that women had limited opportunities to communicate about sex prior to marriage, as Raana (42, married, Iraqi) said: "My mum was so embarrassed to tell me anything." Some women disclosed they were unable to access information about sex, sexual health, or contraception, because they felt too shy to ask about it or it was seen as inappropriate for unmarried women. For example, one participant admitted: "I didn't ask anyone [about sex] because I am shy" (Hasina, 25, married, Somali). Others related: "I had bad acne, and the doctor suggested to take contraception. But obviously unless you are married in my culture, the girl shouldn't take it… . They question why you are taking the contraceptive pill" (Ara, 34, single, Afghani); "When I got married I didn't know anything about it [contraception]" (Azita, 37, married, Afghani). This led women to seek sexual health information from less reliable sources, such as the "cinema, from the movies" (FG, married, Tamil); "we learn from stories" (FG, mixed, Sudanese); and "most of my friends, they got

married, so they told me" (Saadia, 30, married, Iraqi). The discursive positioning of sex as unspeakable for unmarried women also meant many participants had no knowledge of what to expect on their wedding night: "On the wedding night, in the hotel, I didn't know what will happen" (Madina, 45, married, Iraqi). An absence of knowledge about contraception also led to a number of participants having unplanned pregnancies shortly after marriage, as Andrea (26, married, Tamil) told us: "The second month [after marriage] I got pregnant… . Everything [was a] shock. I was really upset. I didn't cope with that… . No one didn't give any advice, nothing." These findings reflect how a lack of comprehensive sex education can affect women's experiences of first sex, and the importance of sexual and reproductive health information prior to sex, to enable greater agency over women's reproductive choices.

Constructions of virginity: The hymen and beyond.

In women's accounts, constructions of virginity were complex and described differently within and across cultural groups. Many women from Muslim backgrounds discursively constructed virginity in an abstract manner as a symbol of purity, cleanliness, and honor. For example, being a virgin was described as being "pure and clean" (Suhaira, 21, single, Afghani); "not corrupted in mind" (Samira, 21, single, Afghani); "still innocent" (Raana, 43, married, Iraqi); and that "beauty and dignity depend on it" (Saafi, 43, married, Somali). Other participants cross-culturally told us that the importance of virginity was centered on personal, family, and community dignity, which was positioned as their primary motivation to remain virginal prior to marriage: "You keep it for yourself, for your husband, for community, for family" (Nyandeng, 34, married, South Sudanese); "I don't do sex because, number one, for my religion and, number two, for myself, my dignity, and

for my family" (Manoo, 19, single, Somali). These accounts highlight how unmarried women's sexuality is potentially shaped by both the individual desire to remain virginal as well as the expectations of family and the wider community. While an absence of premarital sexual exploration may be considered retrograde in some Western contexts, this was not the case for some women interviewed. A number of participants cross-culturally described remaining virginal until marriage as a choice, positioning it as a positive decision. For example, Akeck stated she was "proud knowing that I haven't been sleeping with a lot of other men … no one will say something about your past, no one['s] got your privacy" (31, married, South Sudanese) and Eira (26, married, Sudanese) said its "good" to be a virgin because "you can't have sex with everyone."

For other women interviewed, constructions of virginity frequently centered on the materiality of the hymen; the presence of a hymen discursively signified a woman's chastity and virginity. Most notably among Muslim women, the hymen was constructed as a "membrane" that could be "broken" or "ruptured" through penetration during first sexual intercourse. Bleeding because of a ruptured hymen signified that a woman was no longer a virgin: "Virginity is determined by when the hymen is broken… . They say it's blood that indicates it" (Samira, 21, single, Afghani). The discursive positioning of the hymen as delicate and a material symbol of virginity led some Muslim participants to regulate their premarital physical activities. Carrying heavy objects, bike riding, falling, skipping, and the use of tampons were all described as "risky" behaviors that could damage the hymen. A few participants believed that "when you ride a bicycle you may lose your virginity" (FG, single, Somali) and "no more playing skip rope … especially until you get

married" (Geti, 30, married, Afghani); "it would be a bit risky [to use tampons]… . What if … I wouldn't be a virgin anymore?" (Setara, 23, single, Afghani).

A further consequence of the construction of virginity as related to the materiality of the hymen and hymeneal blood was the expectation that women would bleed on their wedding night. This finding was absent in Tamil women's narratives, and mentioned only briefly across other cultural and religious contexts, such as Christian, Latina, or South Sudanese women. It was, however, commonly mentioned among women from Muslim backgrounds. A married Sudanese focus group member said, "We needed to prove that we are a virgin. They don't know that if blood doesn't come, a girl still could be [a] virgin." Akeck (31, married, South Sudanese) told us, "Normally it's a white bed sheet that is spread on the bed … they expect blood on that thing." While the majority of accounts positioned this expectation in retrospect, in one account, Suhaira (20, single, Afghani) reported that women in her community were still expected to show blood following their wedding night even after migration: "Yes, it happens in Australia. Even if you come to a new country doesn't mean we have to forget our tradition and culture and our beliefs." The pressure to bleed on her wedding night caused Suhaira anxiety. She went on to say:

> I wish [that] all our Afghan people, women especially, our grandmas, were educated. They'll know that, look, not many girls bleed… . I'm very worried. I know I should bleed, but … when the girls talk about this issue, I get kind of nerve-wracking in my body… . I know I'm a very pure girl … this sort of thing is a big part of my life.

This account highlights the emotional consequences for women who are embedded within cultures that still highly regard hymeneal blood, and in this case may be suggestive that this expectation for some women may continue even following

migration to Australia or Canada. In addition, these findings suggest that new migrant women of all ages may benefit from education surrounding the physical structure of the hymen and variability of bleeding following first sex.

Resisting the virginity imperative.

While the virginity imperative served to regulate women's premarital sexuality, there were also accounts of resistance to this cultural and religious discourse. One woman exercised resistance by stating she would like to engage in sex before marriage: "I think it's a good experience…. I'd rather have experience before marriage to know what it is" (FG, mixed, Iraqi). A minority of women reported that they had acted on their sexual desire and had premarital sex: "My first relationship was when I was 22…I just wanted to experience sex" (FG, mixed, Latina); "I did it [premarital sex] because I was sure he would be the man that I was going to get married to and be with him forever" (FG, mixed, Latina). However, women's attempts to resist the virginity imperative were not always experienced positively. Participants who had sex outside of wedlock were predominantly from Latina backgrounds and disclosed feeling "bad" and "guilty," with women stating they were "thinking that I'm a sinner" (FG, mixed, Latina) and now have "this connotation of sex as something bad and dirty" (FG, mixed, Latina). Across cultural contexts, other participants stated that some unmarried women in their communities did engage in sex since migration, but that it needed to remain a secret. As Safia (28, single, Afghani) said, "Some people have sex before marriage, but no one will know, no one will find out." Nasima (43, married, Iraqi) also said, "It stays a secret … that does not mean that they are not practicing it." These accounts illustrate women's agency and resistance in choosing to engage in premarital sex, at the same time as adhering to cultural expectations by maintaining their virginal image through

secrecy. Other participants described resistance to the virginity imperative by drawing on a sexual rights discourse: “She has the right [to sex]; no one can choose for her” (Shima, 39, married, Iraqi); or through stating that sex before marriage was acceptable if the two people “have the intentions of getting married” (Setara, 23, single, Afghani) or “if she is in love” (Nasima, 43, married, Iraqi).

Accounts of resistance or negotiation were most common among women who were younger and unmarried, even if they had migrated more recently, suggesting there may be an attitudinal shift in younger generations of women or those who may have attended school within an Australian or Canadian context. Unmarried women frequently challenged the sexual double standard, positioning the asymmetric expectations on women as being “not fair” and by stating, “If someone is going to want a virgin, then the guy should be a virgin as well” (Samira, 21, single, Afghani). In a further account from a focus group, an unmarried Iraqi woman stated:

> Unfortunately, this is in the culture. It’s all on the woman; why not on the men? Why are they allowed to do things? Why is the woman not allowed to do that? They have the same desire for sex. Why she cannot express her desire and she will be punished for that if she does?

This account suggests the participant is situated within a resistant identity position by both acknowledging the sexual double standard as an “unfortunate” aspect of her culture and by drawing on a sexual drive discourse, a discourse that acknowledges one’s need to have sex, and in this case that this may exist even prior to marriage for women as well as men. Furthermore, while the majority of unmarried participants did not disclose engaging in premarital sex themselves, resistance was demonstrated through women’s accounts of not judging women who did. For example:

> I don't have any position against that. I think it's just a way of life that people choose for themselves… . You can't really judge people's relationships based on your own experiences or opinions. (Setara, 23, single, Afghani)

> Everyone has their own choice if they want to have sex before marriage or if they don't want to have sex I really think that is up to them. (Fahmo, 23, single, Somali)

Unmarried women also showed resistance to the cultural silencing of sex by discussing it with potential partners or friends, as in these examples: "I was close to being engaged with someone, and I talked about it and how we were going to approach this, every detail I wanted to know" (FG, mixed, Iraqi); "Sometimes I talk about it. I mean, my friends talk about it as well … but it's a very intimate [thing]" (Samira, 21, single, Afghani).

Resistance was also evident in accounts where participants positioned proof of virginity, through the showing of hymeneal blood, as being outdated and a practice rejected in an Australian or Canadian context: "Here, no one knows. It's between you and your partner" (FG, married, Afghani); "It's not right to, I guess, [to] judge someone's character or their life based on whether they are going to bleed on the night of the marriage" (Samira, 21, single, Afghani). Other participants gave accounts of resistance to this practice in their home countries prior to migration: "My mother just told me to take white clothes to put it under me… . I didn't use it" (Madina, 45, married, Iraqi), suggesting women's negotiation occurred both prior to and following migration.

Negotiating the virginity imperative with daughters: "I tell my daughter her body is for her husband."

Discrepancies in cultural outlooks toward premarital sex were a major cause of concern for older women who had daughters. Women cross-culturally described the experience of having their daughters raised in a Western society as being "very scary" and "very difficult," and that they were "afraid" or "worried." Mothers were concerned about the amount of "freedom" young women have in their new countries and the influence that peers may have, with many women describing it as their role to educate their daughters about these differences. As Hooria (35, married, Sudanese) told us, "I do have worries, especially the older daughter, because of culture differences and freedom for the girls … other girls from other backgrounds also worry me." Women described using public displays of affection or intimacy on television to explain cultural variances to their children and to reinforce their own belief systems surrounding premarital sexuality. As Kamelah (36, married, Sudanese) said:

> If they watch something [kissing] on the TV, it's a chance for me to explain to them that is not acceptable… . One time they saw a couple kissing each other on the street… . [I] told them this is normal in Australia, but in our culture and Islam it is wrong.

Sex education provided by mothers to their daughters often contained warning messages surrounding relationships with men, reinforcement of the importance of chastity and the consequences of degeneracy, as highlighted in the following examples:

> I always talked to her about the culture in Australia and the things that is not acceptable in our culture. (Saba, 48, married, Sudanese)

> I tell them [daughters] this country is free … people have sex before they get married … but our religion doesn't allow this … I don't approve [of] it. (Amran, 47, married, Somali)

> You have to tell her that this is wrong in Islam… . They're going to see you like trash. Like you are nothing, and no man commit to you again because he doesn't trust you… . No one likes you at home, even your family, even anyone. (FG, mixed, Sudanese)

Other mothers negotiated the differences in culture by monitoring their daughter's relationships with friends and online activities. A member of a mixed Sudanese focus group said, "We're trying to keep our kids from the bad girls"; and Hooria (35, married, Sudanese) told us, "I always check on what she is doing on her laptop." These accounts suggest that mothers may police their daughters' activities in an attempt to preserve culturally appropriate sexual ideals for young unmarried women and how such ideals shape the educational messages mothers may pass on to their daughters.

While having virginal daughters at marriage was very important to some women, other participants resisted the virginity imperative for their daughters by stating, "We should trust our children here" (FG, married, Afghani). A minority of participants disclosed that they did not mind if their daughters engaged in premarital sex: "Although I am Catholic … I'm not a fanatic, and I don't think that she needs to be a virgin until marriage" (Mariana, 38, married, Latina). A number of women stated that they recognized they could not control their daughters growing up in a

different cultural environment, nor did they want to: “It depends on them … you can’t like control them” (Saadia, 30, married, Iraqi); “I will tell her it is your choice … you can’t control a human being” (Erina, 39, married, Somali).

Regulation of premarital relationships with men: “Your purity is much better than any love in the world.”

The imperative to be a virgin extended beyond the control of the hymen to the regulation of any premarital contact with men. A number of unmarried participants cross-culturally described how family members, particularly fathers, brothers, and uncles, positioned any contact with men, including extended family, as being forbidden: “My family, they don’t accept any relations with a male … even if he is just a friend, not my love… . My parents don’t accept it, and even my brothers don’t accept it” (FG, single, Iraqi); “I am not even allowed with my cousin in a room alone… . My father would say to someone to stay with us” (FG, single, Afghani). Consequently, the Western notion of dating was an unfamiliar and unacceptable concept. Married women told us: “I didn’t come across this sort of dating thing in my culture. That’s why it’s hard to accept by me” (Janni, 32, married, Tamil); “No, definitely, no boyfriend usually in our culture, no” (FG, mixed, Somali). In other accounts, particularly from unmarried Muslim participants, women reported that even following migration, premarital dating was positioned as culturally unacceptable and there was “no option for a boyfriend” (Ara, 34, single, Afghani) and “girlfriend and boyfriend, I can’t do that” (FG, single, Iraqi).

Across cultural groups, women described strict etiquette with regard to physical intimacy limits prior to marriage. For example: “Holding hands, cuddling, all these are not acceptable, so we never did it” (Zarina, 32, married, Tamil); “It’s forbidden … you guys can talk, but you cannot touch” (Faaiso, 32, married, Somali).

Some women attributed the prohibitions to culture: "[It's] not in my culture … we don't do that" (Hawa, 30, single, Sudanese); "Somali culture says … if the women allow the man to touch her she's not a good woman" (Arliyo, 26, single, Somali). Other participants, particularly Muslim women, focused on religion: "You know, holding hands and stuff like that, it's not okay in Islam. What's the point in being a Muslim if you're going to do these things?" (FG, married, Afghani); "In our religion it is not encouraged, touching, kissing, or any sort of physical relationship" (Fahmo, 23, single, Somali). This was because of the fear that any premarital intimacy may lead to further sexual acts, thereby threatening the virginity imperative: "It's common sense. When you love someone and you guys see each other every day, something will happen" (Faaiso, 32, married, Somali); "Holding hands, it's the first thing … then I would kiss you. It leads to sexual intercourse" (Wafa, 40, married, Sudanese). For these reasons, participants across cultures described having limited or regulated contact with their future husband prior to marriage: "For four months just talking by phone… . We are a little bit strict" (Farah, 36, married, Iraqi); "Privately you cannot see him… . My mother is very strict and even my uncle" (Andrea, 26, married, Tamil).

Negotiation of the differing cultural beliefs following migration was sometimes positioned as challenging by unmarried women. For some women, being touched, hugged, or even seen in public with a man was described as being inappropriate as it may give the erroneous impression of being in a premarital relationship, leading to judgment by family and the wider community: "Some people here [Canada] try to tap your back… . If someone saw me in this condition, they may think I have a relation with this boy" (FG, single, Iraqi). This led unmarried women to self-regulate their sexuality following migration, such as "avoiding boys" in order

to maintain culturally appropriate ideals of premarital feminine sexuality. A single Afghani focus group member told us:

> In school, if there are boys and if we need to share the same room for study it is all good, but anything more than that … even talking, I don't really feel comfortable… . If a boy is sitting next to me I would try to sit somewhere else … I am very careful…. It is better to stay away from them altogether.

Following migration, some participants described being embedded between two conflicting cultural spaces as difficult: "You see your friends in the school, they are free to do anything and you can't do this" (FG, mixed, Iraqi); "They're like a free bird [Australian women] … having so much fun in their life and you're like … locked up in the cage… . It's kind of difficult" (Suhaira, 20, single, Afghani). Setara (23, single, Afghani) also questioned the impact of sex segregation on how she may experience intimacy in the future: "Coming from a Muslim background and covering up all the time, it kind of worries me how would I open up suddenly to a person … I think I would be shy." Setara went on to show resistance to the practice of sex segregation and prohibition of premarital intimacy: "I'm totally against it … understanding between the couple … builds up, definitely by getting to know each other beforehand, not being forced into kind of like [a] lifetime relationship." Further resistance was evident in the account by Ara (34, single, Afghani), where she questioned the purpose of a relationship without contact prior to marriage:

> There's no point to be in a relationship… . Because of my culture you can't hang around with that person, you can't go anywhere unless someone is with you outside … you've got to be all the time on the phone or text message, and [in] my understanding, that's not a relationship.

Resistance was also evident in accounts of mothers allowing their daughters to spend time with their future partners to avoid the stressful marriages they had experienced: "I encourage young people getting to know each other, so what happened to me doesn't also happen to them" (Homa, 44, married, Afghani). Other mothers described the segregation of sexes as unnecessary following migration: "If they go and they have coffee and they are going out with friends of the opposite gender, I think it's not a big deal and it's unavoidable" (FG, married, Afghani), which may be suggestive of acculturation toward norms in the West.

Regulation of the sexual body: "If girls are not circumcised they become hyperactive."

Participants from Sudanese and Somali communities described the cultural imperative to be virginal at marriage as being so vital that women were required to undergo the practice of FGM or "circumcision," as they described the procedure. The material practice of removing the clitoris and infibulation of a woman's labia was positioned as an act that physically prevented sexual intercourse prior to marriage. Women reported, "There is no space for the man to penetrate" (Hido, 68, married, Somali) because they had been stitched "to the size of rice" (FG, mixed, Somali). Many participants discursively positioned FGM as a procedure that served to regulate an unmarried woman's sexual desire. Participants told us, "The meaning behind [it] is just to control them, the sex, whether they have sex or not" (FG, mixed, Somali) and to "stop the desire of the girl to have sex before marriage" (FG, mixed, Sudanese). In this way, the honor of the family would be maintained:

> The families are scared; they're worried about their honor or maintaining their honor. So that's why they cut girls down below… . Families are afraid

> that girls might do anything that would bring the family's name to shame. (Nafiso, 36, married, Sudanese)

In their countries of origin, female circumcision was positioned as essential to avoid women being publicly ridiculed and labeled promiscuous: "My mother was sure that I have to be circumcised. She said, 'People will say bad things about my daughter … that she is not circumcised, that she will be looking for men'" (FG, married, Somali). Faaiso (32, married, Somali) told us, "People used to call me names, and when I came home, I'm crying … I wanted this thing off [clitoris]." Undergoing FGM was also described as being prerequisite for getting married in women's home countries, as men associated the procedure with a guaranteed virgin bride: "If a girl doesn't do this, she doesn't get married … no men will be interested in her" (Hawa, 30, married, Sudanese); "If she gets married and the place is not stitched up, the man will think that she is not a virgin" (Amran, 47, married, Somali). These examples illustrate the extent of the material practices that serve to control a woman's premarital sexuality and the role that men may have in reinforcing this practice.

A small number of participants continued to support the idea that the removal or nicking of the clitoris was important in the control of a woman's premarital sexual desire:

> The clitoris is the one that makes you want to have more sex. I think if it was left … I'll be just all over men and having sex like crazy… . It's been removed, so I'm not hyperactive … but if that thing was not removed … I would just have babies before the age of fifteen because I would just engage in sex. That's my belief. (FG, married, Somali)

Another participant in the same group told us that she had circumcised her older daughters for this very reason, but that she couldn't circumcise her younger daughters as it was against the law in Canada, which made her worry because "it's going to make them look for men." Some women supported cutting of the clitoris but not infibulation, stating that the removal of the clitoris was supportable "because you move quickly" (FG, mixed, Sudanese) and "We call it sunna; they only take a little part" (Ammal, 42, married, Somali). These accounts demonstrate that some migrant and refugee women continue to support the cultural meanings associated with FGM and virginity, highlighting the importance of their consideration in sexual health education with women from communities in which FGM is practiced.

The large majority of participants, however, openly resisted the practice of FGM, saying, "I'm totally against it" (FG, single, Somali); "It's wrong and barbaric" (Hoodo, 29, married, Somali); "That's bad; I hate it" (Arliyo, 26, single, Somali); and felt it should not be continued. Others said: "I wouldn't do that to my kids, it's not good" (Faaiso, 32, married, Somali); and "I respect the law in Australia. I am not going to do it" (Hooria, 35, married, Sudanese). Muslim women positioned FGM as a "bad cultural practice" that "my religion is against" (Saafi, 43, married, Somali) or something that "doesn't have a basis in Islamic religion" (Hoodo, 29, married, Somali). These accounts of resistance to FGM drew on religious discourse to challenge cultural practices, with some women going further and describing a woman's right to sexual pleasure as a God-given right: "It's killing off a part of women's lives. I believe this part is very important when you have sex. God created this part for a reason" (Kamelah, 36, married, Sudanese). Other women said that FGM now only happened in rural areas in their home countries and that they were happy it was not practiced following migration.

Reconstructing reputations.

Physical regulation over women's premarital sexual bodies extended to the practice of hymenoplasty. A number of women from Iraqi backgrounds stated that hymen reconstructions were frequently practiced in their community, while in other cultural groups, such as South Sudanese and Tamil, women had not heard of this practice being undertaken in their contexts. While no participant interviewed for this study disclosed having undergone hymenoplasty, women had polarizing opinions about this practice. Women told us: "It depends on the culture she is living in. In our culture, this has happened a lot" (Sharifa, 43, married, Iraqi); "Many women repair their hymen before marriage due to the pressure and demand of the society, culture, and the men themselves" (Nasima, 43, married, Iraqi). In these accounts, the function of the intact hymen in signifying virginity was reified, at the same time as women manipulated this practice through surgical intervention. For other participants, virginity was discursively positioned as something that could not simply be replaced or repaired through a surgical procedure. As one woman said: "You are born with virginity. People think they can make it, but it is not so. It is something God made … it's only one chance. I am sorry, but it's not repairable" (Safi, 43, married, Somali). For other women, a hymen reconstruction was positioned as "cheating for the future husband" (FG, married, Iraqi), "wrong," and "deceiving" and therefore was not supported; "What she has done is wrong and she has to be responsible for her own doings and bear the consequences" (Sharifa, 43, married, Iraqi); "She is deceiving the person that she is going to marry. I don't agree with this" (Wafa, 40, married, Sudanese).

Social stigma was positioned as a major regulatory factor shaping a woman's decision to undergo hymenoplasty: "If I wasn't a virgin, yes, I would [get a hymen

repair] … because of the stigma… . If you get married and you're not a virgin, your in-laws will not respect you, nor will your husband respect you" (FG, single, Iraqi). In a further account, Najiba (64, married, Iraqi) told us:

> I feel sorry for the girls who do it, they [are] forced to do it, the community and the culture force them to lie… . The society treats her unfairly when it comes to remain[ing] virginal, so they have to do hymen repair to prove they are still virgin.

Other participants supported the procedure on the grounds of being "raped," an "accident," or a "mistake." For example, participants told us: "If the girl had hymen rupture by raping or accident, this type of hymen repair operation is good" (FG, married, Iraqi); "One may deceive her … or she may enter into a love story, so why we don't help her … to have [a] repair or to be fixed again, and improve herself" (Madina, 45, married, Iraqi). These accounts suggest that women who are concerned about the presence of their hymen, or who have had premarital sex, may approach health care professionals in their new countries of residence to seek advice or to request a hymenoplasty.

Discussion

Across each of the cultural groups that took part in this study, traditional cultural and religious discourses positioned premarital sex as forbidden for women, as reported in previous research with women from migrant backgrounds (Meldrum et al., 2014; Ussher et al., 2012; Wray et al., 2014). While it appeared the imperative to remain virginal effectively regulated many of the participants' premarital sexual knowledge and experience, other women gave accounts that suggested they were challenging or resisting these dominant discourses to negotiate their own meanings

of sexuality prior to marriage. These findings demonstrate how women negotiate cultural or religious discourses in order to obtain a degree of sexual agency or a desired sexual subjectivity (Day et al., 2010). An exemplar of such negotiation occurred where women took up a "both/and" position (C. Brown, 2007), both reproducing dominant discourses surrounding premarital sexuality by refraining from premarital sex and enacting a degree of agency by resisting cultural and religious discourses, through talking about sex, thinking about sex, and accepting premarital sex as appropriate for "other" women.

It is important to note, however, that discursive options available to migrant women were not endless, reflected in the fact that the virginity imperative was still strongly supported across all cultural groups interviewed, regardless of length of stay in Australia or Canada. Even following migration, feared consequences of transgression acted to limit the discursive space available to women to negotiate agentic premarital sexuality or relationships with men. Loss of reputation, stigmatization, and being considered unmarriageable are societal mechanisms frequently enacted to regulate unmarried women's sexualities, reduce their sexual autonomy, and restrict exploration of their own sexual desires (L. R. Bennett, 2005). While it is important to recognize that some of the women interviewed valued remaining virginal until marriage, the harsh consequences of transgression reinforce the notion of women's uncontrolled sexuality as being dangerous and potentially threatening to patriarchy (Khan, 2012). Latina women who transgressed from the cultural norm of premarital chastity predominantly expressed ongoing guilt and experienced negative connotations toward their sexuality. This suggests that when women do diverge from cultural expectations, they are faced with conflict between their desire for sexual agency and cultural traditions and/or religious morals

(Meldrum et al., 2014). In addition, as found in previous research (Abboud et al., 2015; Meldrum et al., 2014), across cultures women's expression of premarital sex was regulated through a sexual double-standard discourse. In comparison to men, there was no discursive or material space for women's exploration of premarital sexuality. In the context of migration, the "symbolic role attributed to women as carriers of ethnic identity" (Akpinar, 2003, p. 428) arguably results in greater pressure being exerted on women to uphold and reproduce traditional cultural values. Thus, women and their bodies may primarily be held responsible for the preservation of sexual morality, with it being a woman's responsibility to control and discipline her desire, while men's behavior is not so scrutinized (Kaivanara, 2016).

In this study, across participant groups, cultural and religious discourses shaped ideals of feminine sexuality that required unmarried women to remain chaste, sexually innocent, and in control of their sexual desire. These findings resulted in unmarried women across the cultural groups engaging in a process of self-policing (Foucault, 1975), such as refraining from thinking or talking about sex and avoiding men, particularly in public spaces. These accounts are analogous to research with young Western women from Australasia, Canada, and the United States, where dominant discourses of feminine sexuality have customarily been tied to a "good girl" discourse, which idealizes the image of women who are passive, asexual, and not knowledgeable about sex (Harris, Aapola, & Gonick, 2000; S. M. Jackson & Cram, 2003; Tolman, 2002b). In this vein, young women are required to navigate their sexual expression according to a slut/prude/virgin continuum, expressing enough sexuality to be normative but not so much as to be labeled a "slut"(Holland, Ramazanoglu, Sharpe, & Thomson, 2004; Tolman, 2002a; Tolman, Anderson, & Belmonte, 2015). However, these discourses have consequences for women's sexual

knowledge, sexual agency, and sexual subjectivity. Women who adopt gendered sexual scripts may have decreased sexual-risk knowledge, are less likely to advocate for themselves sexually, such as negotiating the use of contraception (L. R. Bennett, 2005; Curtin, Ward, Merriwether, & Caruthers, 2011), and may have a limited understanding of their own sexual desires and right to pleasure (Tolman, 2002a). A lack of dialogue surrounding sex prior to marriage also results in women being vulnerable to negative embodied experiences of first sex (N. Ahmadi, 2003a; Menger et al., 2015; Ussher et al., 2012), as reported by women interviewed in this study. The discursive positioning of sex as culturally and religiously forbidden may prohibit access to sexual health information and services for unmarried women, as being seen by other members of the community at sexual health clinics could result in public ridicule and family conflict (Beck et al., 2005; Rawson & Liamputtong, 2010; Rogers & Earnest, 2015). Consequently, migrant and refugee women may be at risk of poor sexual health outcomes, such as untreated STIs and unplanned pregnancies, if they do have premarital sex (L. R. Bennett, 2005; Meldrum et al., 2016).

Our study revealed that, cross-culturally, the majority of mothers we interviewed continued to internalize the virginity imperative for their daughters following migration. In line with previous research with migrant women (Manderson et al., 2002; Salad et al., 2015), mothers used strategies of social control and reiteration of religious norms to promote chastity among their daughters. Across cultural groups, many of the sexual health discussions between mothers and daughters revolved around the material consequences of transgression, through religious and cultural "moralizing" discourses, limiting young women's ability to make sense of their sexuality, with no acknowledgment of sexually safe practices, sexual rights, or a discourse of desire (Tolman, 2002a). Disparities in generational

beliefs surrounding sexuality, parental control, and pressure to preserve cultural identity may contribute to intergenerational tension (Abboud et al., 2015; Dean et al., 2017; Manderson et al., 2002) and prevent young women from addressing sexual health concerns with their mothers (Rogers & Earnest, 2015). This has implications for young women's sexual health, as the ability to address sexual concerns with parents is a strong predictor of good sexual and reproductive health outcomes (Aggleton & Campbell, 2000). Our findings suggest that new migrant parents may need help to facilitate open sexual health communication with their daughters, as well as support in understanding how migration can affect their daughters' negotiation of premarital sexuality (Dean et al., 2017).

As found in previous research (Cinthio, 2015), crossculturally, a number of Muslim women who participated in this study discursively constructed the hymen to be a material symbol of virginity. Participants' reference to the hymen as an anatomical structure that "breaks" and "bleeds" reifies constructions of the hymen as a corporeal membrane. This discursive construction is problematic, however, as the hymen is not a reliable indicator of prior sexual experience (Adams, Botash, & Kellogg, 2004; Edgardh & Ormstad, 2002), nor is it a physical structure covering the opening of a woman's vagina. Women may damage the hymen in other nonsexual activities (Essén et al., 2010) or be sexually inexperienced but still not bleed during first sexual intercourse (van Moorst, van Lunsen, van Dijken, & Salvatore, 2012). It is suggested that factors such as forced sexual relations, lack of sexual arousal, or a vaginal infection are more likely to contribute to the possibility of vaginal bleeding at first sex (Essén et al., 2010). The sociocultural fixation on the hymen as proof of virginity puts pressure on women to bleed following first coitus, leaving women vulnerable to anxiety, violence, depression, and family ostracism (Bekker et al.,

1996; Cinthio, 2015; R. J. Cook & Dickens, 2009), as reported by women in this study. The continued material significance placed on hymeneal blood may force migrant women to consider hymenoplasty to avoid consequences of transgression (Loeber, 2015; van Moorst et al., 2012). However, the medicalization of the hymen is concerning, given the lack of medical guidelines surrounding the procedure in a Western context (Essén et al., 2010), as well as its questionable efficacy (van Moorst et al., 2012). There is a need to integrate virginity-based education into sexual health information for new migrant and refugee women and men, their families, and community leaders. This includes material aimed to challenge the construction of the hymen as a tangible structure that can verify virginity, as has been done in a European context (Knöfel Magnusson, 2009).

While there have been many explanations for the practice of FGM, such as "tradition" and affirmation of femininity or womanhood (Vissandjée et al., 2003), the majority of Sudanese and Somali women interviewed in this study drew on a discourse of premarital sexual chastity and control to describe why FGM was carried out in their communities, as noted in previous literature (Johnsdotter et al., 2009; Vissandjée et al., 2003). Similar to prior research with migrant women from countries where FGM is practiced (Johnsdotter et al., 2009; Morison, Dirir, Elmi, Warsame, & Dirir, 2004), this study demonstrated a cultural shift in attitudes toward FGM, with it no longer being positioned as a favorable practice. Women drew on religious discourse to challenge FGM, which confirms previous reports that Islam can be deployed to either criticize or legitimize particular subject positions in sexual health discourse (Sargent, 2006). Following migration, women are more likely to be in a position to resist FGM, as it is no longer considered to provide the advantages it did in their countries of origin, and legal discourse can be drawn on to justify

refusing the practice. Exposure to alternative ways of conceptualizing feminine sexuality and a reduction in societal pressure to circumcise daughters may have supported attitude change (Johnsdotter & Essén, 2016; Johnsdotter et al., 2009). However, given the small number of participants who supported FGM, some new migrant women from FGM-practicing countries may benefit from ongoing counseling that is considerate of the sociocultural discourses surrounding women's premarital virginity (Johansen, 2017), as well as education to facilitate understanding of the consequences of FGM for women's health (Elneil, 2016; Wagner, 2015).

The findings of this study have a number of practical implications for service providers and sexual health educators working with migrant and refugee women and their communities. Due to the virginity imperative, sexual and reproductive health services for unmarried migrant women need to be provided discreetly and ensure confidentiality. Single women's prerogative to access sexual and reproductive health information and care, within a human rights perspective (WHO, 2015), needs to be emphasized among migrant communities. Sexual health promotion and education for migrant and refugee women needs to be culturally appropriate and spiritually significant, by acknowledging the complex realities associated with premarital sex within culturally diverse communities (Kebede, Hilden, & Middelthon, 2014; Mosavi, Babazadeh, Najmabadi, & Shariati, 2014). Specific religious principles could be drawn on to promote a sex-positive approach to sexual health education, strengthening women's sense of entitlement to sexual and reproductive health rights (L. R. Bennett, 2005). Health care professionals also need to be aware of the sociocultural constructions of virginity to be responsive to migrant and refugee women's questions and requests in relation to hymenoplasty and fear of the absence of blood at first sex.

Strengths of the study include participants being interviewed in their first language, allowing women to explore their experiences in depth; it also meant that newly arrived migrant women could participate in the study. Interviewing women from varying cultural backgrounds also allowed for within- and between-group comparisons. Limitations include the inability of researchers to back-check translated transcripts for accuracy and the fact that transcripts were not member checked. This process would be a helpful addition to future research studies with migrant and refugee women and would facilitate validation of findings and accuracy of interpretation. In addition, many of the participants' accounts were retrospective, which means their experiences may not be reflective of women in their home countries today or of all young migrant women currently living in Australia and Canada. Given the small number of women interviewed from each cultural group, experiences and constructions may not be representative of the communities as a whole. Similarly, given this research is specific to the context of Australia and Canada, our findings may not be generalizable to other Western countries that host migrant and refugee women, particularly where virginity norms may differ from those presented in this study. Further, given the utilization of focus groups as part of the methodology, participants may have felt pressured to provide socially and culturally desirable accounts, rather than their personal experiences and constructions, due to concerns for reputation. For example, if participants had engaged in premarital sex, it is unlikely this would have been disclosed in a group setting, given the stigma attached to such practice in the communities interviewed.

In conclusion, using a material-discursive theoretical framework this study demonstrated that migrant and refugee women's premarital sexuality is closely regulated through cultural and religious discourse and material practice. The

imperative to be virginal at marriage shaped women's sexual behavior and premarital relationships, and in some instances denied women their bodily integrity. While previous research has primarily examined migrant women's sexual health within a specific cultural group, the findings of this study have highlighted the importance of considering how multiple intersecting identities, such as cultural identity, gender, religion, and marital status shape women's constructions and experiences of premarital sexuality in the context of migration. Identifying the nuanced ways in which women both reproduce and resist dominant discourses of premarital sexuality is important in understanding their impact on women's sexual subjectivity, is essential to destabilize unitary assumptions about migrant and refugee women, and plays a critical role in the development of culturally safe sexuality education and health care.

Chapter Five: Negotiating Sexual Agency in Marriage: The Experience of Migrant and Refugee Women

In the previous chapter, I examined women's constructions and experiences of sexuality as young unmarried women. In this next chapter, I progress to explore how women enter into marriage, the only legitimate space in which women are permitted to be sexual beings. I examine how women construct, experience and negotiate sexual desire, sexual pain, sexual pleasure and sex consent in the context of their marital relationships. This paper was submitted for publication to the journal *Health Care for Women International*, 10th March 2018.

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Abstract

In this study, adult migrant and refugee women's negotiation of sexual agency in the context of marriage is explored. In Sydney, Australia and Vancouver, Canada, 78 semi-structured individual interviews, and 15 (n=82) focus groups were conducted, with women who had recently migrated from Afghanistan, Iraq, Somalia, South Sudan, Sudan, Sri Lanka and South America. Women's negotiation of sexual agency was evident with respect to husband choice, disclosure of sexual desire, pleasure, pain and sexual consent. While some participants took up subjugated sexual subject positions reflecting dominant cultural or religious discourses, many women also resisted these discourses to enact sexual agency.

Keywords: qualitative methodology, refugees, migrant, sexuality, women, marriage

Introduction

Sexuality is recognised as an important aspect of people's lives, with the expression of sexuality and intimacy playing a significant role in a person's sense of self, their psychological wellbeing and quality of life (Daker-White & Donovan, 2002; WHO, 1995). The WHO defines sexual health as "requiring a positive and respectful approach to sexuality and sexual relationships…with the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence" (WHO, 2006a). For the sexual health of an individual to be preserved, sexual rights must be respected, protected and fulfilled. Sexual rights align closely with human rights, and include the right to seek and receive information surrounding sexuality; the right to the highest attainable standard of health, including access to sexual and reproductive health services; and the right to decide whether to be sexually active, to choose ones partner, and to enter into consensual sexual relations (Corrêa et al., 2008, p. 4; WHO, 2006a). Adoption of a rights-based approach to sexual health serves to facilitate and legitimate women's sexual agency, the ability for a woman to realise and act upon their wishes, interests and needs in relation to their sexual decision-making and sexual behaviour (Fine, 1988; Wood, Mansfield, & Koch, 2007). Despite recognition of the importance of sexual agency, globally many women continue to experience discrimination and violations to their sexual rights (OHCHR [Office of the United Nations High Commissioner for Human Rights], 2017). In this paper, we aim to examine the way in which culturally and linguistically diverse (CALD) migrant and refugee women construct, embody and negotiate discourses in relation to their sexual rights and agency in the context of marriage. We are focusing on women who have transitioned from countries where a discourse of women's sexual rights is less prevalent, to two countries that adopt a

rights-based approach to sexual health, Australia and Canada. The term CALD is used in Australia to describe people who have a cultural heritage different from the dominant Anglo Australian culture (Department of Health, 2016a), replacing the previously used term of people from a "non-English-speaking background" (NESB). As this term is not used in Canada, where many of our participants reside, we are describing our participants as "migrant and refugee women."

The way in which sexuality is experienced is dependent on the sociocultural, historical, and political milieu in which one is embedded, with the "forces that shape the erotic possibilities of the body" varying "from society to society" (Weeks, 1986, p. 24). Historically, in contexts such as Western Europe, North America, and Australasia (often defined as 'the West'), marriage was the only legitimate context in which coital sex could occur (Blank, 2008). Primarily an economic and familial transaction, the concept of loved-based marriage of choice, as a cultural ideal, only emerged in the nineteenth century (Coontz, 2005). In most contemporary Western societies, the institutional norms surrounding sex and marriage have undergone significant change. Sex outside of marriage is now the norm (de Visser et al., 2014), and it is widely accepted that a discourse of romantic love and individual choice is a necessary perquisite to marriage, which usually occurs after a significant period of courtship and cohabitation (Chantler, 2014). At the same time, there has been an emergence of casual sexual relationships, described as a 'hook-up' culture, where sexual contact between non-dating partners occurs without an expectation of forming a committed relationship (Farvid & Braun, 2014). Described as a 'sexual revolution' (H. Cook, 2004), these changes in sexual norms and relationships occurred in parallel with women's emancipation and widespread acceptance of women's sexual rights.

Many migrant and refugee women are transitioning from contexts where pathways to sexual relationships and marriage differ from that of their new host country (Meldrum et al., 2014). For example, some women migrate from countries where a discourse of romantic love is not prioritised, and marriages are arranged by the family, with sex before marriage forbidden (Wray et al., 2014). Women's sexual rights may be subjugated through the practice of child or forced marriages, which is problematic as adolescent or child wives are less able to negotiate sex, access healthcare services or make informed decisions affecting their sexual and reproductive health; this leaves them vulnerable to sexually transmitted infections, such HIV, along with early childbearing (UNICEF, 2014). In a number of countries across South Asia, Africa and the Middle East, spousal rape is not recognised as a criminal offence (Randall & Venkatesh, 2015), severely undermining women's rights to 'safe sexual experiences free of…discrimination and violence' (WHO, 2006a). In the Middle East, women's bodies and their sexuality have increasingly become a politically contested space (Ilkkaracan, 2016). Changes in political systems, in particular the uprise of conservative religious groups, coupled with patriarchal gender constructs in relation to women and their bodies, serve to regulate women's sexual agency and rights in negative ways (Ercevik Amado, 2004; Ilkkaracan, 2016). For example, in Iraq, a household survey found that the right for a woman to refuse sex within marriage was not well supported by either men or women (Amowitz, Kim, Reis, Asher, & Iacopino, 2004).

Across cultural contexts, many women engage in activities of resistance to oppressive cultural or religious discourses and practices that attempt to deny women's sexual rights, in order to attain sexual agency (Hélie & Hoodfar, 2012). This suggests that women have the potential to 'rewrite' ideologies of gender, by

destabilizing dominant cultural or religious discourse through mobilisation of 'alternative' or counter narratives to position themselves in more agentic ways (Day et al., 2010, p. 238). Examining women's resistance through counter-storying is important to challenge hegemonic narratives of social realties, but also because it offers a means by which individuals can re-define their identities or create alternative versions of a story which more accurately captures the complexities of a person's life (McKenzie-Mohr & Lafrance, 2014a). There are a number of reasons for examining how migrant and refugee women negotiate their sexual agency, in the context of complex and potentially competing discourses associated with sexual rights.

Sexual agency and the adoption of a discourse of sexual rights has positive implications for women's sexual and reproductive health (WHO, 2015). It legitimates women's ability to access information about sex and sexual health services, which facilitates fertility control and increases the likelihood of satisfying sexual relationships (WHO, 2015). Conversely, women who adopt traditional gendered discourses associated with sexuality, such as being a passive and responsive to the sexual needs of men, are more likely to have decreased levels of sexual risk knowledge, lowered body esteem during sex and decreased sexual assertiveness (Curtin et al., 2011). Gendered power relations mean that women who are in an unequal sexual relationship are less able to negotiate their sexual safety, such as the use of contraception to prevent unplanned or unwanted pregnancy and STIs (Jewkes, Dunkle, Nduna, & Shai, 2010; Quelopana & Alcalde, 2014). Recognition of women's negotiation of sexual relationships is also critical to understanding and preventing sexual violence against adult women, particularly within intimate contexts (Gavey, 2005).

Previous research has found that meanings of sexuality for migrant and refugee women are strongly shaped by the intersections of culture, religion, gender and migration (Dune, 2015; Meldrum et al., 2014). For example, amongst some Iranian migrant women, sexual obedience is reported to be a religious duty that is symbolic of idealised Muslim femininity, and an indicator of modesty or self-respect (Khoei et al., 2008). Similarly, it has been found that some migrant Assyrian women position coital sex, vaginal-penile intercourse, as a marital duty which they have no right to refuse, even if they experience pain during sex (Wray et al., 2014). In contrast, Connor et al. (2016) found that Muslim Somali migrant women generally had the right to refuse unwanted sexual encounters, particularly those which are religiously prohibited, such as oral or anal sex, and that within Islam married women had the right to seek sexual satisfaction from their husbands. It has also been reported that migrant Iranian women exposed to more egalitarian attitudes towards sexuality following migration to Western contexts challenged traditional patriarchal norms and demanded sexual satisfaction for themselves (N. Ahmadi, 2003b). These contrasting findings suggest that further exploration into how migrant and refugee women negotiate sexual agency within their marital relationship is warranted.

Much of the previous research considering migrant women's sexuality and sexual agency has focused on young unmarried women, the majority of whom were not engaged in sexual relationships, due to taboos associated with pre-marital sex (Meldrum et al., 2014; Wray et al., 2014). The few studies that explore experiences of sexually active married migrant and refugee women predominantly focus on singular cultural groups, such as migrant Iranian women (N. Ahmadi, 2003b; Khoei et al., 2008). There is a need for research that examines how sexually active adult migrant and refugee women make sense of and negotiate their sexual agency in the

context of marriage, across a range of cultural and religious backgrounds. This is the aim of this study.

Methods

Design.

This study, based in Sydney, Australia and Vancouver, Canada, utilised a qualitative research design to explore recent migrant and refugee women's negotiation of sexual agency in the context of marriage. The findings presented in this paper are a part of a larger program of research considering sexual and reproductive health of migrant and refugee women. Seventy-eight individual semi-structured interviews and 15 focus groups (n=82), were conducted between July 2014 to November 2015. Women were born in, and had migrated from, Afghanistan, Iraq, Somalia and Sudan. Further, Sri-Lankan (Tamil) and South Sudanese women were interviewed in an Australian context, and South American (Latina) women in Canada. Australia and Canada were selected for this research as they have comparable migrant populations and are similar economically, geographically and politically.

Participants and recruitment.

Participants were women ranging from 18-70 years old with a mean age of 35 years. All women, with the exception of one Latina woman, who disclosed being in a same sex relationship, identified as heterosexual. The mean time since migration was seven years. Women disclosed following a range of religions, with the majority of participants stating that they practised Islam or Christianity. Most participants had migrated to Australia or Canada on a Humanitarian Visa. Table 1 (See Chapter 2) provides further detail surrounding participant demographics.

We sought to recruit migrant and refugee women 18 years and older who had settled in Australia or Canada within the past 10 years. Specific cultural backgrounds were chosen in consultation with our community stakeholder partners, organizations who provide reproductive health services and resettlement support to migrant and refugee populations. Cultural groups selected were identified as poorly served within existing sexual and reproductive health services; they were also identified as being underrepresented in prior sexual and reproductive health research. Participants were recruited through advertisement flyers displayed in sexual and reproductive health clinics, pre-existing community migrant support groups, through community workers employed by stakeholders, the community interviewers and through snowball recruitment. Recruitment continued within each cultural group until there was evidence of data saturation.

Procedure.

This research was approved by the University of Western Sydney Human Ethics Community and Simon Fraser University Human Ethics Committees and the ethics committee of one of our major stakeholders. Community stakeholders, who provide support and sexual and reproductive health care to migrant and refugee women aligned with the research team to provide feedback on the research aims, methods and offered advice on research with culturally diverse women. Trained bilingual community interviewers within each of the language or cultural groups carried out the majority of interviews and focus groups (n=115). Community interviewers received training on how to conduct interviews and focus groups, and the process of transcribing interview data, in a one-day workshop delivered by academic staff on the research team (JU and JP). A female member (AH) of the research team conducted interviews and focus groups with women who had

conversational English, or who wanted to be interviewed by a non-community member (n=45). Individual interviews were used to collect in-depth information, which may not be disclosed in a group setting due to its sensitive nature, while focus groups were used to provide insight into cultural or community norms (Creswell, 2009). As advised by Krueger and Casey (2014), focus groups where possible were homogenous, with women from the same country of origin interviewed together, and married and unmarried women interviewed separately. Interviews took place at a destination allocated by participants and focus groups at easily accessible locations such as community libraries or migrant resource centres. With permission from participants, interviews and focus groups were digitally audio-recorded, and lasted on average 90 minutes. Prior to participation, women received information about the purpose of the research and what the study involved. All women gave informed consent to participate.

Topic areas for the wider project covered questions relating to menarche and menopause, contraception knowledge and use, sexuality and sexual health screening. The specific questions associated with sexual agency, the focus of this paper, were: Were you able to choose your husband? What does sexual desire feel like to you? Can you express your desire for sex to your husband? Can you tell your partner what feels sexually pleasurable or painful? Are you able to say no to having sex, and what would happen if you said no?

Analysis.

Interviews and focus groups that were carried out in languages other than English were translated and transcribed by the bi-lingual community interviewers. English spoken interviews were professionally transcribed verbatim and were

integrity checked to ensure accuracy. All participant names were replaced by pseudonyms.

Our epistemological standpoint was critical realism, a framework which affirms both the materiality of an experience, but conceptualises this materiality as being mediated by culture, language and politics (Bhaskar, 2011). Within this critical realist position, we drew on a material-discursive-intrapsychic approach, in which the biological, psychosocial and discursive aspects of a phenomenon or experience are considered, without one being privileged over the other (Ussher, 2000). Theorizing women's sexuality within this approach allowed a detailed and integrated examination of the multiple factors that shape adult women's experience of sexual agency. For example, this included acknowledgment of 'material' factors such as the experience of sexual pain, the 'discursive' factors, including the cultural ideologies surrounding women as sexual beings and the meaning of marriage, as well as 'intrapsychic' aspects, such as the impact of unwanted sex on women's mental health and wellbeing, and women's active negotiation of sexual relationships.

Data was analysed using thematic-decomposition (Stenner, 1993). This form of discourse analysis firstly identifies patterns or themes across the data, and then considers how participants subjectively position themselves according to such discourses (Braun & Clarke, 2006). To begin this analysis a subset of participant transcripts were read and re-read by the first author and research officer on the project. First order concepts such as "experiences of sexual pain", "communicating pleasure" and "inability to say 'no' to sex" were noted on the transcripts. Following this, commonalities and differences across the two researchers notes and memos were discussed, and the entire data set was coded under the agreed first order concepts. This process was facilitated using NVivo, a software program which aids

in the organisation of qualitative data. The second author checked coding for consistency and variability. Codes were then collapsed into fewer more distinct categories such as "sexual enjoyment and desire" through discussion with all authors. During this process, four main concepts associated with sexual agency became apparent. These concepts formed the basis of the themes presented in this paper; "Pathways into a Sexual Life", "Taking Desire to the Grave", "Women's Sexual Pain and the Privileging of Male Pleasure" and "Sexual Consent and Concession". Quotes are validated with the participant pseudonym or "FG" in the case of a focus group, age and ethnic background. In our analysis, no substantive differences were identified between accounts by women in Australia or Canada, thus country of origin when reporting findings has not been noted.

Results

Pathways into a sexual life: "If it is an arranged marriage women don't enjoy sex."

Across cultural contexts, the majority of women reported that they could not legitimately experience sexual agency prior to marriage, because of cultural and religious taboos surrounding premarital sex. The first possibility for women to negotiate sexual agency was in relation to choice of husband. With the exception of a number of Latina women who described choosing their partners "in a 'free' way" (Catalina, 45, Latina), for many of the participants interviewed, marriages were arranged by the woman's family. While not all women positioned arranged marriages negatively, women who had no agency in choice of partner, or had limited contact with their future husbands prior to marriage, were more likely to describe negative experiences of sex immediately after marriage, and into adult life. For example, an Afghani focus group member told us, "it was my parents' selection they

selected my husband for me. I didn't even know about it". Similarly, a South Sudanese focus group member stated, "my marriage is not based on love, it was an arranged marriage…[I was] married to a man I didn't even know…I was given to him." Women frequently described experiences in which they were married without knowing their future husband, or were married quickly after engagement, as was normal cultural practice: "no one asked whether I am happy, or I like the person…they got me all ready, took me to the beauty salon…suddenly the groom is sitting next to me. I had never met this person before" (Mahta, 39, Afghani); "I got married when I was 16 years old. I left for the honeymoon, my husband was sitting next to me in the aeroplane like a stranger…I didn't know anything about him" (Najiba, 64, Iraqi). While there is often overlap in definitions, arranged marriages are generally defined as a marriage facilitated by family, but which requires the consent of both partners; in contrast, as alluded to above, forced marriages are when either one or both parties do not give their consent, or do so only under duress (Chantler, 2014; Gangoli, Razak, & McCarry, 2006).

It has long been recognised that there are a number of differing pressures on women to marry within patriarchal cultural and religious contexts, including poverty, social norms and the containment of women's sexuality (Anitha & Gill, 2009; Bunting, 2005). In this vein, the agency accessible to women in this study was shaped by cultural norms of their countries of origin, such as normative age of marriage, and the sociocultural and economic positioning of women. For example, some women were very young when they married or had husbands who were significantly older. As Minoo said, "I got engaged when I was 12 years old and I got married when I was 14 years old." A South Sudanese focus group participant stated, "My dad gave me my husband…they marry me, I'm 15 years old and [he was] 32."

While it is important to acknowledge that men too are implicated in arranged marriages (Samad, 2010), in this study it was evident that women were nearly always in subordinate positions, particularly given the large age gaps between women and their husbands.

A lack of agency with respect to partner choice and timing of marriage had implications for women's first experiences of sex as a newlywed. For instance, Akon (30, South Sudanese) described, "When I first met my husband, because it was not the man I wanted to get married to, I was feeling miserable, distressed and in pain." Anosha (30, Afghani) said she "hadn't even met the guy" she was going to marry, thus sex was a "concept that was very scary for me." Similarly, Minoo (32, Afghani) reflected, "I was not happy with my marriage. I hated it… it was a struggle…I would cry after it [sex]. In my opinion if the husband and wife love each other deeply from the heart …life would be more enjoyable." A number of women positioned their arranged marriages as contributing to an absence of an ongoing fulfilling sexual relationship and partnership with their husbands: "I did not choose my partner, it was organised by my parents and in cases like mine, sometimes it ends in [an] unhappy life" (Akon, 30, South Sudanese); "I was forced to marry my husband…my parents imposed him upon me…I never had any kind of relationship with him" (Wafa, 40, Sudanese). These accounts reflect the importance of women's sexual agency for positive experiences of first sex (Tolman, 2002a) and emphasises the importance of husband choice in relation to women's ongoing sexual trajectories.

Across cultural groups, heterosexism was implicit in women's stories of partner choice and sexual agency. Negative cultural and religious attitudes surrounding same-sex marriages meant that there was no room for women to consider partnership outside of a heterosexual marriage, should they want to. As

Ariana (40, Latina) told us, "I remember my mum telling me…she would prefer me to get pregnant before getting married than telling her that I am lesbian…. the Mexican society is very homophobic." Likewise, Amaal (40, Somali) stated, "It's not even accepted in our religion, and it's not nice for a woman to fall for another woman…this has never happened in my culture… it's not the right thing to do. It's a sinful thing."

The large majority of participants who had experienced a forced or arranged marriage did so prior to migration. Many of the women who described unfulfilling or abusive relationships stated that they had since left their husband, some before and some after migration, despite the community stigma and consequences associated with divorce. As women told us, "They see it like you're weak…they talk about you" (FG, Sudanese); "When I say I don't want him no more, I mean, they took my children away…I got divorced, yes, but I lost my children" (FG, Somali). These accounts are evidence of women's resistance to cultural discourse and practice, which demonstrate the strength of women's feelings of dissatisfaction with their marriages, and the consequences they were willing to face in order to enact agency in leaving.

Sexual agency through acceptance of arranged marriage.

Not all accounts of arranged marriage were positioned negatively, with some participants telling us that, "Mine was arranged, thanks to God, I'm happy" (FG, Somali); "I'm happy and grateful for my life" (FG, Afghani). Further, a number of women in the study were able to demonstrate a degree of sexual agency by choosing their husbands, or by declining a marriage proposal, positioning consent of both parties as central to the process. For instance, an Iraqi focus group participant stated, "In our family, no girl is obliged to marry…my husband came and asked to marry

me and my family asked me if I agree or not" (FG, Iraqi), and a Somali focus group member said, "I chose to marry my husband because my father…he told me that I will never arrange your marriage unless you agree to it." In further accounts, women described that although their marriages were arranged they saw pictures of their future husbands and communicated by phone prior to agreeing to marry; "they just show his picture…they said you can talk to him over the phone...I liked him, so that's why we got married. I had the option if I didn't want to get married" (Jaani, 32, Tamil). Participants who were able to exercise agency with respect to choosing their husband were more likely to provide positive accounts of sexual experience, with first sex described as being "nice, it was good" (Nadiya, 70, Iraqi) and "I was really happy, I was very happy" (Erina, 39, Somali).

The majority of unmarried participants across cultural groups, said that they expected to be able to choose a husband. However, they are required to follow culturally prescribed rules, such as informing the parents of a potential husband, having supervised family meetings and requiring family approval to marry; and often, marrying a man from the same cultural and religious background. Resistance to the cultural practice of arranged marriage was also evident in accounts of women allowing their daughters to choose marital partners following migration. As Azita (37 Afghani) described, "I wasn't allowed to choose, my father told me to marry my husband and I did it. Now my way of thinking is changed since I came to Australia. I'd like my girls to choose their partner."

Conversely, some women adopted a position of agency by accepting the partner that their parents had selected for them, rejecting Western notions of romantic love (Chantler, 2014). For example, Nita (27, Tamil) when describing her entry into married life said, "I didn't want to fall in love or to give a hard time for my

mother. I was agreeable to marry whoever my mother chose...love didn't mean anything to me." Further, even following migration to contexts where arranged marriages are not the norm, the anticipation of parental selection of their future husband was positioned positively by a small number of unmarried Afghani participants, "I like the parents to choose for me, because maybe they know better than me...I think it's good when the parents are choosing [a] husband" (Zahra, 25, Afghani); "I will respect whoever they [family] choose for me, I will give them the priority" (FG, Afghani). In these accounts women position their parents as "knowing better" and thus in a good position to make the decision on behalf of the woman. In other accounts, participants privileged culture over romantic love, describing arranged marriages as the best option for a fulfilling partnership, as evidenced in the following account, "The closeness is after marriage. My opinion is our way [arranged marriage] is better for a strong marriage as well as a healthy relationship" (Madhu, 35, Tamil). These accounts demonstrate the complex ways in which women take up and resist cultural discourse in relation to choice of marital partner, including instances where women did not position themselves as subjected to cultural discourse, but as active agents in embracing it, even when they had no choice in who they would marry.

Taking desire to the grave: "She keeps that desire inside until she dies."

Pleasurable sexual experiences, including experience of sexual desire and satisfaction, are a central component of sexual health and sexual rights (Fine & McClelland, 2006; WHO, 2006a). The way in which sexual desire was constructed, and a woman's ability to articulate desire within the marital relationship, differed across and within cultural groups. Some women reported that they were not freely

able to verbalise their sexual desire, while others drew on gendered and 'culturally appropriate' approaches to express desire, and thus sexual agency.

Across cultural groups, women rarely gave accounts of their own sexual desire, even when asked to describe it. For example, some participants stated that they "Don't know how to answer this question" (Sharifa, 43, Iraqi) or that "This is a too hard question" (Amer, 34, South Sudanese). This 'missing discourse of desire', which results in women having no language within which to construct an active sexual subjectivity, has been reported in previous research with Western women (Fine & McClelland, 2006; Hollway, 1995; Tolman, 2002a). The small number of women who could verbalise what sexual desire felt like described it as "just like an appetite" (FG, Somali), and drew on a heteronormative discourse, stating that they "need a man" (Arifa, 48, Iraqi) or that "I need to physically feel and touch a man" (Nasima, 34, Iraqi).

Heteronormativity was also reflected in account of women taking up a gendered subject position of the passive and receptive woman (Ussher, 1997b), potentially limiting their capacity to express their desire with their partner. For example, participants told us, "All my life I didn't ask him even once for sexual relation[s]" (FG, Iraqi); "I never ask for sex, never ever" (Mahta, 39, Afghani). Some women normalised and legitimated this passive and receptive subject position, through describing a woman's request for sex as not "in our nature" (FG, Somali), or "we women, we are shy, we don't say anything" (Amran, 47, Somali). Other women's accounts suggested the internalisation of a critical male gaze (Fredrickson & Roberts, 1997) in explaining their inability to disclose their desire for sex, as a husband "would think about it as inappropriate, therefore it is better to stay silent" (Arifa, 48, Iraqi). Women's conformity to a passive sexual role reflects a male sexual

drive discourse, wherein normative heterosexuality situates men as the initiators of sex and women as the means to satisfy his sexual drive (Hollway, 1989; Potts, 2002; Ussher, 1997b). Consequently, some women were reluctant to step outside of their culturally defined sexual script by communicating desire, as they are at risk of being negatively judged or labelled by their husbands.

The influence of gendered cultural discourses was evident in accounts of women's sexual desire being positioned as secondary to men's, particularly in their home countries. As Shiwa (50, Afghani) said, "In Afghanistan it really doesn't matter what a woman wants, it is always about men. [A] woman will take her wishes to her grave." Shiwa's emphasis on 'in Afghanistan' suggests that there may be room for greater sexual agency for women after migration. Conversely, some Muslim participants drew on a religious discourse to support women's right to express their desire for sex. However, at the same time they indicated that this clashed with cultural ideologies, which prevented women initiating sex with their husbands. As a Sudanese focus group member told us, "In Islam, you have the right to ask your husband about sex, but the people and the culture, they make it worse, they say no, don't ask the husband for sex" (FG, Sudanese). Similarly, Saafi (43, Somali) described, "the religion allows women to ask [for sex]…some women in my culture can ask, and know that sex is part of life and others will shy away…the man initiates most of the time…my culture encourages woman to shy away." These accounts demonstrate how the intersections of patriarchal culture and religion interact to shape women's sexual agency and demonstrate how gender-biased discourses and practices result in repressive attitudes towards married women's sexual agency, negatively influencing women's sexual subjectivity.

'His eyes in the day time and his nose in the night time": Resisting the subject position of passive and receptive woman.

In a counter-narrative, some women reported that they were free to verbally express their desire for sex with their husbands and actively resist the subject position of a passive receptive woman: "I have no hesitations in talking in a direct way… [I] voice my needs or my thoughts about sex" (Sofia, 40, Latina); "I feel complete freedom to communicate my feelings and what I want" (Ariana, 40, Latina). Others argued that men and women should equally have the right to initiate sex, "There should be no boundaries, no power games, and no control of feelings…when he needs you and comes to you for sex, you should do the same" (Sharifa, 43, Iraqi). In a few instances women reported that their husbands even encouraged them to initiate sex, as Habibah (43, Iraqi) disclosed, "He is the one to ask for it [sex]…sometimes he tells me 'you should'", and Isabella (46, Latina) stated, "I think my husband will be very happy if I am the one that initiates [sex]." Other women drew on biological and religious discourse to justify their sexual agency. For example, Banoo (28, Afghani) stated that, "It is biologically a part of a woman…To want [sex] is god given…it's a human thing... as a human you want [it], it just should be that way…like why should I hide it." In other accounts, although not always through explicit talk, women described being embodied sexual agents who can and do express their sexual desire in creative ways. For example, a number of women from Sudanese backgrounds described how "Women can prepare themselves for their husbands, with traditional perfume and smoke" Elmera (34, Sudanese) and that, "We have a specific perfume for sex…when you use it…that means you need it, you can't say it, your actions indicate that you want it" (FG, Sudanese). Other participants across cultures described that they would "get close to him and he would

understand what I want" (Azita, 37, Afghani) or "I just stroke him, touch him" (Lokoya, 42, South Sudanese). These practices indicate women's active participation and expression of their sexual agency within sexual encounters, without having to verbally articulate sexual desire (Muhanguzi, 2015).

For other participants, the ability to initiate sex was positioned as not important, because of a low desire for sex. As an Afghani focus group member reflected, "If I didn't have any of it [sex] in my life it just wouldn't make a difference to me at all…it could be three years…I just wouldn't care" (FG, Afghani). Similarly, a Latina focus group participant stated, "for me, sex is not the best thing…not the most important thing…to be honest, I don't like having sex much." These accounts remind us that cultural restrictions on expression of sexual desire may not be problematic for some women, and that women may have different desires for sex based on factors other than 'culture', such as personal preferences, psychological factors and relational contexts; this challenges contemporary Western assumptions about women's sexuality and their 'need' to desire sex (Tiefer, Hall, & Tavris, 2002).

Women's sexual pain and the privileging of male pleasure.

In many cultural and religious contexts, coital sex has traditionally been positioned as necessary for the purpose of bearing children (Dune, 2015; Wiesner-Hanks, 2014), with women's sexual pleasure not prioritised (Dialmy & Uhlmann, 2005). This construction of sex was evident in a number of accounts in the present study. For example, Nasima (34, Iraqi) told us that in her culture a woman is there to "bear children" and that men had little regard for a woman's experience of sexual pleasure. Fahmo (23, Somali) also described that, "It has always been about satisfying the man, man's pleasure… even growing up I was told as a woman, I have to satisfy my husband." This excerpt highlights how gendered roles within

heterosexual relationships are instilled in women from a young age, and reiterates the messages women receive in relation to "giving" pleasure to their husbands, rather than it being something that a couple does to give one another pleasure (Nicolson & Burr, 2003).

A number of women told us that they still could not express sexual pleasure or sexual preferences with their husbands as they were "shy" and that such an act was inappropriate for 'a woman'. Eira (26, Sudanese) told us, "It's in our blood, that's a shame…back in our country, a woman is a woman, so we are always under the shoes [of men]…like if you talk about this [pleasure], they're going to say you're not a good girl." Similarly, Kamila, (34, Sudanese), told us that if she disclosed her sexual preferences, such as suggesting a change in sexual position, her husband would say, "'Why [did] you say that, you are a woman', you know, women are just not meant to say anything like this." This finding confirms previous research with migrant women (Khoei et al., 2008), in which traditional discourses of feminine sexuality position 'modest' women and 'good girls' as those who were quiet and not sexually expressive, a requirement for a happy and peaceful marital life.

The construction of marital sex as a duty was often associated with absence of women's sexual enjoyment, as Mahta (39, Afghani) described, "rarely I like it…most of the time I just say to myself 'oh no here he comes'". A number of women disclosed experiencing sexual discomfort or pain, particularly surrounding a lack of vaginal lubrication; "It can be painful especially with the dryness" (Hoodo, 29, Somali), "You can't always be 'on' all the time so sometimes it's fairly dry…it has stung or it's hurt yes" (Banoo, 28, Afghani). Despite experiencing ongoing discomfort, few women disclosed seeking medical attention or knowing of solutions to overcome sexual pain, as described by Mariana (38, Latina), "I am very dry, so the

sex is very painful…I haven't gone to the doctor, I haven't used any lubricant or anything…I don't know what kind are on the market." The reluctance of migrant and refugee women to seek medical attention for sexual pain, often accompanied by a lack of knowledge about potential avenues of intervention, has been reported previously (Ussher et al., 2012). However, these experiences are not confined to migrant and refugee women, as previous research has reported that a significant proportion of women in the general population state that they did not seek help from a healthcare professional for sexual pain or problems, due to embarrassment or lack of knowledge about solutions (Berman et al., 2003). Addressing absence of vaginal lubrication and pain during sex is important as a rights-based issue where women are entitled to pain free sex, but is also important in relation to women's sexual subjectivity, as sexual pain is often associated with shame, distress and feelings of inadequacy as a woman (Ayling & Ussher, 2008).

Communication between couples is an important first step in addressing sexual pain, or other sexual difficulties (Merwin, O'Sullivan, & Rosen, 2017; Rancourt, Rosen, Bergeron, & Nealis, 2016). The majority of women disclosed being able to tell their husbands when they experienced sexual pain. For example, "At any point if I feel pain I can talk to my husband and let him know" (Nafiso, 28, Somali) and "If it's painful, of course, I'm going to tell him…you can't handle it" (Eira, 26, Sudanese). However, a small number of women described enduring pain to please their husband. For instance, Azita (27, Afghani) said she, "would not talk about this stuff with my husband" and Saba (48, Sudanese) described that she "kept quiet and didn't tell anyone." Other women positioned their sexual pain as being related to unwanted sex, primarily with ex-husbands. For instance, a Latina focus group member disclosed, "It was a torture…it was like a punishment... I can't remember

once when I wanted to have sex or once that I enjoyed having sex…I couldn't communicate that I didn't want to have sex." Experiences of painful and unwanted sex were reported to have negative consequences for women's mental health, as epitomised in Sharifa's (42, Iraqi) account, "I convince[d] myself to do it…the blessing, it was very short... If he had been one of those men who took longer, probably I would have taken my own life." These findings highlight how sexual pain has implications for women's psychological well-being (Hinchliff, Gott, & Wylie, 2012), and suggests that some migrant and refugee women may require support surrounding the negotiation of unwanted or painful sex within marriage.

"Pleasure is not just a man's business": Women's acknowledgment of their right to pleasure.

In a further counter-narrative, participants demonstrated sexual agency through acceptance that women's pleasure is an integral part of sex. In this vein, most participants across cultural groups described sex as not just about "making kids" (Janni, 32, Tamil) or "only to get babies" (Aameeka, 40, Tamil), rather as "something to enjoy" (Saadia, 30, Iraqi), describing sexual intercourse as, "a good feeling" (Azita, 37, Afghani) reflecting "a great connection" (Ariana, 40, Latina) with their husband. Some Muslim women drew on religion to support a woman's right to sexual pleasure stating that; **"**you must enjoy sex. It says in the Koran" (Homa, 40, Afghani) and that, "Islam says that it has to be initiated and consensual between man and women...so that they can both enjoy" (FG, Afghani). In a similar light, some women drew on a discourse of reciprocity, reporting that they were in relationships in which their husband encouraged their enjoyment of sex, stating, "sometimes my husband tells me that he thinks that he is having sex with a dead body…he loves me to contribute" (FG, Afghani). Other women disclosed that they

could tell their partner what they enjoy sexually "all the time" (FG, Sudanese) and that women "are allowed to have pleasure" (Azita, 37, Afghani). Likewise, expressing sexual pleasure or sexual pain; "anything I enjoy or anything he enjoys we talk about everything" (FG, Iraqi); "I can talk to him, he understands me" (Hasina, 25, Somali). For a small number of women, the meaning and purpose of sex was reported to have changed following migration, "Now the husband is understanding a little bit, it's for enjoying, but back in our country [it is] for kids, yeah, it's not for enjoying" (Eira, 26, Sudanese). In a similar light Suz (42, South Sudanese) described, "When you come to Australia…it's something enjoyable and you plan the kids...but Sudanese culture you did it for the babies."

Accounts of pleasure were generally associated with sexual intercourse, with other forms of pleasure such as masturbation, anal sex or oral sex being described as "very dirty", "haram" (unlawful), "very bad" or undesirable. For example, in relation to oral sex, Darya (24, Afghani), stated: "I don't imagine that's very good…I would never allow myself to do that (sex) outside of the activities of making a child…my comfort just doesn't even allow me, I don't even imagine that to be okay, or desirable." This excerpt reflects a coital imperative discourse, whereby penis-vagina penetrative sex is prioritised over other forms of sexual intimacy, and coitus is considered the most "natural" form of heterosexual activity (Braun et al., 2003). The prioritisation of coitus alone may mean that women miss out on other opportunities to experience pleasure, particularly given women often report sexual activities other than coitus as being equally or more pleasurable (Nicolson & Burr, 2003), and women's orgasm through coitus alone is not always achieved (Fahs, 2014; Richters et al., 2006).

Sexual consent and concession: "Women aren't really allowed to say no."

A central facet of a sexual rights discourse is the ability for a woman to refuse sex both within and outside of a marital relationship (Gavey, 2005). Such rights are recognised in Australian and Canadian State and Territory laws, which provide legal frameworks against sexual discrimination and sexual violence (Fileborn, 2011). Across cultural groups, a number of participants disclosed feeling unable to refuse unwanted sexual advances from their husbands, due to traditional cultural and religious discourse. Muslim women were most likely to draw on religious discourse, as Amran (47, Somali) told us, "I cannot say no, our religion tells us if your husband needs you, never say no". Others said, "It's not good in Islam… you don't have to say no" (FG, Mixed, Sudanese). A woman's refusal of her husband's sexual advances was constructed as being sinful, worthy of being "cursed", and potentially leading to punishment, "The rule is three days, three nights, if you keep them away for more than three nights, then it's a sin" (FG, Afghani). In a further example, a Somali focus group member told us, "I believe, that if you are a Muslim and you don't say yes to your husband, you don't submit yourself to him, for 40 days your prayers will never be accepted for that one act. So I have to say, yes." Another woman in the group went on to say "I don't want to upset my Lord…I don't want to say no because I know later it's going to have some consequences on me, so I will just go ahead and say yes." However as Hoel and Shaikh (2013) argue, the positioning of sex as an act of religious worship and pleasing in the eye of god is problematic. If sexual submission is a requirement to evade sin and have prayers answered, women's sexual agency may be obscured, and men's desires prioritised (Hoel & Shaikh, 2013). This is evident in the following accounts, where participants told us "a woman has no

choice" (FG, Somali) and that "I used to feel like this is his right" (Wafa, 40, Sudanese).

In the present study, the expectation that a woman 'submits' sexually to her husband was described as having been culturally and religiously inculcated from a young age, and was a taken for granted expectation of a married woman. As Hani (32, Somali) told us:

> If you say no to your husband…we used to hear that you would go to hell. Our parents used to tell us that, our Islamic school teacher used to tell us that, our neighbours they used to tell us the same story, that any woman who goes against her husband, that she will not enter heaven…I don't think I will say no to my husband. I will just say yes.

In addition to religious consequences, other penalties resulting from sex refusal included being seen as being unfaithful, or risk of divorce, "Maybe he will go outside to do something bad. That's going to be your fault…it is not good" (FG, Sudanese); "Some of the husbands make cultural things, if the women say 'no' too many times, maybe they think you have another boyfriend" (Elmera, 34, Sudanese). These accounts further suggest that not only is it the woman's role to satisfy a man's sexual desire (Ussher, 1997b), but that sexual obedience is maintained through material and discursive consequences, such as being labelled promiscuous, or divorce. This reflects the regulatory control of patriarchal cultural and religious discourse, which in this study intersected to privilege men's sexual pleasure and deny women's sexual agency and rights. These findings are concerning as engagement in unwanted sex, despite being consensual, is associated with negative intrapsychic implications for women (O'Sullivan & Allgeier, 1998).

Pushing back and saying 'no'.

The adoption of a position of submission in relation to sex with their husbands when it was not desired was not uniform across women. Taking up a counter-narrative, Zarina (32, Tamil) told us, "he has never forced me, if I say no, he will accept" and an Iraqi focus group participant said, "I can refuse if I am tired." Many women stated that sex should be an act in which both the husband and the wife are "consenting and happy" (FG, Afghani) and "both of them have a say" (Amaal, 42, Somali). Minoo (32, Afghani), stated "Even in our religion it is mentioned that if a woman is not happy or agreeing it is 'haram' (unlawful)." A number of participants reported that since migration their ability to refuse sex has increased, "Since I came here I say 'no' quite often, but back home I was scared to say 'no'" (Mahta, 39, Afghani), and that "In Australia if you didn't want to have sex with your partner or you didn't feel like having sex you have all your rights to say no…even if your husband forces himself that's still considered rape" (FG, Somali). Confirming previous research with Iranian migrant women (N. Ahmadi, 2003b; Rashidian, Hussain, & Minichiello, 2013), these findings suggest that exposure to different sexual ideologies and a discourse of sexual rights, may facilitate women negotiating sexual agency.

Discussion

The findings of this study suggest that the sexual agency of adult migrant and refugee women is negotiated through the intersection of patriarchal cultural and religious discourse, influenced by the context of a woman's relationship with her husband and the intrapsychic and material consequences of resistance. For some participants, this resulted in the adoption of a subject position that subordinated their sexual rights, associated with an absent discourse of desire, lack of pleasure in sex,

sexual pain, and inability to say no to sex with their husband. However, there were also a number of women who adopted a position of sexual agency, through verbal and non-verbal disclosure of sexual desire and pleasure, refusal of unwanted sex, and resistance to the practice of forced marriages for their daughters. These findings highlight that in the context of migration, some women were not merely positioned within hegemonic cultural or religious discourse, but were able to take up, resist and negotiate such discourses in order to tailor a desired sexual subjectivity and acquire a degree of sexual agency (Day et al., 2010).

Women's negotiation of sexual agency was not dichotomous, reflecting the 'either/or' subject position of submission or resistance. Many participants adopted a 'both/and' subject position (McKenzie-Mohr & Lafrance, 2011) in relation to dominant discourses of 'culturally appropriate' hetero-feminine sexuality. This has been described as 'tightrope talk', whereby individuals construct themselves as agents who are active and acted upon, allowing individuals to move beyond 'either/or' binaries, such as a sexually passive woman or a sexually agentic woman, to be both passive and agentic (McKenzie-Mohr & Lafrance, 2011). This was reflected in instances where women stated that they would like parental involvement in their choice of husband, or where women did not verbally express the desire for sex, but communicated through other means, including dress, incense or perfume. In this vein, women are able to enact sexual agency, without risking material consequences associated with transgression from culturally determined ideals of feminine sexuality, where women are responsive to the desire of men (Nicolson & Burr, 2003). As C. Brown (2007) argues, a 'both/and' position "honours women's agency…while not minimizing the impact of oppressive social discourses" (p.275), such as those described by some women in this study.

The findings of this study suggest that migrant and refugee women's experiences of sexual agency within marriage are not uniform, with differences found both between and within cultural and religious groups. This suggests that whilst there may be commonalities, such as a woman's reluctance to initiate sex, differences exist across culture in relation to issues such as arranged marriages, which did not occur in Latina women's accounts; and the burning of incense as a signal of sexual desire, discussed only within Sudanese women's narratives. Equally, only Muslim women drew on religion in ways that both enhanced and denied women's sexual agency. These findings suggest that migrant and refugee women are not a homogenous group, and that health educators and sexual health care providers need to be sensitive to the nuances of a woman's cultural and religious context, as well as the way a woman negotiates cultural and religious discourses within her marital relationship.

Some participants described migration as having allowed them the material and discursive space to challenge traditional views on women's sexual agency. However, as reported in previous research (Rashidian et al., 2013; Ussher et al., 2012; Wray et al., 2014), a number of participants described the intersections of gender, culture and religion, and their associated heterosexist and sexist ideologies, as continuing to influence their choice of husband, sexual subjectivity and ability to negotiate sexual agency within marriage following migration. The influence of cultural norms and religion on women's sexual agency and sexual health has previously been reported in relation to unmarried migrant women's negotiation of premarital sexuality (Meldrum et al., 2014; Wray et al., 2014), as well as migrant women's contraception use and fertility control ((Rogers & Earnest, 2014; Sargent,

2006), demonstrating how the subordination of women, and regulation of women's sexuality has broader implications for sexual health.

Sexual subordination of women is not exclusive to migrant populations or non-Western societies however. This is evidenced in the fact that one in five Australian women report experiencing sexual violence, and one in ten women have experienced sexual violence by a male intimate partner (Cox, 2015). Research with women in Western contexts has found that dominant discourses of heterosexuality continue to shape women's sexual experiences negatively. For example, women often engage in non-pleasurable or unwanted, but consensual, sex in order to satisfy what women perceive as a man's 'need' for coital sex (Hayfield & Clarke, 2012). Gender inequalities around sex are also evident in women's accounts of feigning sexual pleasure or orgasm as a way to end unwanted sexual encounters or to please men (Fahs, 2014; Thomas, Stelzl, & Lafrance, 2017); where women silence sexual pain as means of satisfying their male partners (Ayling & Ussher, 2008) and where women engage in, or are coerced into sexual acts (e.g., anal sex) that they do not desire or do not find pleasurable (Fahs & Gonzalez, 2014). Our findings therefore also add to this body of literature and illustrate how the culturally defined boundaries of feminine sexuality have material consequences for both women's experiences of sexual intimacy, agency, and the formation of a desired sexual subjectivity (Ussher, 1997b).

Similar to the findings reported by Muslim women in this study, prior research has suggested that religious ideologies shape the sexual behaviours deemed permissible for migrant women (Connor et al., 2016); with the interpretation of conservative religious texts limiting a woman's sexual agency by demanding sexual compliance and prioritising male pleasure (Hoel & Shaikh, 2013). However, in the

present study Islam was also utilised to reinforce women's right to experience sexual pleasure, to demand acknowledgment of their sexual agency and to promote reciprocity in sexual relationships. This finding reiterates how religion is both utilised to support women's sexual autonomy, as well as limit a woman's sexual subjectivity (Hoel & Shaikh, 2013), resulting in women potentially receiving contradictory messages in relation to their sexuality. While it is important to recognise there are many differing levels of faith, varying interpretations of religious texts, and that Muslim women are diverse in terms of class, ethnicity and education (Ali, 2016), it has been suggested that the "only solution to achieve [sexual] reform in the name of Islam, is through the reinterpretation of repressive holy texts" (Dialmy, 2010, p. 166). Critical engagement with sexually oppressive traditions or religious ideologies may in turn facilitate a contemporary framework that promotes the sexual wellbeing of men and women alike (Hoel & Shaikh, 2013).

Given the importance of sexual rights for women's positive sexual health outcomes, it is important that healthcare providers are aware of these deeply rooted cultural and religious discourses and material practices that may shape women's sexual agency (Benson et al., 2010). Sexual health educators could work alongside migrant and refugee women and religious clergy in the community to identify and challenge limiting religious interpretations and sociocultural discourses that restrict women's sexual agency. This will serve to facilitate migrant women in realising their sexual agency through the instillation of a rights-based approach to sexual health education (Svensson, Carlzén, & Agardh, 2017), including the discussion of women's sexual rights, which are upheld within law.

In addition, given the gender inequalities that exist within many migrant and refugee communities, it is important that sexual health education is available to men.

Future research could consider how this could be done in the most culturally appropriate way. It is also important that the lack of dedicated sexual health services for migrant and refugee women is addressed, as many women are coming from contexts where they have received little sexual health information, as the discussion of this topic is positioned as shameful (Ussher, Perz, et al., 2017). Migrant and refugee women may benefit from sexual health education that moves beyond a disease discourse, and is inclusive of information surrounding the body in relation to sexual response or pleasure (Fileborn et al., 2015), and which provides practical information to prevent sexual pain, such as the importance of arousal and the use of lubricants (Weijmar Schultz et al., 2005).

There are a number of strengths and limitations to this study. Strengths include the focus on adult married women's subjective experience of sexuality, a group that have been overlooked in previous research. We interviewed women across a range of cultural groups, which meant we could examine commonalities and differences across cultural groups, providing insights into the intersection of identities, such as religion and culture. The fact that participants had the option of undertaking their interview in English or their native language, meant that newly arrived migrant women could participate regardless of English language proficiency. Limitations include the relatively small sample set within each cultural group, and the retrospective nature of women's accounts, which means that experiences may not be representative of women's experiences in their home countries today. Our inability to back-check transcripts as they were not in English, was also a limitation, to be considered in future research. Lastly, given the gendered nature of sexual agency described by participants in this study, and the fact that we only interviewed women, future research would benefit from considering men's perspectives in

relation to women's sexual agency, to consider how perceptions of their sexual self may have shifted after migration, particularly in relation to their cultural roles or identity.

In conclusion, migrant and refugee women's negotiation of sexual agency within marriage is much more nuanced than representations displayed in mainstream media in the West suggest; such as that of the Muslim woman as a figure of sexual oppression, symbolized by "the veil", forced marriages and female seclusion (Ali, 2016). Whilst some women adopted a subjugated position, many others subverted potentially limiting cultural and religious discourse to negotiate sexual agency and take up an agentic sexual subjectivity within their marital relationship. Experiences and constructions of sexual agency varied both within and across cultural groups, depending on women's interpretation of cultural and religious dictates associated with sexuality, their relationship with their partner, and their awareness and adoption of a sexual rights discourse in their new country of abode. It is important that sexual health education and care provided to migrant and refugee women recognises the diversity of women's experiences highlighted in this study, but also recognises the pressures and restrictions placed on migrant and refugee women's sexual agency, which may influence their sexual health and well-being.

Chapter Six: “If you don’t have a baby, you can’t be in our culture”: Migrant and Refugee Women’s Experiences and Constructions of Fertility and Fertility Control.

In this last analysis chapter, I explore the ways in which migrant and refugee women experience and construct fertility and fertility control. I first focus on the importance of motherhood in the context of women’s lives and then unpick the web of interconnected material, cultural and religious factors that shape the acceptability of contraception use for fertility control. The analysis presented in this chapter is in the form of an academic journal article, accepted in the journal *Women’s Reproductive Health*. Appendix J presents the published manuscript.

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Abstract

The present study was designed to explore experiences and constructions of fertility and fertility control among new migrant and refugee women in Sydney, Australia and Vancouver, Canada. Seventy-eight individual interviews and 15 focus groups (n = 82) were conducted with women who had migrated from Afghanistan, Iraq, Somalia, South Sudan, Sudan, Sri Lanka, and South America. Participants positioned having children as a cultural and religious mandate and as central to a woman's identity. Many women had limited knowledge about contraception, positioned contraception as forbidden or dangerous, and described negative experiences with its use. These findings are interpreted in relation to the provision of culturally safe medical practice and sexual and reproductive health education.

Key words

Contraception, fertility, migrant and refugee women, qualitative methods, Australia, Canada

Introduction

The ability for a woman to choose whether and when to have children is an essential human right endorsed by international health governing bodies (UNFPA, 2013; WHO, 2014). Women's access to reliable information and to a preferred method of contraception, free from coercion, discrimination, or violence, is fundamental to gender equality and makes possible women's full participation in society (WHO, 2014). Contraception facilitates women's ability to space or limit the number of children they have, reduces associated morbidity and mortality, and enables women to complete their education, thereby improving the economic security of women and their families (WHO, 2017c).

In industrialized Western countries, such as Australia, Canada, and the U.K., a range of hormonal contraceptive methods are available at a low cost through government subsidy programs. Despite this, inequalities in contraceptive use exist amongst women from disadvantaged ethnic or racial groups, including women from migrant and refugee[1] communities (Aptekman et al., 2014; Sangi-Haghpeykar, Ali, Posner, & Poindexter, 2006). Research conducted in Canada, Australia, and Nordic countries has shown that, in comparison to native-born women, migrant and refugee women are less likely to use contraception (Family Planning New South Wales, 2013; Omland et al., 2014); are more likely to use utilize less effective methods of contraception, such as condoms, withdrawal, and rhythm methods (Family Planning New South Wales, 2013; Richters et al., 2016); and have higher rates of abortion

[1] The term "culturally and linguistically diverse" (CALD) is used in Australia to describe people who have a cultural heritage different from the dominant Anglo Australian culture (Australian Government Department of Health, 2016); it replaced the previously used term of people from a "non-English-speaking background" (NESB). As this term is not used in Canada, where many of our participants reside, we define our sample as "migrant and refugee women."

following an unintended pregnancy (Helström, Zätterström, & Odlind, 2006; Vangen et al., 2008).

Migrant and refugee women also have fewer consultations with general practitioners to discuss contraception management than native-born women do, and contraception is less often prescribed to them (Mazza et al., 2012; Raben & van den Muijsenbergh, 2018). Further, in an Australian survey, Sri Lankan migrants were less likely than Australian-born participants to have heard of more effective means of contraception, such as contraceptive implants and IUD's (intrauterine device), and they were more likely to report that they had difficulty in accessing helpful contraception advice (Ellawela et al., 2017). Understanding the factors that impede migrant and refugee women's access to and use of contraception is essential to their reproductive rights, but also important because the ability to plan pregnancy is key to a woman's quality of life, as unintended pregnancies have substantial social, health, and financial costs for women and their families (Cheng, Schwarz, Douglas, & Horon, 2009; WHO, 2009).

Qualitative studies have shown that migrant and refugee women often arrive in their host countries with limited knowledge, or even misinformation, about the range of contraceptive methods available to them (Watts et al., 2014). Religious objections to family planning (Degni et al., 2006), myths and misconceptions about contraception use (Rogers & Earnest, 2014; Watts et al., 2014), and sociocultural attitudes that prohibit premarital sex continue to shape women's access to fertility control (Wray et al., 2014). The influence of patriarchal discourse and practice is evident in migrant and refugee communities, where the use of contraception is often not supported by husbands (Degni, Mazengo, Vaskilampi, & Essén, 2008; Sargent, 2006; Ussher et al., 2012), which suggests that, despite having transitioned to

countries where a reproductive rights discourse is more widely accepted, gender inequalities may persist following resettlement (Khawaja & Milner, 2012).

Socially acceptable family sizes and timing of childbearing differs across cultures, religions, and history (Hampshire, Blell, & Simpson, 2012; Srikanthan & Reid, 2008). Some migrant and refugee communities, particularly those from Africa and the Middle East, are expected to have large families following resettlement (Allotey et al., 2004), a cultural norm that may impact on the acceptability of contraception use. In contrast, over the past decades in developed countries there has been significant transformation in fertility patterns and family size (Bongaarts, 2002), facilitated by a shared cultural acceptance of modern forms of contraception. For example, the majority of sexually active heterosexual women of reproductive age in Australia use some form of contraception (Freilich et al., 2017; Richters et al., 2016). This has resulted in delayed childbearing, declining fertility rates, and an increasing number of women who choose not to have children at all (Carmichael & Whittaker, 2007; Rowland, 2007), which stands in contrast to discourses and practices associated with women's fertility and fertility control within some migrant and refugee communities (Ussher et al., 2012; Watts, McMichael, et al., 2015).

Although previous research has documented rates of contraception use with women from migrant and refugee communities (Family Planning New South Wales, 2013; Omland et al., 2014), we lack an in-depth understanding of how such women experience and construct fertility and fertility control. Exploring women's subjective experiences in this sphere is important to understand factors that shape migrant and refugee women's fertility practices, information that is crucial to inform culturally safe sexual and reproductive healthcare, sex education, and health promotion (Allotey et al., 2004). Past researchers have focused on knowledge and experiences

of contraception or fertility amongst migrant women who have experienced unintended teen pregnancy (McMichael, 2013; Watts et al., 2014; Watts, McMichael, et al., 2015). Qualitative research on contraceptive beliefs and practices has focused on specific populations, such as women from African countries (Degni et al., 2006; Rogers & Earnest, 2014; Sargent, 2006) or young unmarried women (Meldrum et al., 2014, 2016; Wray et al., 2014). Migrant and refugee women are not a homogenous group, but come from a wide variety of sociocultural contexts that shape beliefs and practices concerning sexual and reproductive health (Ussher et al., 2012). This suggests that an understanding of the nuanced ways in which intersecting identities, such as gender, religion, and culture, shape adult migrant and refugee women's experience of fertility and reproductive agency is paramount. That was the aim of the current study.

To explore this issue, we formulated the following research questions: How do migrant and refugee women experience and construct fertility and fertility control? How may understanding of these experiences and constructions be used to shape and deliver appropriate sexual and reproductive health information and promotion, education, and clinical practice?

Method

Participants and recruitment.

Seventy-eight individual interviews and 15 focus groups (n =82) were conducted between July 2014 and November 2015 in Sydney, Australia and Vancouver, Canada. Our study sample was made up of migrant and refugee women who were between the ages of 18 and 70 years old, with a mean age of 35 years. To allow for analysis within and across diverse cultural communities of migrant and refugee women, we recruited participants who had migrated from Afghanistan, Iraq,

Somalia, and Sudan in both locations. Women from Sri Lanka (Tamil) and South Sudan were included in the Australian sample, and women from South America (Latina) were included in the Canadian sample. The women practiced a range of religions including Islam, Christianity, and Hinduism. With the exception of one Latina who reported that she was in a same-sex relationship, all participants identified as heterosexual. Most participants had arrived in Australia and Canada on humanitarian visas; the average time since migration was 7 years. See Table 1 (See Chapter 2) for more detailed demographics of the sample.

We recruited for migrant and refugee women 18 years and older who had settled in Australia or Canada within the past 10 years. Specific cultural backgrounds were chosen in consultation with our community partners, organizations who provide reproductive health services and resettlement support to migrant and refugee populations. The cultural groups selected were identified as poorly served within existing sexual and reproductive health services, despite the fact that they make up a significant proportion of newly arrived migrant and refugee women; they were also identified as underrepresented in prior sexual and reproductive health research. Australia and Canada were selected as the study locations due to their geographic, political, economic, and sociocultural similarity; they also have comparable migrant and refugee populations.

Participants were recruited for the study through the distribution of flyers, by staff members employed by migrant resource centers, by the community interviewers themselves, and through snowball methodology. In addition, women were invited to participate through pre-existing cultural community groups and through flyers displayed in sexual and reproductive health clinics that service migrant women. We

continued recruitment within each cultural group until there was evidence of data saturation.

Procedure.

This research was approved by Western Sydney University Human Research Ethics Committee, Simon Fraser University Human Research Ethics, and by the ethics committee of one of our community stakeholder organizations. To gain cultural insights and to refine the study aims and methods, we consulted key informants and stakeholder organizations. Following this, two members of the research team, in a 1-day workshop, trained community interviewers in qualitative research methods. Training included how to conduct interviews and focus groups and how to transcribe data. Community interviewers were migrant or former refugee women, who were engaged specifically for the study through our stakeholder partnerships. This methodology has been successfully adopted in prior sexual and reproductive health research with non-English speaking women (Morrow et al., 2008). The majority of participants (n =115) were interviewed in their first languages by trained community interviewers, who were women of the same ethnic background (n = 9) or who spoke the same languages as the participants (n = 3). Participants who preferred to speak English or preferred not to be interviewed by a community interviewer undertook interviews with a non-migrant member of the research team; this occurred with 29 interviews and five focus groups (n = 16).

Prior to participation, the women received information about the purpose of the research and what the study involved. Participants provided informed consent before the interview or focus group. With the exception of one participant who declined, all participants consented to having their interviews audio-recorded. The interviews and focus groups were semi-structured and lasted on average 90 minutes.

The broader study covered questions about menarche and menstruation, sexuality, and health service provision (Ussher, Perz, et al., 2017). The questions related to contraception were: Tell me about the use of contraception in your culture?; Have you used something to help you not have babies, and how do you find these method/s?; Tell me about the importance of having babies in your culture. The use of focus groups was intended to facilitate the collection of data that highlighted cultural or community norms and practices concerning fertility and fertility control, whereas interviews were utilized to gain more nuanced in-depth and personal accounts of women's constructions and experiences (Creswell, 2013). However, following data analysis, there were no obvious patterns of disclosure identified across these two methods. As recommended (Krueger & Casey, 2014), focus groups were homogenous; the women were of the same cultural group, but separate groups were conducted for single and married women where possible. Interviews and focus groups took place at locations nominated by participants, such as their homes, community centers, and libraries.

Analysis.

We adopted a material-discursive-intrapsychic theoretical approach (Ussher, 2000) situated within a critical realist epistemology (Bhaskar, 2011). Critical realism recognizes the materiality of the body or experience, but conceptualizes such materiality as mediated by culture and language (Bhaskar, 2011; Ussher, 2000). A material-discursive-intrapsychic analysis allows researchers to acknowledge the 'real' aspects of the body or experience, but conceptualizes these events as discursively constructed or shaped within a specific sociocultural and historical context (S. J. Williams, 2003). Within a critical-realist epistemology, none of these

material, discursive, or intrapsychic levels of analysis is privileged above the other, but are seen as irrevocably interconnected (Ussher, 2010).

We also drew on the concept of intersectionality (Crenshaw, 1991) to consider how categories of difference (e.g., gender, culture, religion) intersect to shape individual lives, social practices, and cultural discourses (Davis, 2008). An elemental principle of intersectionality is the view that social categories are not independent or unidimensional but multiple, interdependent, and mutually constitutive (Crenshaw, 1991). Thus, in order to understand or address health disparities, intersectionality moves away from an additive approach of single variables (e.g., gender or race) to consider experience in the light of multiple influential factors that are continuously interacting (Bowleg, 2008).

Data were analyzed using a process of thematic-decomposition, a form of discourse analysis that identifies participants' subjectivity and positionality across themes within data (Stenner, 1993). Data analysis was inductive, whereby the development of the themes was driven by the data, not by pre-existing theory, concepts, or research. Interviews and focus groups that were not carried out in spoken English were translated and transcribed by the bilingual community interviewers. English spoken interviews were professionally transcribed verbatim and integrity checked to ensure accuracy. Participants' names were replaced with pseudonyms. A subset of transcripts of interviews and focus groups was read and re-read by members of the research team. During this process first-order concepts, such as "learning about contraception" and "experiences of contraception use," were noted. Through discussion and modification, these first-order concepts formed the basis of the coding framework. Two members of the research team then concurrently discussed, crosschecked, and coded the entire data set using NVivo, a software

program that facilitates the organization of coded data. A third member of the research team monitored this process for accuracy.

Codes were then grouped into fewer distinct categories and summarized in detail; notes were made of participants' cultural background and geographical location to highlight commonalities and unique experiences across the data set. The research team met several times to discuss central themes identified through the coding process. Three core ideas were recognized: the mandate that all women have children, men's role in women's fertility choices, and the impact of discursive meanings on the acceptability of contraceptive use. These core concepts formed the three discursive themes described and discussed below: "The Motherhood Imperative," "Patriarchy, Power and Parity: Motherhood and Male Control," and "Negotiating Fertility Control: Balancing the Unknown, Forbidden, and Dangerous." Quotes are marked with the participant's pseudonym or "FG" in the case of a focus group, age, and ethnic background. As no substantive differences were identified between accounts by women in Australia and Canada, country of origin is not noted.

The researchers for this study were of a non-migrant or refugee background, as defined by the project. We were aware of our positioning and engaged in a process of reflexivity during the design, data collection, and analysis stages of the research. Reflexivity requires a process of critical self-reflection into the ways in which a researcher's social background, assumptions, positioning, and behavior may shape the research process (Finlay & Gough, 2003). As a part of our reflexive model, and central to an intersectional approach (Hankivsky et al., 2010), we consulted with stakeholders and community members who work with migrant and refugee women at each point of the project. We also had lengthy discussions as a research team to

examine and reflect upon the ways in which our own subjectivities and identities might have shaped our analysis.

Results and Discussion

The motherhood imperative.

The discursive theme 'The Motherhood Imperative', which encapsulates the cultural and familial requirement for women to have children, was discussed by the majority of participants interviewed. Womanhood was strongly linked to ideals of motherhood, and thus played a central role in the women's identity. Not only were the women expected to be mothers, but they faced additional pressure to reproduce immediately after marriage and to provide a boy child. This is reflected in the subthemes: 'Motherhood as central to identity,' 'Immediate motherhood as a social requirement,' and 'Preference for a boy child.'

Motherhood as central to identity.

Across cultural groups, motherhood was positioned by all participants as synonymous with womanhood. As Akoi (40, South Sudanese) told us, "you are a woman, you are considered to have kids," and an Iraqi focus-group member stated, "everybody wants children, it's nature." Participants drew on religious and cultural discourses to emphasize the importance of motherhood for women: "if you don't have a baby, you can't be in our culture" (FG, Tamil); "we always respect our religion…you can't say 'I don't want marriage' and 'I don't want children'" (Arliyo, 26, Somali). The prerequisite of motherhood to achieve womanhood has previously been reported amongst migrant women, with childbearing positioned as synonymous with being a "proper," happy, and fulfilled woman (van Rooij, van Balen, & Hermanns, 2009; Yebei, 2000, p. 136). Motherhood is also privileged in Western societies, as evident in discourses that denigrate women who choose to be voluntarily

childless (Gillespie, 2000) or in women's reported feelings of inadequacy when faced with infertility (Dryden et al., 2014). However, in the West, many women have alternative identity positions or social roles available to them (Batool & de Visser, 2016), and voluntarily child free women increasingly report positive feminine identities that are separate from that of motherhood (Gillespie, 2003).

The discursive construction of motherhood as central to a woman's identity, and as a cultural or religious duty, had material implications for migrant and refugee women. Our findings suggest that compulsory motherhood may mean that there is little room for women to explore other identities, life achievements, or life pathways. As Janni (32, Tamil) told us: "in our culture, we don't have that sort of choice, lots of women they have the baby, we don't have a choice." As a consequence, women may feel devalued and distressed when they cannot fulfil the motherhood imperative (Kholer Riessman, 2000; Remennick, 2000). This was reflected in accounts where women were described by participants as "very broken" (Saadia, 30, Iraqi); "our culture is like poor her, if you don't have a baby" (Raana, 43, Iraqi).

Amongst Tamil participants, women without children were described as at risk of stigmatization and exclusion. Sumi (37, Tamil), a participant who described having had trouble conceiving said, "life was going okay until about 2 years after marriage. Since we didn't have any babies, my relations and friend's parents started calling me names." Tamil focus groups participants stated that women who could not have children were labelled "the unluckies." Janni (32, Tamil) told us:

> When you have a wedding, or…you have your first period, they have a ceremony…women who don't have children they don't really take these women to this function…they think maybe the couple won't have babies because of this woman.

Severe social repercussions of infertility, including ostracism, exclusion, and abuse have similarly been reported amongst women from other non-Western contexts (Fledderjohann, 2012; Kholer Riessman, 2000). However, a cross-cultural study (Batool & de Visser, 2016) showed that, although Western women do experience infertility-related stigma, there was no public scrutiny, rather an internalized "felt stigma" (Scambler, 1984). This is in contrast with the overt social discrimination or "enacted stigma" experienced by infertile women in non-Western contexts.

Immediate motherhood as a social requirement: "When you get married you have to get pregnant straightaway."

With the exception of Latinas, participants across all cultural groups described having been expected to have children immediately after they got married. As Eira (26, Sudanese) said, "when you get married in our culture, they're going to count the first month…[by] the third [month], you are going to get in big trouble." The ability to get pregnant straight after marriage was positioned as "like a test for the woman, if she can give birth or not" (Nasira, 52, Iraqi) and was seen to be important in getting the "reproduction system going" (FG, Afghan). Western women may be located by others within a deficit identity position if they are not partnered with children by a certain age (Addie & Brownlow, 2014), however they are unlikely to experience such overt expectations and pressures to have children immediately after marriage.

The cultural expectation to reproduce immediately after marriage caused a number of participants to become worried about their fertility. Mahta (39, Afghan) told us, "I didn't get pregnant for the first 5 years, everyone was talking about this…[later] I got pregnant until we reached five [children]. I wanted his family to see we could have children." In instances where conception did not happen

immediately, the woman's body was always considered at fault; as Hido (68, Somali) said, "if a man and a woman are married and they cannot have babies, most of the time they will normally check the woman, even the traditional medicine will only treat the woman." In the present study, cross culturally, much of the reproductive pressure was said to come from mothers-in-law and extended family, as has been found in other studies with migrant women (Hampshire et al., 2012). An Afghan focus group member said:

> My mother-in-law and all the in-law family were getting louder and more boisterous about what's going on, 'why isn't she having a child'…'it's been 6 months how come she is not pregnant'…I thought they were going to think I am barren or something so…I tried to make it as quick as possible.

The expectation to reproduce immediately after marriage had a number of material consequences for women's sexual and reproductive agency, including the autonomy to choose whether and when to use contraception and to determine the timing of childbearing. For example, a Sudanese focus group participant said: "I didn't want to get pregnant for 2 years after marriage but…my aunt stopped me, she told me 'you don't know if you can get pregnant or not, so no contraceptive pills for now.'" Even where women were able to negotiate the timing of childbearing with their husbands following migration, they then faced questioning by wider family and community members, as the thought of delaying childbearing was unthinkable to others. For instance, Janni (32, Married, Tamil) described an aunt questioning her choice to use contraception by stating that is was "not really right" and that she would "end up having an IVF baby." In the West women's contraception decisions generally follow a "my body, my choice" discourse (Wigginton, Moran, Harris, Loxton, & Lucke, 2016, p. 734), but our participants' stories reflect a collective

governance over women's reproductive bodies, which had implications for their reproductive agency.

Preference for a boy child: "It's a problem when you only have girls."

One of the major differences found between the participants and native-born Australians and Canadians is the expectation for women to provide a boy child. As a consequence of this requirement, many women reported that they felt pressured to continue to fall pregnant until they had a boy: "if you don't have a boy, they will try until they get the boy" (FG, Tamil); "people encourage you, you have to have a boy, you have to have a boy" (Nasira, 52, Iraqi). Across cultural groups, having a boy child was described as important because boys are responsible for "carrying the surname," "the inheritance," and supporting parents in later life. Male offspring are also responsible for ensuring the appropriate burial of parents in the case of Hindu Tamil women. Some women described the pressure to have a boy child as having decreased since migration, but others said such pressure continued: "here and back home as well, it's the same…they prefer a boy to carry the name" (FG, Iraqi). The pressure to have a boy child confirms previous research with women from migrant backgrounds (Morrow et al., 2008; Puri, Adams, Ivey, & Nachtigall, 2011). This is partly a reflection of gender inequalities and patriarchal cultural beliefs that men provide greater economic security for parents in old age (Puri et al., 2011). It is also likely to be linked to patrilineal social systems that marginalize and devalue women (Das Gupta et al., 2003).

The expectation to have a boy impacted on the acceptability of contraception use following the birth of a child: "if you got a boy, you will be on the safe side, if you got a girl then no, she has to try [again], they will keep pushing" (FG, Iraqi). Such expectations were reported to have made some participants anxious,

particularly due to their husband's disappointment about having girls. Azita (37, Afghan) told us: "I was worried because my husband wanted a boy and we only had girls." For some women, this resulted in multiple pregnancies in close succession to achieve the reproductive wishes of their partners and extended family. As Kamila (34, Sudanese) said, "I have two girls first, everyone say you have to get pregnant quick to bring a boy." The sociocultural expectation to give birth to a boy is problematic, as it may increase the likelihood that migrant women experience post-partum depression, reproductive anxiety, and/or verbal or physical abuse from husbands and family if they do not give birth to a son (Morrow et al., 2008; Puri et al., 2011).

Patriarchy, power and parity: Motherhood and male control.

Across all cultural groups, a number of women described their husbands as having the authority to decide when, and how many, children to have. Minoo (32, Afghan) told us: "[if] their husband says he would like to have more children…the woman does not have much say and needs to obey her husband." In addition to the expectation to have children, women in the Sudanese and Somali communities positioned husbands as pressuring wives to conceive a large number of children: "the man will say, we should have kids every year, he will just say that it's the religion which suggests so" (FG, Somali). Faaiso (32, Somali) said: "it's really crazy, it's the pressure from the husband, it's a culture, men like to have more kids."

When women did not fulfil their husbands' demands for children, divorce was a potential consequence. Participants said things like: "if you don't want any more [babies], they are going to find another wife" (Kamila, 34, Sudanese). This was further epitomized in Nosheen's (37, Afghan) account:

> I was with him [husband] for 10 years, after that we separated because I didn't get pregnant…he was happy, but only because I couldn't give him a child, he got married again. It is our culture to have children.

This practice continued after migration, as Ranna (43, Iraqi) said, "even here [Australia]…they have the same mentality, she should have a baby because maybe the husband will marry another lady." The fear of being left by their husband had material and psychological consequences for women's health. As Hasina (25, Somali) told us, "sometimes they get sick [women], the doctor says don't get pregnant again, and she is thinking 'the man will leave,' that's why she risks herself." The expectation to have many children was also difficult for women to manage, particularly following migration where women lose traditional familial support networks that help them to raise children. As Akoi (40, South Sudanese) said, "raising a kid is extremely difficult, we are not in Sudan where we get support, here it's just you and your baby."

A further consequence of men's preference for large families was that, in some instances, husbands prohibited their wives from using contraception. As Joyce (45, South Sudanese) said, "some of the men are not accepting it [contraception]…they want to have a big family." Other women reported that contraception use may be allowed, however, they would need to gain consent from their husbands: "we would talk to our husbands, we will not do anything before talking to them" (FG, Somali). Similar accounts have been reported by other migrant and refugee women (Rogers & Earnest, 2014) and acknowledged by healthcare professionals who work within these communities (Kolak et al., 2017; Mengesha et al., 2017). Consequently, addressing patriarchal control over women's reproductive

bodies needs to be made a priority in future programs that address contraception use in migrant and refugee communities.

Resistance to patriarchy: Negotiating fertility control with partners.

In a number of accounts, women described having resisted attempts to control their fertility. Some women reported taking hormonal contraceptives in secret: "I used to do it [use contraception], but still men don't like it you know…I used to hide them from him" (Faaiso, 32, Somali); "I used the tablet for 2 or 3 months…he didn't know" (Nyandeng, 34, South Sudanese). Other women resisted their husband's control over their fertility by stating that contraception use was up to the woman, as she was the one carrying the pregnancy, or by asserting their own wishes: "it's up to me…they're not the one carrying for 9 months" (Faaiso, 32, Somali); "I just tell me husband to back off" (FG, Somali). Participants described migration as having provided women with the ability to challenge patriarchal control, which resulted in greater reproductive freedom than they had in their home countries: "in Afghanistan the males are dominant…in Australia, the woman has to be happy to get pregnant, the husband cannot force her" (Safia, 28, Afghan).

Not all husbands were described as controlling their wife's fertility, which suggests that not all migrant and refugee women are denied reproductive agency. A number of women positioned contraception use as a joint decision and felt supported in their decisions: "he would happily support me on whatever I wanted to use" (Akeck, 31, South Sudanese); "I made a decision…so I talk to my husband and he was like really keen" (Janni, 32, Tamil). Other women described normalization of family planning within the marital relationship as having been facilitated by healthcare professionals after migration; as Eira (26, Sudanese) said:

> When you give birth to the baby at the hospital, the nurse comes and talks to you, even your husband…to tell you after 6 weeks, you have to go and get it [contraception], its normal, not like Sudan, if you do it your husband can hit you.

Such accounts suggest that including women's husbands when healthcare professionals are providing contraceptive counselling to women may support the acceptability of its use. This recommendation stands in contrast to practices of healthcare professionals in the West, who believe that the presence of men may inhibit women's reproductive choices (Mengesha et al., 2017; Newbold & Willinsky, 2009).

Across Somali, Sudanese, and South Sudanese participants' accounts, women positioned large families as a choice that reflects culture, migration, and their own personal desires. For example, Elmera (34, Sudanese) said that, having come from a "big family background" herself, she would prefer a large family. The importance of large families was enhanced in the context of migration for some women, particularly when they had migrated alone or had few family members in their new host countries: "I came by myself…I don't have any family here. What can I do better [than] to make my own family" (Lokoya, 42, South Sudanese). Large families were also constructed as providing more status within the community: "big families, nobody can bother you" (Suz, 42, South Sudanese). Large families were also seen as necessary, in case children should die of illness or not fulfil their duty to look after parents in old age. These accounts reveal that large family sizes were celebrated and wanted by some women, who adopted positions of agency in relation to their reproductive choices. This suggests caution in positioning migrant and refugee

women as passive victims of patriarchal cultural norms or expectations if they fail to conform to Western norms of small family size (Hampshire et al., 2012).

Negotiating fertility control: Balancing the unknown, forbidden, and dangerous.

Participants who had considered fertility control described themselves as navigating a myriad of discourses and regulatory practices associated with contraception use. The three subthemes that fall beneath this central theme are: "Fertility control: An unknown territory," "Contraception as forbidden," and "Dangerous liaisons: Adverse contraceptive experiences, fears, and misconceptions."

Fertility control: An unknown territory.

Across and within cultural groups, women reported various levels of knowledge and uncertainty about contraception methods, which had implications for their decision-making in relation to fertility control. In some instances, women reported that they "don't know anything" and have "zero awareness" (FG, Tamil) or "have no idea" (Suz, 42, South Sudanese) about contraception. Other women had some knowledge and could describe a small number of contraception options; "all I know is the IUD or taking pills" (Mahta, 39, Afghan). Modern forms of fertility control most commonly mentioned by women were the pill, IUD (without differentiation between hormonal and non-hormonal devices), injectable contraception, implants, and condoms. However, the women did not discuss, or demonstrate awareness of, the range of contraceptive pills available, vaginal rings, tubal ligation, or the use of emergency contraception.

Women 'not knowing' about contraception, or about specific contraceptive methods, may be a reflection of limited knowledge of fertility control. In line with previous research with migrant and refugee women (Quelopana & Alcalde, 2014;

Watts et al., 2014), this suggests that some women may arrive in host countries with limited or inaccurate knowledge of contraception and the reproductive functions of the body. However, women's self-positioning as having "no idea" may also be a reflection of a cultural reluctance to discuss such a topic in an interview context. For example, some participants described a lack of contraceptive knowledge as being a consequence of "culture", in which sexuality and reproductive talk is discouraged: "we can't talk like that, we are very shy" (FG, Tamil); "in general it is really hard to speak about it" (Azita, 37, Afghan).

One of the consequences of this silence is that a few women reported reluctance to speak to one another about contraception or to seek medical advice about its use. Akeck (31, South Sudanese) said: "No-one would talk to another person regarding that [contraception]… I never seek any…like health advice in that regard. I just make my own analysis." A reluctance to discuss contraception has similarly been reported in prior research with migrant and refugee women (Rogers & Earnest, 2014); it may, in part, explain why migrant women are less likely than other women to discuss contraception management with their general practitioner (Mazza et al., 2012). It may also mean that women could find it difficult to discuss contraception with their husbands, which is problematic as spousal communication is associated with greater contraception use (Kamal & Islam, 2012).

Across the cultural groups interviewed, many women described having received extremely limited education about contraception prior to migration; thus they arrived in their new countries of residence with little or no sexual and reproductive health knowledge: "education is very low, that part of education is nil" (FG, Tamil); "in Afghanistan, it is very hard to find information about stuff like this" (Azita, 37, Afghan). The majority of women interviewed said they had learned about

contraception following migration: “it wasn’t until I came here [Canada] that I got information and knowledge about the big variety of different contraceptive methods” (FG, Latina); “I got to know about it [contraception] here” (Nita, 27, Tamil). Other reasons for poor contraceptive knowledge included not having had the time to look into it and ambivalence about contraception information, particularly if women had no intention of using it: “it's a very busy life…I have no time to think about that [contraception] now” (Andrea, 26, Tamil); “no, I don’t know anything about it…honestly I don’t want to take it” (Amaal, 42, Somali). These accounts highlight the importance of recognizing the structural factors that may impede women’s ability to prioritize their sexual and reproductive health. Migrant and refugee women face multiple challenges during the resettlement period, such as finding employment and securing housing, which may result in their sexual and reproductive health needs being given a low priority (Benson et al., 2010).

In a few accounts, women did report good knowledge about contraception, gained through seminars while in refugee camps, the internet, family doctors, and community health programs. Participants also described seeking information from mothers, aunts, sisters, and married friends, whom they positioned as well-trusted and frequently accessed resources: “I also knew about it [contraception] from my aunts…we have a strong connection, they are like our sisters” (FG, Sudanese); “[I learnt] from my sister, she is older than me and is married” (FG, Iraqi). However, across cultural groups, even where women could describe contraceptive methods and options, this did not guarantee that they used them. Bashira (44, Iraqi) said, “I know some information about it, but actually I didn’t use it” and Banoo (28, Afghan) said, “yes, I have heard of them, but I haven’t used any.” This disjuncture between contraception knowledge and behavior has similarly been reflected in previous

literature with migrant and refugee women (Watts, McMichael, et al., 2015). Women need accurate contraceptive information for informed decision-making, and it is equally important that women's wider sociocultural contexts are recognized, as knowledge alone does not always lead to changes in fertility-related behavior (Marston, Renedo, & Nyaaba, 2017; Watts, McMichael, et al., 2015).

Many women, across all cultural groups, constructed contraception as untrustworthy. This was reflected in accounts where women described falling pregnant despite having used contraception: "in spite of taking pills…I got pregnant" (FG, Latina); "we used condoms, but then, that's how I got pregnant with my second child, so I didn't trust it anymore" (Homa, 40, Afghan). Contraceptive failure is a commonly endorsed reason why many non-migrant women experience unintended pregnancies (Rowe et al., 2016). However, women or their partners may also be unaware of the ways in which specific forms of contraception prevent pregnancy, or they may not use contraception regularly. For example, Sharifa (43, Iraqi) told us, "the two sides of the IUD close the two passages to tubes that take you to the eggs…sperm can't get through and they have to return back" and Faaiso (32, Somali) said, "I got pregnant while using the tablet, maybe I forgot sometimes."

A large number of women across all cultural groups gave accounts that suggested that they did not have adequate knowledge about their reproductive bodies, particularly in relation to menstrual cycles, breastfeeding, and pregnancy. A Tamil focus group member said, "when I got the first child, after 6 months I'm pregnant with the second one…we never expected that" and Erina (39, Somali) said, "I was breastfeeding only, I was thinking if someone is breastfeeding they can't get pregnant…I got pregnant so quick." Similar findings of low knowledge in relation to fertile days of the menstrual cycle (Rowe et al., 2016) and the use of breastfeeding as

a form of contraception (Richters et al., 2016) have also been reported amongst women in population-based surveys within Australia.

Limited knowledge about fertility was also evident when women no longer took precautions to prevent pregnancy in midlife, as they believed they were no longer fertile in their early 40s. Ariana (40, Married, Latina) said, "I'm currently not using any method [of contraception]…fortunately now I am 40, so it is difficult for me to get pregnant…I can finally enjoy sex without being worried that I am going to get pregnant." Inadequate knowledge about the reproductive body and contraception methods may leave women vulnerable to unintended pregnancy (Watts et al., 2014). Consequently, migrant and refugee women may benefit from access to comprehensive sexual and reproductive health information that details contraception options, specifics about the way in which they function, and provides broader knowledge of the reproductive body.

Contraception as forbidden: "My religion doesn't allow us to stop having children."

Although religious beliefs are important in some Western women's fertility choices, migrants are even more likely to report being influenced by the teachings of their affiliated religions (Ellawela et al., 2017). In a number of participants' accounts, contraception was discursively positioned as culturally or religiously forbidden. Such beliefs were described as having strongly shaped women's reluctance to use hormonal contraceptive methods: "Whatever number of kids God will give me, I will keep on having…my religion doesn't allow us to stop having children" Hani (32, Somali); "my religion doesn't allow it…it's like killing" (Maano, 19, Somali). The cultural and religious prohibition of hormonal methods of contraception resulted in many women using "natural" methods of contraception, such as withdrawal or the

rhythm method. This was particularly evident in interviews with Muslim women and in some Christian women's accounts. Elmera (34, Sudanese) told us, "in my religion, I can't go to the doctor to make the medicine [contraception], I use natural rhythm." Fears about hormonal contraception use were a further reason why some women used natural methods. Anju (44, Tamil) said she "never used anything…we avoided the conceiving time" and Kamelah (36, Sudanese) told us, "I think the 'days system' is safer for me and it works." A high use of withdrawal for contraception has similarly been reported in population-based studies in Australia and Canada (Black et al., 2009; Rowe et al., 2016). This may reflect broader concerns that women and couples have about side effects of hormonal contraception, as well as the view that withdrawal offers a safe, convenient, and free alternative (Jones, Fennell, Higgins, & Blanchard).

However, practices such as withdrawal and the rhythm method are problematic as they are less effective methods of pregnancy prevention (Trussell, 2004), which was confirmed by Zarina (32, Tamil), "[I didn't] use any pills or condoms I made a mistake on the day's calculation and fell pregnant with my second child" and a Tamil focus group participant, "two time[s], it was an accident, then I got a termination." Natural methods also had intrapsychic implications for women; participants described feeling anxious about unwanted pregnancy, as it was always "on your mind" (Tamil, FG).

Religious edicts also prohibited contraception for unmarried women, as they are often forbidden to be sexually active prior to marriage: "I don't use it you know, we are not married" (FG, Somali); "I've never been in that sort of [sexual] relationship…I haven't had the need to think about it…I don't find any interest to ask people either" (Samira, 21, Afghan). However, a lack of contraception knowledge

prior to marriage may leave married women vulnerable to unintended pregnancy, as evident in Nasira's (52, Iraqi) account: "I didn't know how to use it...the contraception pills, so I didn't use them." It could also mean that when young women choose to have premarital sex, that they may avoid contraception use, or healthcare services, in fear that their parents or community would discover they are sexually active (Rogers & Earnest, 2014; Shoveller, Chabot, Soon, & Levine, 2007).

In a few accounts however, women drew on religion to justify family planning and fertility control. Amran (47, Somali) told us, "even the religion itself talks about spacing the children" and Arliyo (26, Somali) said, "I don't know why they think you can't use it [contraception]…the religion allows that." These contrasting findings highlight how diverse religious interpretations account for different reproductive practices (Degni et al., 2006; Srikanthan & Reid, 2008) and how religion may be employed to both criticize and legitimize sexual and reproductive health practice (Sargent, 2006).

Dangerous liaisons: Adverse contraceptive experiences, fears and misconceptions.

Negative experiences with hormonal contraception and fear of its side effects are consistently cited across global contexts and sociocultural settings in both Western and developing countries (Chebet et al., 2015; Dixon et al., 2014). In line with previous research, women in our study, across all cultural groups, described concerns about side effects and constructed contraception as dangerous. For example, women reported that in their communities, "there's a lot of concerns" (FG, Sudanese) and "there were a lot of horror stories" because contraception "creates a whole range of damages to other parts of the body" (FG, Afghan). Feared concerns and embodied experiences included weight gain, hair loss, growths in the uterus,

fibroids, cancer, changes in libido, headaches, infertility, fluctuations in mood, and changes to the menstrual cycle. As Sumi (37, Tamil) said, "we didn't want to use contraceptives because through my friends I knew it can mess up conceiving." A Latina focus group participant told us, "the pills had a very negative effect on my body and my overall emotional life."

A "disturbance to the menstrual cycle" (Setara, 23, Afghan) as a consequence of contraception was culturally constructed as "very unhealthy" or "harmful" because menstruation is thought to play a cleansing role in the body. For example, Habibah (43, Iraqi) said, "in our culture, we say that if there is no bleeding, the blood will harm the body." Anosha (30, Afghan) had questions about the long-term ramifications of no monthly bleeding: "I wonder… will it create complications? So, all those periods just stay in and gather up, right? I don't know, but these are the kind of problems." The value of regular monthly menstruation has also been reported in other non-Western contexts in relation to its 'cleaning' function and as a signifier of fertility (Marston et al., 2017). Although some women in Western contexts view regular menstruation as important, many other women see the absence of menses as a positive non-contraceptive benefit of methods such as subdermal implants (Flore et al., 2016; Kelly et al., 2017). This highlights how different cultural constructions of menstruation influence the acceptability of certain contraceptive methods.

Similar to past research (Kelly et al., 2017; Weisberg, Bateson, McGeechan, & Mohapatra, 2014) many of our participants described experiences of heavy bleeding after having used the IUD, "the implant," or "the injection." Madina (45, Iraqi) said, "I had bleeding for 4 months…so I went to the physician and told him 'I can't stand it, I want to pray, I want to fast…I don't want it. Please remove it.'" Cultural constructions that position a woman's menstrual blood as dirty and polluting

prohibit some women from diverse cultural and religious backgrounds from engaging in specific activities during menses, including praying and sexual intercourse (Dunnavant & Roberts, 2013; Hawkey et al., 2017). It is therefore likely that these restrictions render some forms of contraception, which may cause unpredictable or prolonged bleeding, as unacceptable (Hawkey et al., 2017). Consequently, possible changes in bleeding patterns following initiation of contraception, such as long-acting reversible methods, must be sufficiently acknowledged with women during pre-contraception counselling (Weisberg et al., 2014).

These negative embodied and psychological experiences led women to use a range of contraceptive methods in an attempt to find an appropriate fit or to stop using contraception altogether. As one participant said, "I tried the IUD, it was not suitable for me because of the continuous bleeding…then I used contraception pills, it caused nervousness and headaches…I have no other options" (FG, Iraqi); another said, "once I used the IUD and it made me bleed and I stopped it. I didn't do anything else" (FG, Sudanese). Feelings of dissatisfaction with available contraceptive methods that led to discontinuation have similarly been reported by Western women (Dixon et al., 2014; Mills & Barclay, 2006). This not only highlights women's 'experimentation' with contraceptive methods to avoid pregnancy and find an appropriate 'fit,' but also highlights the need for clinicians to adopt a model of shared responsibility, such as encouraging the use of male condoms (Wigginton et al., 2015).

In contrast to the positioning of contraception as dangerous, a few women described being "very happy," feeling "safe," and "worry free" with their choice of contraception and reported no negative effects on their health and well-being. For

example, one woman said that she liked having no periods following the insertion of her IUD: "I didn't get any period…I think it's a good thing because I had over-bleeding" (FG, Tamil). Similarly, Nafisa (36, Sudanese) told us, "I'm very happy…I would not try something else, it's [IUD] very convenient for me right now." These examples show that some women were able to overcome negative past experiences and community myths or misconceptions to find an appropriate contraceptive fit.

Implications and suggestions for future research.

The results indicate that migrant and refugee women's fertility and fertility control were shaped by the interplay of cultural and religious discourse and the materiality of women's relational context and influenced by women's negotiation of both. Although cultural or religious discourse acted to regulate some women's fertility and fertility control, other women actively resisted restrictive discourses and practices to enact their own reproductive agency. This finding illustrates how women have the potential to 'rewrite' or resist traditional constructs and practices associated with their reproductive bodies by mobilizing counter-stories that position their fertility choices in more agentic ways (McKenzie-Mohr & Lafrance, 2014a). These nuanced differences highlight the heterogeneity that exists both within and across cultural and religious groups of migrant women, and show that religion and culture are often exaggerated categories of difference that are drawn on to describe the cultural 'other' as devoid of agency or autonomy (Bilge, 2010). It is important that healthcare professionals recognize migrant and refugee women's different constructions and experiences by providing individualized sexual and reproductive care that avoids stereotypical constructions often attached to specific cultural or religious groups (Srikanthan & Reid, 2008).

At the same time, however, healthcare professionals working with migrant and refugee women need to be aware of the range of sociocultural factors that shape women's ability or willingness to use contraception (Newbold & Willinsky, 2009). To address these factors, it is important that healthcare professionals ask women whether there are any cultural or religious beliefs that they should be aware of when discussing contraceptive methods. To facilitate such conversation in practice, future researchers could work with migrant and refugee women and healthcare professionals to develop a contraception decision-making tool to be used during contraceptive counselling. This could provide clear information of the contraception options available and how they work, their efficacy, and potential side effects.

It is also important that, where possible, healthcare professionals employ a whole-of-family approach to education and decision-making about contraception and family planning (Rogers & Earnest, 2014; Watts, McMichael, et al., 2015). It is equally important that women are aware of their own sexual and reproductive rights following migration to Australia, Canada, or elsewhere. For women who wish to enact control over their fertility, and who do not have support from their husband or family, it is important that healthcare professionals encourage women to make their own contraceptive decisions by drawing on a human rights-based approach (WHO, 2014). Furthermore, given the reported effect of husbands on some women's reproductive agency, future researchers need to include in their studies migrant and refugee men's perspectives on fertility and fertility control. This could include possible changes in gender roles in the context of migration, how men themselves construct hormonal methods of contraception, strategies that best foster husbands' support of contraception, and the most appropriate ways to increase men's access to sexual and reproductive health education.

High-quality communication between patient and healthcare providers about contraception has been associated with patients' continued use of highly effective contraceptive methods (Ramarao, Lacuesta, Costello, Pangolibay, & Jones, 2003). However, migrant and refugee women often report a lack of cultural competency and ineffective communication with healthcare professionals (Degni et al., 2006; Rogers & Earnest, 2014). This suggests the need for cultural competency training for healthcare professionals and health educators who work with migrant and refugee communities (Mengesha et al., 2018; Rogers & Earnest, 2014). Such training could cover ways to initiate and discuss sexual and reproductive health effectively, as well as provide insight into health issues specific to migrant and refugee women (Mengesha et al., 2018). To support women in finding the most appropriate contraceptive fit, healthcare professionals must go beyond simply prescribing contraception, but enter into a process of shared-decision making, information sharing, and they must appropriately respond to concerns and manage side effects (Carvajal, Gioia, Mudafort, Brown, & Barnet, 2017; Chebet et al., 2015).

It is critical to address misconceptions about and negative experiences with hormonal contraception methods in order to support migrant and refugee women to achieve reproductive goals and counter second-hand knowledge that may be present within their communities (Chebet et al., 2015). Following arrival, and during resettlement, migrant and refugee women need access to transparent information about culturally constructed contraceptive misconceptions, the ways in which contraceptive methods work, and comprehensive education about the reproductive body (Rogers & Earnest, 2014). Women may also need reassurances that, although some women do experience mild side effects, such as headaches or weight gain, severe complications are rare (Kiley & Hammond, 2007). Given women's reluctance

to communicate about contraception, providing sexual and reproductive health information in the women's native languages that accommodates different literacy levels may also facilitate increased reproductive health knowledge and awareness of available healthcare services (Rogers & Earnest, 2014). To ensure cultural sensitivity, education sessions focused on sexual and reproductive health topics could be developed and disseminated by same-sex community educators or community leaders, and could take place at migrant resource centers or as outreach activities attached to community events (Kolak et al., 2017).

Strengths and limitations.

The strengths of the current study include the use of a qualitative research methodology, which captured women's voices, subjective experiences, and constructions of fertility control. Including women from multiple different cultural backgrounds facilitated examination of differences and commonalities across cultural groups. Interviewing women in their first language allowed women to explore their experiences without the limits of their spoken English and meant that newly arrived migrant women could participate in the study. Providing English-speaking participants with the option of being interviewed in English with a non-migrant interviewer meant that we could provide women with choices in relation to how they were interviewed, as some might have felt more comfortable talking with another member of their community, whereas others might have felt more comfortable with an 'outsider.' Limitations include the fact that some participants' accounts were retrospective (i.e., they may not be representative of women's experiences in their home countries today). Furthermore, we could not back-check translated transcripts for accuracy or complete member checking of our findings. Member checking, particularly where researchers do not share the same cultural background as

participants, could be a useful strategy in future research with migrant and refugee women to help ensure the realities of women's lived experiences are represented appropriately.

Conclusion.

It is important that migrant and refugee women have access to appropriate contraceptive information and methods, but education about methods of fertility control alone is unlikely to result in changes to fertility behaviors. Greater recognition of the complex cultural, religious, and gendered discourses and practices that restrict women's reproductive agency must be reflected in sexual and reproductive healthcare provision, education, and health promotion programs.

Chapter Seven: Discussion

Throughout history and across sociocultural settings women's sexual and reproductive bodies have been a site of contradiction. Representations of the feminine position women on one hand, as "powerful, impure and corrupt, [a] source of moral and physical contamination" yet on the other hand, as "sacred, asexual [and] nourishing" (Ussher, 2006, p. 1). These representations of women carry weight by reflecting the constructs and regimes of truth, within which women become 'woman' (Ussher, 2006). In this thesis, it is evident that the meanings and practices associated with being a sexual or reproductive 'woman' were heavily regulated through cultural and religious discourse and material practice, with subsequent implications for women's health, subjectivity and agency. While there were a number of common threads found across each of the cultural groups interviewed, women were not homogenous. This thesis has highlighted variation in cultural and religious discourse and practice, associated with women's sexual and reproductive bodies both across and within cultural groups. Women's experiences were not static or monolithic, but complex and fluid, particularly in the context of transnational migration.

At the outset of this thesis, I acknowledged that constructions and experiences of sexual and reproductive health are strongly influenced by the social, cultural and historical milieu in which a woman is embedded. However, there is limited research considering women's experiences across different intersections of identity, in the context of migrant and refugee women from diverse cultural and religious backgrounds. I thus argued that understanding migrant and refugee women's constructions and embodied experiences of sexual and reproductive health is important for a number of reasons. Access to sexual and reproductive health services is associated with positive physical and mental health outcomes (WHO,

2009), as well as quality of life (Daker-White & Donovan, 2002; WHO, 1995). However, migrant and refugee women are less likely to access sexual and reproductive health services compared to native born populations (Botfield et al., 2016; Manderson & Allotey, 2003), and such women often report limited levels of sexual and reproductive health literacy (McMichael & Gifford, 2010; Quelopana & Alcalde, 2014), associated with poor sexual and reproductive health outcomes, such as lower levels of effective contraceptive uptake (Trinh, McGeechan, Estoesta, Bateson, & Sullivan, 2016; Wiebe, 2013).

Much of the past research in this sphere has focused on material barriers to healthcare and sexual health risk, as a result, it is less attentive to cultural meanings associated with sexuality and reproduction, or women's embodied experiences. A review of the literature indicated that previous research in this field largely focused on migrant and refugee women's experiences of childbirth, cervical screening and STIs, with a paucity of research that considers broader aspects of women's sexual and reproductive wellbeing (Gagnon & Redden, 2016; Mengesha et al., 2016). Research that does examine migrant and refugee women's sexual health, frequently concentrates on the perspectives of young, unmarried women (Meldrum et al., 2014; Watts, McMichael, et al., 2015; Wray et al., 2014), meaning that the experiences of adult married women remain under-explored. Such research is also often undertaken with second-generation migrants (Hendrickx, Lodewijckx, Van Royen, & Denekens, 2002; Rawson & Liamputtong, 2009), with more recent migrant and refugee women from across a range of cultural or religious communities being less frequently considered.

The aim of the research presented in this thesis was to explore how new migrant and refugee women negotiate discourses and practices in relation to their

sexual and reproductive health when transitioning from countries where cultural constructions and practices, associated with sexuality and reproduction, may differ from hegemonic discourse and practice in their new countries of residence, Australia or Canada. To address this aim, I asked the questions: How is sexual and reproductive health constructed and experienced among recent migrant and refugee women living in Australia and Canada? What are the implications of these constructions and experiences for the sexual and reproductive health of migrant and refugee women?

In this final chapter, I first provide a summation of the overarching research findings. I then further explore the implications of these findings for conceptualising migrant and refugee women's sexual and reproductive embodiment, and the provision of sexual and reproductive healthcare. Next, I identify strengths and limitations of this study, as well as provide suggestions for future research. This chapter concludes with my final thoughts and reflections on undertaking this study.

The Regulation of Migrant and Refugee Women's Sexuality and Reproductive Bodies

The ways in which patriarchal cultural and religious discourse intersected to regulate women and their sexual and reproductive bodies was a major commonality found across all of the cultural groups interviewed. This began at puberty, where a discourse of shame, secrecy and silence prohibited women from learning about their reproductive bodies at menarche. It continued through adulthood, serving to inhibit young women from exploring themselves as sexual beings prior to marriage, shaped the way women entered into marital relationships and the manner in which women could express themselves sexually. It also strongly influenced women's autonomy in contraception choices. I now examine each of these areas in turn below.

Regulation of the abject menstrual body.

Across cultural contexts, constructions of menarche and menstruation were strongly tied to notions of 'womanhood', interlinked with reproduction and emergent sexuality. While there was variation in relation to traditional cultural practice, such as engagement in menstrual celebrations and rituals, nearly all women who took part in the study discursively positioned menarche and menstruation as shameful and abject, requiring associated regulatory practices of silencing and concealment. The cultural positioning of women's bodies as polluting and impure in relation to menstruation was reinforced by religious discourse and practice, particularly for Muslim and Hindu women, who were excluded from religious rituals during menses. Findings from this thesis align with other research that highlights that within patriarchal societies women receive contradictory messages in relation to their reproductive bodies (Christoforou, 2018; Goldenberg & Roberts, 2011). On one hand, women are highly valued for their fertility, with the materiality of menstrual blood signifying the potential to reproduce. On the other hand, women are discursively positioned as the 'monstrous feminine' (Ussher, 2006), impure, dirty and inferior to men whose body fluids (semen) are glorified or highly valued (Moore, 2007).

Silencing menarche and menstruation acts as a reinforcer of the discursive positioning of a woman's bleeding as a source of stigma (Johnston-Robledo & Chrisler, 2013; Ussher, 2006), with material and intrapsychic consequences for women, as was found in this study. Shame and silencing denied women the right to learn about the functioning of their reproductive bodies and therefore women had no framework to make sense of their experiences at menarche, resulting in confusion, humiliation and guilt. Where mothers did impart information to their daughters it

generally only conveyed details of appropriate ‘menstrual etiquette’ to ensure concealment and avoidance of public ridicule, particularly at the hands of men who “must not know” about or see menstrual blood (Laws, 1990, p. 19). This focus on menstrual etiquette is problematic, as young women are more likely to describe positive experiences of menarche if they have emotionally engaged mothers, rather than receiving factual information about menstrual management in isolation (Lee, 2008). In addition, women who experience shame about their own reproductive functions, as was the case with women in the present study, are more likely to transmit messages of shame to their daughters (Stubbs & Costos, 2004). Further, the positioning of women’s bodies as abject may lead to the internalisation of shame in relation to menstruation, which could delay diagnosis and treatment for serious reproductive conditions, such as endometriosis (Seear, 2009). Internalising shame may also affect women’s sexual health and sense of self more broadly, as shame towards menstruation has been associated with less body comfort, less sexual assertiveness and increased sexual risk-taking (Schooler et al., 2005).

Regulation of the virginal body.

Patriarchal cultural and religious discourse was also found to regulate unmarried women’s sexual agency and subjectivity. Across all cultural groups, women were expected to be virgins at marriage. A sexual double standard acted to control women’s sexuality through reputation and the threat of becoming a ‘fallen women’ (Wray et al., 2014); one who is stigmatised, at risk of violence and “unmarriageable”. Knowledge of sex or talking about sex as an unmarried woman was positioned as “bad” and “shameful” resulting in many participants engaging in a process of self-policing (Foucault, 1975), as has been described in other studies with young unmarried migrant women (Cinthio, 2015; Wray et al., 2014). By engaging in

self-discipline, young women maintained the idealised feminine subject position of being chaste, sexually innocent and in control of their sexual desire. In doing so, they also avoid collective judgement by their wider communities and negate the risk of bringing shame or dishonour to family (Cinthio, 2015).

However, these patriarchal constructions of feminine sexuality deny young women sexual agency. Feminist scholars have argued it is essential that there is cultural space to allow girls and young women to acknowledge themselves as sexual beings (Fine & McClelland, 2006; Lamb, 2002; Tolman, 2002b). Without such acknowledgement, women may associate their sexuality with shame and guilt across their life course (Hoga et al., 2010; Lamb, 2002), as reported by many women in this study, most notably by Latina women. It also denies women any acknowledgement of their own right to experience sexual desire and pleasure (Tolman, 2002a) potentially creating women who are 'ready-made' for an adult sexual life that prioritises the sexual desires of men (Gavey, 2005; Lamb, 2002).

Internalisation of shame may also inhibit young women's willingness and ability to access sexual and reproductive health services, as being seen at such services may result in stigmatisation or questioning by members of the woman's community (Beck et al., 2005; Rogers & Earnest, 2014). It also impacts heavily on communication about sexual and reproductive health within the family, as young unmarried women are not considered to be sexually active, and thus do not need to know or speak about sex (Rogers & Earnest, 2014; Watts, McMichael, et al., 2015). Consequently, young women are left with few reliable avenues from which to gain access to important sexual and reproductive health information, meaning they are at risk of poor sexual health outcomes, such as untreated STIs and unintended pregnancies, if they do have premarital sex (Meldrum et al., 2016).

The cultural construction of the hymen as a material "membrane" that "breaks", acted as a discursive marker of virginity and honour, aligning with past research in this sphere (Amer, Howarth, & Sen, 2015; Cinthio, 2015). However, for some women, particularly unmarried Muslim participants, this had intrapsychic implications, such as being "very worried" about whether they would bleed on their wedding nights. As described by Cinthio (2015), legitimating and policing the physicality of virginity acts as a means of patriarchal control, ensuring unmarried women believe that virginity is manifested by a material structure, and that they should regulate their sexual behaviours to preserve an intact hymen. This focus on the hymen as a manifestation and symbol of virginity, in conjunction with concepts of shame and honour, reifies a material-discursive relationship in which the hymen becomes a "very fine membrane called honour" (El-Saadawi, 1991, p. 25).

The most extreme form of material regulation of women's sexual bodies was demonstrated through the cultural practice of FGM. The material cutting away of women's genitalia in an attempt to regulate desire, denies women the right to bodily integrity and the right to experience pleasure (WHO, 2016). The continued support for the milder forms of FGM by a minority of Sudanese and Somali women interviewed corroborate previous research (Isman et al., 2013), demonstrating that entrenched cultural beliefs do not simply change following migration, and that women may need time to internalise new understandings of their bodies, as well as sexual and reproductive health and rights.

The regulation of unmarried women's sexuality and their relationships with men prior to marriage reflects patriarchal constructions of heterosexuality, in which men are positioned as lustful and unable to control their sexual desire (Sadr, 2012). Consequently, it is a woman's responsibility to contain her sexual body, averting the

male sexual gaze, and avoiding the discursive construction of herself as a sexual subject in the public sphere. Mothers' surveillance of their unmarried daughter's behaviour and the prohibition of premarital relationships or intimacy has been reported in previous research with young women living in diasporic contexts (Abboud et al., 2015; Amer et al., 2015). However, parental control and pressure to maintain specific cultural identities, such as the "good girl", contributes to intergenerational tension, resulting in conflict with parents and young women distancing themselves from family and community (Abboud et al., 2015).

Regulating the sexual body in marriage.

Regulation of women's sexuality through a discourse of silence and secrecy continued throughout adult married life. In this study, the sexual agency of married women was negotiated through the intersection of patriarchal cultural and religious discourse, influenced by women's relationships with their husbands. Firstly, a lack of agency in husband choice, in conjunction with restrictions on information about sex prior to marriage, resulted in many women describing negative experiences of first sex and unfulfilling ongoing sexual relationships, as has previously been reported amongst Iranian migrant women (Farahani, 2018). The practice of arranged marriage also regulated women through compulsory heterosexuality (Rich, 1980), reinforced by cultural and religious discourse that positioned heterosexuality as the only legitimate sexual identity. While forced marriage may appear to be a 'problem' that exists outside of countries such as Australia and Canada, this is no longer the case. With increasing migration, comes increasing diversity in cultural practices, not all which are positive. A recent report in Australia for example, has highlighted that although exact numbers on forced marriage of young women is not known, this practice continues to exist amongst migrant communities (Australian Institute of

Criminology, 2018). It is critical that this issue is brought to light, as young women are often vulnerable to abusive, violent, controlling and exploitative experiences while married, as reported by women in this study.

Women's narratives in this study demonstrated the power of patriarchal cultural and religious discourse in shaping the sexual scripts in which women were permitted to adopt. Within a discursive framework of heterosexuality, idealised femininity in this study required women to supress their own sexual desires and resulted in women being unable to refuse unwanted or painful sex. Farahani (2018) argues that cultural conditioning of women as passive makes those women who do initiate sex directly less attractive in the eyes of men. This aligns with findings in this study as women disclosed being unable to articulate their desire for sex due to shame and fear of negative judgement from their husbands. Similarly, some women felt unable to voice sexual thoughts or preferences in an attempt to experience sexual pleasure, as this was not appropriate for 'a woman', reflecting heteronormative scripts that require women to be passive and not knowledgeable about sex (Ussher, 1997b). Sexual regulation extended to a woman's inability to disclose undesired or unpleasurable sex with her husband. Such a requirement was reinforced through the interpretation of conservative religious texts that acted to regulate women's sexual agency by demanding sexual compliance, as has been previously reported (Hoel & Shaikh, 2013).

In this vein, women are denied a positive and agentic sexual subjectivity, becoming objects of men's sexual desire (Gavey, 2005); they are also at risk of shame and distress which is often associated with sexual pain (Ayling & Ussher, 2008; Hinchliff et al., 2012). An adoption of gendered sexual scripts, wherein women are positioned as passive and receptive to the needs of men also has

implications for sexual health, including negative impacts on women's sexual arousal (Sanchez, Kiefer, & Ybarra, 2006), in addition to, decreased sexual-risk knowledge and women being less likely to advocate for themselves sexually, such as negotiating the use of contraception (Curtin et al., 2011). It is therefore not surprising, that sexual coercion as a consequence of unequal power relations between sexual partners, is strongly associated with women's experiences of unintended pregnancy (Rowe et al., 2016).

Regulating female fertility.

In this study, fecundity and provision of the 'vital' male child was central to the identity of women interviewed and was not negotiable, meaning women experienced shame and stigma if they were unable to fulfil this cultural imperative. Consistent with previous research among migrant and refugee communities (Degni et al., 2006; Dune, 2015; Hampshire et al., 2012), this study found that the choices women made about their reproductive bodies were not made in isolation, or at an individual level. Women's reproductive agency appeared to be regulated by an intricate interplay between husbands and family, informed by cultural and religious discourse, serving to shape obligations and contraceptive practices. In addition to negotiating family pressures to reproduce, women described poor knowledge surrounding contraception and had significant concern about the use of hormonal contraception for women's health, particularly ongoing fertility. This resulted in poor uptake of reliable forms of contraception leading to some women experiencing unintended pregnancy, as has previously been reported in the literature (Watts et al., 2014).

Regulation and the interplay of intersections.

While there are different levels of faith, with varying interpretations of religious text and teachings, the findings of this study reiterate how religion permeates nearly all aspects of women's sexual and reproductive lives, influencing their ability to make independent decisions in relation to their sexual embodiment. For example, despite coming from different religious backgrounds, which have different constructions of women and their sexual bodies (Clough, 2017; Moghissi, 1999; Wiesner-Hanks, 2014), Christian and Muslim women alike described religion as playing a significant role in their sexual agency. Similarly, both Muslim and Hindu women described exclusion from religious activities during menses. These examples suggest that across religious sects, the intention of such religious discourse and practice is often to regulate women by demanding the containment of their fecund bodies and patriarchal control over women's sexuality (Ussher, 2006).

Likewise, despite coming from a number of different cultural locations, nearly all women described strict cultural proscriptions surrounding what it means to be a 'good woman', in relation to hiding menstruation, being pure, sexually passive and a mother. To make sure women adhere to these rules, strategies of shame and stigma are drawn on across cultural contexts as a strong regulatory power to maintain patriarchal control over women. As described by B. Brown (2010), shame thrives in silence and secrecy, as evident in women's accounts in this thesis; it demands compliance and conformity, hindering an alternative viewpoint, making it a very effective tool to ensure women are contained and silenced (Clough, 2017). In this respect, it is evident how religion and culture intersect in ways that result in potentially sexist and heterosexist oppression of women with negative consequences not only for women's own subjectivity and agency, but also in acknowledgment of

their sexual and reproductive rights. Understanding the complexity of attaining sexual subjectivity as a woman imbedded in cultural and religious discourse, and its resulting shame, gives insight into why women may not adopt or resist subject positions that could provide them with agency or more subjectivity. In part, this also contributes to our understanding as to why women may be reluctant to access sexual and reproductive health services or discuss topics such as sexual pain and contraception with their healthcare providers.

While I have outlined the ways in which culture and religion intersects to regulate migrant and refugee women's sexual and reproductive health, it is important not to position the West as a utopia for women's sexual and reproductive health and rights. As stated by Hélie (2012), "bodily rights, sexual conduct and gender expression are regulated in all societies" (p.1). For instance, in the West, women's 'disgusting' bodies have long been condemned in their natural state, necessitating management (Roberts & Goldenberg, 2007), such as the removal of body hair to appear more 'feminine' (Fahs, 2011b; Tiggemann & Lewis, 2004). Research in the West exploring casual sex suggests that while female heterosexuality may no longer be characterized by a 'discourse of missing desire' (Fine, 1988), women's sexuality continues to be regulated through the persistence of the sexual double standard and the 'threat' of obtaining a negative sexual reputation (Farvid et al., 2017). Western research also suggests that women are now engaging in 'performative bisexuality', which demands same sex acts from women, for men's viewing, as a means to gain their approval or stimulate their sexual arousal (Fahs, 2009).

Further, in the West today women are now 'expected' to experience sexual pleasure and desire, with women being pathologised if they experience an absence of desire for sex (Tiefer, 2003). Cultural scripts in the West also dictate that women are

required to provide their (male) partners with sexual access to their bodies (Fahs, 2011c), with women often describing narratives of 'obligatory' or coerced sex (Gavey, 2005). Women are also seeking cosmetic vaginal surgery with the promise of enhanced sexual pleasure (Braun, 2005) or to obtain what is seen as a 'desirable' vulval shape (Sharp, Mattiske, & Vale, 2016). And in Australia, only one out of nine jurisdictions has removed abortion from its criminal law, which does not reflect the 'universal' and 'accessible' health care system aspired to in Australia (de Costa, Douglas, Hamblin, Ramsay, & Shircore, 2015). These findings demonstrate that regulation of women's sexual and reproductive health is not limited to migrant and refugee populations, but occurs across cultural contexts within a different rubric of sociocultural discourses, with serious consequences for the health and wellbeing of all women.

Women's Resistance to Regulatory Cultural and Religious Discourse

In the first part of this discussion, I have demonstrated the power of cultural and religious discourse and practice in the regulation of women's sexual and reproductive health. While patriarchal cultural and religious discourse did effectively regulate many participants' sexual rights, subjectivity and agency, other women gave accounts that suggested they were attempting to challenge or resist these dominant discourses to negotiate their own meanings and practices in relation to sexual and reproductive health. Although I did not ask women specifically about resistance to hegemonic discourses and practices, such stories were regularly intertwined throughout women's interviews and focus group discussions.

Participant accounts revealed that women's resistance was demonstrated in many forms, as reported previously in research examining women's narratives of resistance to limiting hegemonic discourse (McKenzie-Mohr & Lafrance, 2014b).

Women voiced their resistance by breaking the menstrual taboo and speaking to their daughters about menarche and menstruation, as well as through openly stating that the virginity imperative for young women was hypocritical or "unfair". Many women openly rejected FGM for their daughters, showed resistance through disclosing sexual pain to their husbands, said "no" to unwanted sex and told their husbands to "back-off" in relation to their fertility decisions.

Women also showed resistance through agentic silencing and secrecy, such as choosing to use contraception in secret or choosing to leave abusive relationships. Other participants drew on interpretations of religious principles that supported women's sexual rights and reproductive autonomy. For example, some Muslim participants described that the Qur'an explicitly stated that it is a husband's duty to satisfy his wife sexually and that women could refuse unwanted sexual advances from their husbands. Religion was also drawn on by Muslim women as a means to reject FGM, positioning women's sexual pleasure as a "God-given right"; others stated that religion supported the use of contraception. Even the process of talking about sexual and reproductive health in the context of an interview is a form of resistance to cultural silencing.

Given the confines of the discursive environment within which many women were embedded, women's resistance could be considered 'fragmentary' or 'fleeting' at times (McKenzie-Mohr & Lafrance, 2014b), such as brief reflections or statements. However, it is important to recognise resistance to hegemonic discourses, even if fleeting, in order to gain insights into the intricacy of women's experience, but also the possibility of nurturing 'counter-stories' (McKenzie-Mohr & Lafrance, 2014b) that contest negative framings of migrant and refugee women, and their sexual and reproductive agency. Nelson (2001) argues that 'counter-stories' are

"narrative acts of insubordination" (p. 8) and act to open up spaces for valued identity constructions, especially for those who have been marginalised; it also allows for the identification of the heterogeneity of women's accounts, challenging the notion of women as cultural dupes. Disrupting the power of hegemonic discourses through recognition of counter-stories is of particular importance in the current socio-political milieu, where migrant and refugee women are often stereotyped or marginalised and positioned as voiceless and racialised 'victims' rather than active agents working to determine and engage in their own sexual and reproductive rights (Farahani, 2018). This is particularly the case within Western feminist discourse where specific cultural practices, such as veiling, are viewed as backward or oppressive and Muslim women are pitied (Golnaraghi & Dye, 2016). This stands in contrast to the accounts from women themselves, who construct veiling as a choice (Zimmerman, 2015), as well as a mechanism to exert respect, protection and modesty (Siraj, 2011).

Regulation, Resistance and Somewhere in Between.

The accounts women gave in this study of their sexual and reproductive health were not always binary, reflecting the 'either/or' subject position of submission or resistance, however. This demonstrates women's active negotiation of their sexual and reproductive health. An exemplar of such negotiation is where women took up a 'both/and' position (C. Brown, 2007) in relation to cultural discourses or practice. By taking up such a position, women *both* reproduced dominant discourses and practice, *and* at the same time resisted such discourses. For example, this was particularly evident in accounts from unmarried women who described premarital sex as being prohibited for them, but possibly enacted by 'other' women. In this vein, women were enacting agency by stating that they were

'choosing' to remain virginal and thus not 'victims' of patriarchal culture, yet simultaneously reinforcing patriarchal control given the requirement that only *women* remain sexually chaste and inexperienced. This oscillation between subject positions can be seen as a form of what McKenzie-Mohr and Lafrance (2011) describe as 'tightrope talk', where 'either/or binaries' are avoided to produce a more nuanced understanding of subjectivity and experience. Similar findings have been reported in relation to women's contraceptive practices in other culturally diverse contexts (Marston et al., 2017), in which women are reported to take up a 'hybrid identity' position to navigate attempts to control their sexual and reproductive health and agency.

Accounts highlighting mother's willingness to educate and support their daughters through menarche, demonstrates resistance to silence and secrecy surrounding menstruation. However, adherence to cultural mores that require it to be done at an 'appropriate' age, is not only evidence of women's negotiation of two differing cultural contexts, but suggests that a discourse of secrecy and silence may be difficult to resist. Such accounts demonstrate that women's negotiation is not always dichotomous, with women often taking up multiple or even contradictory positions in relation to discourse.

Another example of women's negotiation of cultural practice was in relation to menstrual celebrations and rituals. While some women viewed menarche celebrations as being inappropriate following migration, other women, notably in the Tamil community, showed evidence of adapted traditional celebrations, with a focus on having "fun" rather than announcing a woman's marriageability to wider society, as traditionally intended. Similarly, other Tamil mothers described adapted versions of menarche rituals, such as the eating of raw eggs, as a symbolic gesture to

acknowledge cultural practice. These accounts highlight how women are negotiating multiple potentially conflicting discourses and modernisation in the context of migration, affecting the cultural practices they choose to carry out with their daughters today.

The exploration of women's constructions and experiences demonstrates the inherent homogeneity and 'messiness' of women's subjective experience. While subjectivity is a complex topic for all women, the fact that migrant and refugee women are negotiating shifting discourses across two different cultural contexts, adds an additional layer of intricacy to the stories which women told. It also demonstrates the power of social norms and relationships in shaping sexual subjectivity, particularly what people do and think about their sexual selves (Fahs & McClelland, 2016).

Women's Negotiation and Resistance Across Cultural Spaces

As has been previously reported (Quelopana & Alcalde, 2014; Watts et al., 2014), women in this study described migration as having provided them with greater opportunities to engage in education surrounding menstruation and contraception, which were silenced in their home countries, empowering them with greater knowledge to facilitate autonomous decision-making and the sharing of menstrual knowledge with their daughters, as one example. Similar to past research with migrant women (Degni, Ojanlatva, & Essen, 2010; Quelopana & Alcalde, 2014), participants in this study also highlighted that transitioning to their new countries of settlement had facilitated a relaxing of cultural practices which traditionally would have meant certain topics were not allowed to be spoken about. Many women also described migration to Australia or Canada as having facilitated their ability to negotiate or resist negative cultural discourse and practice due to

greater recognition of a sexual rights discourse. This was particularly evident in accounts where women stated they had the "right" to refuse sexual advances from husbands and that unwanted sex even within marriage was considered "rape". Findings in thesis also support previous literature in relation to FGM (Johnsdotter et al., 2009), with women stating that migration had enabled a change in attitude towards FGM, as it no longer had the same meaning in a context where such tradition is not practised.

However, as argued by Farahani (2018) the grounds for migrant women's transformation in discourse and practice cannot simply be reduced to the impact of exposure to 'Westernisation', as women's constructions and practices surrounding sexuality may have shifted over time even if they had remained their countries of origin. Further, while migration may have facilitated women's ability to resist restrictive cultural and religious norms, it is equally important to acknowledge that the West is not the only context in which women resist negative discourse and practice towards women's sexual and reproductive autonomy.

For example, as argued by Ilkkaracan (2016), since the early 1990's a number of NGOs and Muslim feminists in the Middle East have successfully campaigned to increase public awareness towards sexual and bodily rights of women, including the eradication of FGM, honour killings, forced virginity tests and penal code reforms that support the legal recognition of women's sexual autonomy. An exemplar of such movement is the Coalition for Sexual and Reproductive Rights in Muslim Societies (CSBR), which is a transnational advocacy network made up of NGOs, researchers and academic institutions which promotes sexual, bodily and reproductive rights at national and international levels (Ilkkaracan, 2013). One of the central aims of the coalition is to prioritise the rights of people with 'non-conforming' sexualities which

include “sexualities that fall outside the heteronormative, patriarchal social constructs of ‘expected and accepted’ sexual behaviour” (Ercevik Amado, 2006). This includes women who choose not to get married or who do not identify as heterosexual; women who express their sexual desires openly and young unmarried women who experience their sexuality differently to that which is expected by their family and society (Ilkkaracan, 2013).

It is important that this advocacy work is acknowledged in order to avoid reinforcing existing stereotypes about women living in non-Western contexts (particularly the Middle East), as suppressed and unable to defend their sexual rights (Ilkkaracan, 2016). Acknowledgment of women’s resistance outside of Western contexts is also important not only to demonstrate women’s ability to develop empowerment strategies within their own sociocultural contexts, but also in disrupting the belief that women’s emancipation can only be influenced by ‘Western’ values (Hélie, 2012). It is warned that such outlook could result in women’s sexual rights continuing to be dismissed as they may be constructed as ‘foreign’, ‘imported’ or imposed by ‘the West’ (Hélie, 2012, p. 2). Failure to recognise women’s efforts abroad also strengthens the belief often held in the West, that regions such as the Middle East are backward and uphold cultural beliefs that are incongruous with ‘Western values’ (Ilkkaracan, 2016). Such negative perceptions are likely to contribute to ongoing marginalisation and racism towards migrant and refugee women in their new countries of resettlement.

In the discussion above, I have outlined how knowledge of women’s constructions and experiences have implications for the way in which women experience their sexual and reproductive health and embodiment. As outlined at the beginning of this thesis, greater understanding of women’s embodiment has broader

implications for the development of culturally sensitive health education, the delivery of healthcare services to migrant and refugee women and health policy. I now discuss each of these below**.**

Implications for Sexual and Reproductive Health Practice, Policy and Health Promotion

Providing accessible and culturally sensitive information and education to women.

In the present study, many participants acknowledged that they had come from cultural backgrounds that discouraged discussion of their sexual and reproductive health; and consequently, a number of women stated that they had limited knowledge in this sphere. Providing women with access to sexual and reproductive health information and education is important as it has been found to both increase women's factual knowledge, as well as enhance women's understandings of their sexual and reproductive health and rights in the context of migration (Svensson et al., 2017). Given many women described arriving in Australia and Canada with limited knowledge surrounding aspects of their sexual and reproductive health, information and education needs to be made available to migrant and refugee women on arrival into Australia and Canada, and throughout resettlement (McMichael & Gifford, 2010).

The findings from this study suggest that migrant and refugee girls, young women, and women who are mothers, may benefit from access to information surrounding menstruation. Such information should include what menstruation is, its link to fertility and guidance on how menstruation can be navigated in a safe and healthy manner (M. Sommer, Sutherland, et al., 2015). It is also important that in

addition to information surrounding menstrual management, that girls are provided with emotional support that empowers them to feel positively about their reproductive bodies (M. Sommer, Sutherland, et al., 2015). It is vital that such information is delivered to young girls prior to the onset of menstruation to avoid frightening and stressful experiences.

It is important that virginity-based information is integrated into sexual health education for new migrant and refugee women and men, their families, and community leaders. Information should detail what a hymen is, its physical variability among women, and elucidate how post coital bleeding is not a reliable indicator of sexual experience. For example, in Sweden this information has been used to develop an information booklet intended to dispel myths and misconceptions surrounding a woman's hymen and virginity (Knöfel Magnusson, 2009). Such booklet could be delivered through school-based sexual health education or community groups working with migrant and refugee youth and families.

While the majority of Somali and Sudanese women who were interviewed disclosed attitudes that did not endorse the continuation of FGM, a small number of women continued to support milder forms of FGM. This suggests that women from FGM-practicing countries may benefit from ongoing counselling that is considerate of the sociocultural discourses surrounding women's premarital virginity (Johansen, 2017). It is important information and education provided to migrant and refugee women continues to reiterate the negative consequences of FGM for women's health, its interconnection with women's sexual rights and provide alternative ways of conceptualising uncircumcised women's sexuality; this could be facilitated using community-led theatre or movies, as has been done in low-income settings (Vogt, Mohmmed Zaid, El Fadil Ahmed, Fehr, & Efferson, 2016).

Migrant and refugee women may benefit from sexual health education that moves beyond a disease discourse, and is inclusive of information surrounding the body in relation to sexual response, desire and pleasure (Fileborn et al., 2015). It is also important that women are made aware of their own sexual rights; their right to experience pleasure, their right to say no to unwanted or painful sex and their right to be autonomous desirous beings. As part of this, it is also important that education acts to challenge hegemonic discourses in relation to gender and sexuality, particularly destabilising gendered assumption about desire, such as women being passive and responsive to men's sexual needs (Gavey, 2005). This is important because to be autonomous means knowing about, and understanding, one's own sexual desire and pleasure (Tolman, 2002a). Women may also benefit from education that provides practical information to prevent sexual pain, such as the importance of 'foreplay', arousal and the use of lubricants (Weijmar Schultz et al., 2005).

It is critical to address misconceptions about and negative experiences with hormonal contraception methods in order to support migrant and refugee women to achieve reproductive goals and counter second-hand knowledge that may be present within their communities (Chebet et al., 2015). Migrant and refugee women need access to transparent information about culturally constructed contraceptive misconceptions, the ways in which contraceptive methods work, and comprehensive education about the reproductive body, particularly in relation to fertility and information on advantages and disadvantages of differing contraceptive methods (Rogers & Earnest, 2014). It is important that religious leaders that support women's rights and access to contraception be consulted during the development of this

material to negotiate potentially limiting religious discourse that discourages the use of contraception.

The ways in which some mothers conceptualised and regulated their unmarried daughter's sexuality in this study, in conjunction with past research that suggests that intergenerational conflict may impede adolescent sexual and reproductive knowledge (Dean et al., 2017; Kingori et al., 2016), suggests that parents may also need support and education to improve communication with their adolescent children (Santa Maria, Markham, Bluethmann, & Mullen, 2015). For example, to facilitate open sexual health communication with their daughters, parents may benefit from being reassured that obtaining information about sexual and reproductive health is unlikely to result in an increase in sexual activity prior to marriage, it will however, mean their daughters may be more likely to practice safer sexual behaviours when they do have sex (Kirby, Laris, & Rolleri, 2007). High schools could engage with parents to develop programs of sexual and reproductive health education.

Sexual health promotion and education for migrant and refugee women needs to be culturally appropriate and spiritually significant (Kreuter et al., 2003), such as acknowledging the complex realities associated with menstruation, premarital sex, contraception use and negotiation of sexual power within culturally diverse communities. Thus, health promoting activities need to be community designed, community led (Newton et al., 2012), with involvement from community leaders, such as religious clergy. To achieve this, it is important that health providers form partnerships with multicultural community organisations and communities themselves to exchange information about their specific needs (Hach, 2012). Without

such community buy-in, education and informational resources may be viewed as patronising or irrelevant to women and their wider communities.

Informational resources and education would benefit from being delivered in a number of creative means, such as public performance, art and community dialogues (Kelland, Paphitis, & Macleod, 2017), particularly those that include stories of positive deviance or demonstrate women's resistance within communities (J. J. Garrett & Barrington, 2013). Information could also be provided through group sessions attached to community resource centres; it is recommended that such programs are delivered in same-sex groups to ensure women's comfort in participation (Svensson et al., 2017). To overcome potential language and cultural barriers, groups could be facilitated by female peer educators, as has been effectively utilised in relation to HIV education within migrant communities (Drummond, Mizan, Brocx, & Wright, 2011b). Given the potential for shyness, pictures, videos and digital storytelling for promoting sexual health may also be of value (Botfield, Newman, Lenette, Albury, & Zwi, 2017). While it is helpful to have educational resources online, information should also be translated into written materials available from primary care clinics and migrant resources, with infographics for women who are not literate in their own languages.

Finally, as discussed in earlier chapters of this thesis, the provision of information and education is just part of the puzzle, with understanding of the sociocultural constraints that may shape women's sexual and reproductive knowledge and behaviour being equally important to consider. Education alone is unlikely to change complex belief systems surrounding women's sexual and reproductive health. However, access to accurate and appropriate health information is a human right. If delivered in a culturally sensitive manner, it may increase

women's knowledge, stimulating critical reflection about their sexual and reproductive health and rights (Svensson et al., 2017), which in the long-term could contribute to changes in mindset and positive health action.

Involving men for women's sexual and reproductive health.

Research with migrant and refugee families has highlighted that patriarchal gender inequalities persist amongst some men following migration to Western countries (Khawaja & Milner, 2012). In a low-income context, it has been found that involving men in sexual and reproductive health education increases partner support to access sexual health services and increases shared contraceptive decision-making (Stern, Pascoe, Shand, & Richmond, 2015). The involvement of men has also been found to be critical in programs that address the eradication of FGM (Ruiz, Martínez, & del Mar Pastor Bravo, 2016). This suggests that in order to address the patriarchal gender roles and potentially sexist attitudes towards women's sexual and reproductive rights within migrant and refugee communities, men must be involved and equally provided with sexual and reproductive health and rights education.

Education could draw on principles found effective in preventative strategies addressing violence against women (Flood, 2005). For example, workshops could draw on feminist principles to confront specific patriarchal cultural beliefs and discourses in relation to women and their sexual and reproductive rights. Such programs could promote alternative constructions of masculinity and support men to understand the benefits to their wife and the family if women's rights are recognised. For instance, this could include outlining the positive outcomes for women and the wider family, if their wives are autonomous in their reproductive decision-making or experience fulfilling sexual relationships. Such programs could also help to provide strategies to improve communication about sexuality with their wives. It is likely that

the most effective means of providing such education would be using peer educators, who are men from the same cultural background; this is because male educators can act as role models for men and because they may have 'insiders' knowledge (Flood, 2005).

Health system and health policy implications.

Healthcare providers.

Healthcare providers play a major role in shaping women's willingness to access appropriate sexual and reproductive health services, experiences of service provision and supporting women's sexual and reproductive health (Mengesha et al., 2016). However, healthcare professionals report discomfort when discussing sexuality and sexual functioning with women in consultations (Kelly et al., 2017); they have also reported that their knowledge of migrant and refugee women's sexual and reproductive health is low or very low and disclose limited confidence in treating women from migrant and refugee backgrounds (Mengesha et al., 2018). This could in part be attributed to the fact that many healthcare professionals receive no formal undergraduate training in relation to working with migrant and refugee women on issues related to sexual and reproductive health (Mengesha et al., 2018).

It is important that healthcare professionals and sexual health educators have access to sexual and reproductive health training, particularly if they provide care to women from migrant and refugee communities. Specific training could include effective ways to overcome cultural sensitivities surrounding the discussion of sex and reproductive issues; for example, encouraging the use of communication aids or decision-making tools (Macdowall et al., 2010). Education could provide insight into the range of cultural norms, beliefs and practices that may influence migrant and refugee women's sexual and reproductive health, particularly in relation to topics

covered in this thesis. With that being said, given both the commonalities and differences in experiences disclosed by women in this study, it is important that women receive patient-centred care that is responsive and respectful to the needs or concerns of individual women. Training could be delivered during undergraduate education, in addition to online self-directed learning, workshops and professionally accredited courses for qualified healthcare professionals, as has been previously suggested (Mengesha et al., 2018).

Healthcare services.

Young migrant women in particular have disclosed that intergenerational conflict impedes their ability to access healthcare clinics, especially when older community members question women's attendance at sexual and reproductive healthcare facilities (Rogers & Earnest, 2014). This suggests the need to develop resourceful ways to provide safe, welcoming and discrete services, that ensure privacy and confidentiality both when promoting such services and during clinical consultations (Botfield, Newman, & Zwi, 2018b). For example, in some women's community centres in Sydney, young women are able to attend a local arts and crafts session that runs in parallel to a 'drop-in' health clinic (Blue Mountains Women's Health and Resource Centre). This means young women can access services if they need to without the fear of being seen at a sexual health clinic by other members of their community.

Given we know that women are reluctant to access sexual and reproductive healthcare in traditional services and that migrant and refugee women often face barriers accessing services (Botfield et al., 2016), it is important that services and health promotion events are delivered in creative ways. This may involve outreach clinics or events in non-clinical settings, such as English lessons, pre-schools or

community events, as has been undertaken in other Western contexts with migrant communities (Kolak et al., 2017). It is also important that the delivery of services and programs directly reflects the needs of specific communities and draws on the ways in which migrant and refugee women create community and relate to the broader community (Hach, 2012).

Healthcare policy.

While there is a National Women's Health policy in Australia (Department of Health, 2011), with a section that covers sexual and reproductive health, it provides limited scope for strategies that address migrant and refugee women's needs. Currently in Australia, while there are some national policies, there is a division between policy initiatives, for example policy surrounding STIs and HIV (Department of Health, 2016b) are housed under different departments to those which address other aspects of women's sexual and reproductive health, such as childbirth. Consequently, in both Australia and Canada there is a need for a collaborative national strategic sexual and reproductive health policy that includes strategies for marginalised groups in society (O'Rourke, 2008), especially migrant and refugee women. Policies need to reflect the diversity of migrant and refugee women's lives, including being attentive to gender, religion, culture and migration. Without such strategy, there will be continued inequitable access to sexual and reproductive health services (O'Rourke, 2008), especially for migrant and refugee women who have complex sexual and reproductive health needs. Future sexual and reproductive guidelines and policy may also benefit from being gender mainstreamed, which involves infusing "gender analysis…women's perspectives, and gender equity goals into policies, projects and institutions" (Australian Women's Health Network, 2012).

Strengths and Limitations: Implications for Future Research

A number of strengths and limitations were identified in relation to the research reported in this thesis. I begin this section by first looking at the strengths of the study. I then consider the limitations of the study and make suggestions for how these may be utilised to inform future research. Firstly, the use of a qualitative research methodology aided us to capture women's voices, thoughts, feelings and experiences surrounding their sexual and reproductive health. The methods of data collection were flexible to accommodate women's lives and needs; women could choose if they wanted to be involved in a focus group or interview, whether they wanted to be interviewed by phone or face-to-face and for individual interviews, choose the location of their interview. Providing English-speaking participants with the option of being interviewed in English, or with a non-migrant interviewer, meant that we could provide women with choices in relation to how they were interviewed, as some might have felt more comfortable talking with another member of their community, whereas others might have felt more comfortable with an 'outsider.'

In line with an intersectional framework (Hankivsky et al., 2009), we also had considerable stakeholder and community member involvement across all aspects of the project, including design, methodology, recruitment and feedback on our research findings. This guidance and feedback facilitated research that reflected the needs of the communities we were working alongside, enabled respectful and inclusive research methodologies and provided a platform to receive feedback about the overall project findings and recommendations.

Another major strength of the research presented in this thesis is that participants could be interviewed in their own language. This allowed women to explore their experiences without the limits of speaking English. By utilising

community interviewers for non-English speaking participants, it meant that the flow (or content) of conversation was not influenced by the presence of an interpreter. It also meant that participation was not determined by the ability to speak English, a common requirement even within multicultural migrant/refugee research, which excludes the contributions of newly arrived migrant and refugee women.

Further, the overall project had a substantive sample size for a qualitative study and we spoke to women across a number of cultural groups, which allowed for examination of commonalities and differences both between and within differing cultural contexts. We spoke to women from diverse demographic backgrounds, including married women and single women, women who were mothers and women who had not had children; women from a variety of religious backgrounds were also included. This diversity allowed us to capture women's constructions and experiences from a variety of perspectives. Lastly, our interview schedule covered a range of topics in relation to sexual and reproductive health, expanding our knowledge of areas that are often not included in sexual and reproductive health research, such as menstruation and sexual desire or pleasure.

I now discuss limitations of the findings presented in this thesis. Firstly, all women interviewed were able-bodied, and except for one Latina women, all identified as heterosexual. Consequently, our findings do not explore women's experiences and constructions from women of diverse sexual orientations or body ability. We also had a sample that largely followed Islam with other religious groups being underrepresented, particularly in relation to unmarried women, who predominantly followed Islam. In some cultural groups, we also had difficulty recruiting unmarried women, such as Tamil women in Australia. Using an intersectional lens, future research could consider different intersections that have

been seen to shape women's experiences of sexual and reproductive health, such as social class (Muhanguzi, 2015). In a similar light, future research could also more closely examine differences within religious groups, such as the different religious sects within Islam.

As the majority of the data was collected in languages other than English, we may have lost some nuance in meaning through the process of translation. In addition, given I did not speak the languages of women who participated in this study I could not back check transcripts that were translated for accuracy. This limitation could be considered in future research, whereby two community interviewers could be employed to enable crosschecking of transcripts. In a similar sense, future research could also consider member checking of participant transcripts directly. Gaining individual participant feedback on study findings may help to ensure an accurate portrayal of findings and enable reciprocal learning and collective reflexivity (Caretta, 2016).

Further directions for future research.

Throughout this thesis the term 'sex', was orientated to mean vaginal-penile intercourse, as was inferred by participants. Future critical sexual and reproductive health research is needed to deconstruct this further (Fahs & McClelland, 2016). For example, across cultural contexts, how do women construct 'sexuality'? What constitutes 'sex', orgasm, or sexual pleasure? How might women's sexual identities change across their life-course? These questions require further exploration and understanding if we are to support women in developing their own sexual subjectivity and sense of autonomy in relation to sexual fulfilment. Future research could also consider topics not covered in this study, such as sexual violence, sexual and reproductive health needs of same-sex attracted women from migrant and

refugee backgrounds, or migrant and refugee women with physical or intellectual disabilities. Forthcoming research could also consider in more depth women's experiences of abortion, as has been done with other populations of women in Australia (Kirkman et al., 2011). Evaluation of intervention studies, such as those that focus on education provision for women would also be a beneficial addition to the literature.

Methodologically, future projects in this sphere could also consider the possibility of doing follow-up interviews, rather than a one-off interview. Not only could this allow for member checking, but could facilitate in building rapport with women over a series of encounters, potentially leading to a greater depth of data and follow-up. Future research could also consider women's experiences according to migration path to explore if there are differences in constructions and experiences between women who have migrated as a refugee or asylum seeker, as an economic migrant, or as an international student, for example. Similarly, further research could explore other groups of newly arriving migrant women, such as Syrian women, Rohingya women from Myanmar, women from Bhutan and The Democratic Republic of Congo.

Future research could also consider the viewpoints of healthcare professionals who assist migrant and refugee women in relation to their sexual and reproductive health. While there has been some recent research broadly considering healthcare professionals experiences of treating migrant and refugee women in relation to sexual and reproductive health (Mengesha et al., 2017, 2018), future research could consider different aspects of women's sexual and reproductive health service provision in depth (e.g. patients requests for information around the hymen and

virginity, cervical screening, contraception counselling, support around sexuality), rather than just 'sexual and reproductive' health in general.

Given the gendered nature of sexual and reproductive health described by participants in this study, it is essential that future research consider men's perspectives in relation to women's sexual and reproductive health and agency. Specifically, it is important to consider how men's cultural roles, identity or constructions of masculinity may have/have not changed in the context of migration, and the impact that this may have on women's sexual and reproductive health. Unless we understand men's constructions and experiences of sexual and reproductive health, it will be difficult to facilitate women's rights being acknowledged.

Final reflections

As I discussed in the methods section of this thesis, a process of reflexivity in qualitative research is important to understand the ways in which a researcher's social background, assumptions, positioning and behaviour may shape the research process (Finlay & Gough, 2003). To end this thesis I would like to make some final reflections of this research journey.

As noted earlier in this thesis, I am not a migrant or refugee women, and thus have been acutely aware of the different positionings and histories of participants, and me as a researcher, although this had its challenges. I think it is important to acknowledge that despite women themselves continuingly drawing on 'culture' and 'religion' when examining their constructions and experiences of sexual and reproductive health, I was aware of the potential to come across as ethnocentric or upholding cultural imperialistic ideologies which 'other' women. To address this, throughout this thesis I have tried my best to thread in parallel accounts that occur in

a Western context, currently and historically. I have also been mindful to look for women's resistance or pushbacks to dominant discourses or practices. However, admittedly this was not always straightforward, particularly when cultural practices were vastly different to those in my community. Further, there were some findings of the research that I found surprising. Firstly, just how frequently women did resist hegemonic discourses; I think this reflects my own assumptions or preconceptions, which are likely to be shaped by the inaccurate portrayal of migrant and refugee women through images and messages in Australian media. Secondly, I also expected that women would share accounts of racism that may shed light on why women do not access services or use contraception for example, but this was not apparent throughout women's narratives. Perhaps this is because women felt uncomfortable talking about this to me, although it was also not apparent in interviews carried out by community interviewers. This would be important to follow up in future research.

By undertaking my PhD within a larger research project I have learnt a number of new skills. Firstly, the importance of stakeholder involvement in the development and roll-out of research projects, particularly those with marginalised populations. I have seen firsthand their importance in relation to shaping research that reflects the needs of specific communities, accessing participants from hard to reach populations and formulating resources that are aligned with the needs of healthcare professionals that work with migrant and refugee women. I have learnt techniques that have demonstrated that research with migrant and refugee women on sensitive topics *is* possible and *can* be navigated in a safe and thoughtful manner.

Being a member of a project research team has meant I had a greater level of support, particularly because I was able to draw on advice from a number of academic and other professional staff, who had a variety of different expertise. I

entered into a project with established research networks, partnerships and funding, which meant I could focus my attention on recruitment, data collection, analysis and writing. I also had access to a data pool that would be much too ambitious for a PhD student alone. Further, while it may be perceived that PhD candidates are restricted to a distinct topic area being embedded within a project, I did not feel this limitation. I have always known I had wanted to research women's sexual and reproductive health and had a particular interest in migrant and refugee women, this project fostered both of these interests. Finally, moving forward, as a White, Western and privileged female researcher, who is interested in culture and sexuality, I see my role taking this research forward as a facilitator; not as someone who speaks on behalf of migrant and refugee women, but someone who supports women to have their voices heard and their sexual and reproductive health priorities meet, in ways that women see most fit.

Concluding Remarks

This thesis examined migrant and refugee women's experiences and constructions of sexual and reproductive health, across menarche and menstruation, premarital sexuality, sexuality in marriage and fertility and fertility control. The findings of this thesis demonstrate that cultural and religious constructions of a 'good woman' require women to contain their abject menstrual bodies, remain pure and honourable maidens and sexually passive wives; they must also prove their fecundity immediately following marriage by producing many children, which at times limited women's ability to use contraception for fertility control. In this thesis, patriarchal cultural and religious discourse resulted in regulatory practices, such as concealment, exclusion, self-policing, shame, stigmatisation and silencing, which had negative implications for women's sexual and reproductive health, subjectivity and agency.

However, not all women adopted subject positions that subordinated their sexual subjectivity or rights, with many women actively resisting or negotiating limiting cultural or religious discourse, showing that women can and do resist oppressive strategies that disempower them. Yet, the fact that women are being made to 'negotiate' their sexual and reproductive health rights is not acceptable. Women and their bodies are not property or a reflection of their value. This thesis is a call to action. Yes, we need culturally sensitive health promotion and health services for women whose needs are often left on the margins, but it is more than this. Globally, we need critical reflection and fundamental change to treatment of women, and their sexual and reproductive bodies.

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Appendix A: Invitation to Participate in Research

Sexual and Reproductive Health of Migrant and Refugee Women

WE NEED YOUR HELP

Would you like to participate in a project about you and your culture?

We are interested in talking with Iraqi, Afghan, Sudanese, Somali and Tamil women about their knowledge, beliefs and experiences growing up, life changes, sexual and reproductive health, relationships, marriage, children and having children (even if you don't have any).

The study will help us provide better health care services to your community.

We are looking for women who:

- are 18 years or over
- have migrated to Australia in the last 10 years and;
- are willing to speak to us one-to-one and/or in a group

We want to hear about your experiences and views, but only those you wish to share with us. Participation is confidential and voluntary and child minding is available. The discussion will be in your local language or in English. You will be given refreshments and a $25 gift voucher for taking part.

The research is being jointly conducted by the University of Western Sydney, Family Planning NSW and the Community Migrant Resource Centre. For more information about the project please call 4620 3606 or email the PhD student Alexandra Hawkey at a.hawkey@uws.edu.au.

Appendix B: Statement of Ethics Approval

Locked Bag 1797
Penrith NSW 2751 Australia
Office of Research Services

ORS Reference: H10352 13/011669

University of Western Sydney

HUMAN RESEARCH ETHICS COMMITTEE

8 October 2013

Associate Professor Janette Perz
Centre for Health Research

Dear Janette,

I wish to formally advise you that the Human Research Ethics Committee has approved your research proposal H10352 "Sexual health of migrant women from culturally and linguistically diverse (CALD) groups: An international comparison", until 31 December 2017 with the provision of a progress report annually and a final report on completion.

Conditions of Approval

1. A progress report will be due annually on the anniversary of your approval date.

2. A final report will be due at the expiration of your approval period as detailed in the approval letter.

3. Any amendments to the project must be approved by the Human Research Ethics Committee prior to the project continuing. Amendments must be requested using the HREC Amendment Request Form:
http://www.uws.edu.au/__data/assets/pdf_file/0018/491130/HREC_Amendment_Request_Form.pdf

4. Any serious or unexpected adverse events on participants must be reported to the Human Ethics Committee as a matter of priority.

5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the Committee as a matter of priority

6. Consent forms are to be retained within the archives of the School or Research Institute and made available to the Committee upon request

Please quote the registration number and title as indicated above in the subject line on all future correspondence related to this project. All correspondence should be sent to the email address humanethics@uws.edu.au.

This protocol covers the following researchers:
Janette Perz, Renu Narchal, Christine Metusela, Jane Wicks, Melissa Monteiro, Marina Morrow, Jane Ussher, Jane Estoesta

Yours sincerely

A/Professors Debbie Horsfall and Federico Girosi

Deputy Chairs,
Human Researcher Ethics Committee

Appendix C: Participant Information Sheet (Interview)

Sexual and Reproductive Health of Migrant and Refugee Women: Participant Information Sheet for Individual Interviews

Thank you for being willing to be contacted for an individual interview for the *Sexual and reproductive health of migrant and refugee women* study. This study is jointly conducted by the University of Western Sydney, the Centre for the Study of Gender, Social Inequities and Mental Health (Vancouver, Canada), the Community Migrant Resource Centre and Family Planning NSW and is funded by the Australian Research Council. The researchers on the study are A/Professor Janette Perz, Professor Jane Ussher, Dr. Renu Narchal, Jane Estoesta, Ms. Jane Wicks, Ms. Melissa Monteiro and A/Professor Marina Morrow. To help you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve.

Your role

If you decide to be involved in the study, you will be asked to participate in an individual interview with a research team member in your local language. The discussion will be recorded and then written out in English.

We want to hear about your experiences and views on certain topics, but only those you want to share with us. Your input will be valued and respected but if you do not wish to speak about a subject or answer a question, you do not have to. The topics to be discussed will include things like:

- Your knowledge and experiences of menstruation, pregnancy, fertility and sexual health
- Knowledge sharing in your community
- Your experiences of health care services in Australia and what services or support you might need

As part of the study, we are also conducting focus groups, addressing similar topics. If you are willing to be contacted about a focus group, you can fill out a Contact Form.

Confidentiality and choice

All of the information is confidential and you will not be identified in any publication of the research. The information you provide will not be disclosed to any third party and will be securely stored. Translators will also respect your confidentiality and will not talk about who was interviewed or anything that was said. If you decide you want to take part in the research project, you will be asked to sign a consent form. You can indicate on the attached consent form or by telling the researchers if you would like a copy of the report explaining the outcome of the study.

Participation is voluntary. If you decide not to be involved, it will not affect you in any way and it will not affect the relationships you have with any of the organisations involved. You

can change your mind and quit the study at any time and you don't have to give any reasons if you don't want to.

Will taking part in this study cost me anything, and will I be paid?
Participation in this study will not cost you anything and child minding will be provided. If you take part in an interview with us, you will be reimbursed for your time and reasonable travel expenses to the amount of $25.

What are the benefits / positives?
The study will provide the research team with an understanding of the reproductive and sexual health experiences of migrant and refugee women. This understanding will aid in the development of clinical services and programs of sexual health education available to women from migrant and refugee communities. The knowledge generated from this project will benefit migrant women, health educators, the Australian government, and the overall health and economic wellbeing of Australian people.

Are there any risks?
Talking about reproductive and sexual health issues may be uncomfortable topics for you. We will do whatever we can to make sure that you feel safe and comfortable. You do not have to answer any questions that make you feel uncomfortable and you can stop the interview at any time if you want to. There is a possibility of males being present in the building where the interview takes place (but not present in the interview room). There is a potential risk that a male family member may be upset that their relative has participated in research on such a topic. However, we will not disclose any of your information to a family member or any other person.

What will happen with the results?
We plan to talk about the results with organisations (e.g., Family Planning NSW) so other people can learn about the reproductive and sexual health of recent migrant women from migrant and refugee communities. We will do this by presenting and discussing the results with people who look after migrant women. Whenever we present or discuss the results, your name will not be mentioned and no one will know that you participated in the study.

Complaints
This study has been approved by the University of Western Sydney Human Research Ethics Committee (Study ref H10352). If you have any concerns about the conduct of the study, or your rights as a study participant, you may contact the Ethics Committee through the Research Ethics Officer on (02) 4736 0229 or humanethics@uws.edu.au

Contact details
If you have some questions and would like to know more about the study or experience any problems while on the study, please contact the research coordinator, Christine Metusela on (02) 4620 3606 or c.metusela@uws.edu.au

This information sheet is for you to keep and thank you for taking the time to consider this study.

Appendix D: Participant Information Sheet (Focus Group)

Sexual and Reproductive Health of Migrant and Refugee Women: Participant Information Sheet for Focus Groups

Invitation

Thank you for being willing to be contacted about a focus group for the *Sexual and reproductive health of migrant and refugee women* study. This study is jointly conducted by the University of Western Sydney, the Centre for the Study of Gender, Social Inequities and Mental Health (Vancouver, Canada), the Community Migrant Resource Centre and Family Planning NSW and is funded by the Australian Research Council. The researchers on the study are A/Prof Janette Perz, Professor Jane Ussher, Dr. Renu Narchal, Jane Estoesta, Ms. Jane Wicks, Ms. Melissa Monteiro and A/Prof Marina Morrow. To help you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve.

What is the purpose of the study?

In the endeavour to improve health care services for people living in Australia who were born overseas, this study is designed to help us learn more about your culture, beliefs and experiences, particularly around sexual and reproductive health.

Who can become involved in the study?

Women from the age of 18, who migrated to Australia in the last 10 years, and whose first language is not English can be involved in the study.

Your role

If you decide to participate in the study you will join a focus group of 6-8 women, who speak the same language as you. The discussion will be recorded, and then will be translated back to English. In the group discussion we want to hear about your experiences and views on certain topics, but only those you want to share with us. Your input will be valued and respected but if you do not wish to speak about a subject or answer a question, you don't have to. The topics to be discussed will include things like:

- Your knowledge and experiences of menstruation, pregnancy, fertility and sexual health
- Knowledge sharing in your community
- Your experiences of health care services in Australia, and what services or support you might need

As part of the study, we are also conducting individual interviews addressing similar topics. If you haven't already had an individual interview and are willing to be contacted about having one, you can fill out the Further Contact Form, which will be given to you at the time of the focus group.

Can I leave the group?

You can leave the group at any time without needing to explain why, and you can return to the group if you want to. You can also talk to the researchers in private after the group has finished if you want to discuss anything further.

How much time will the study take?

The group discussion may last for about one hour, but you'll need to arrive a little earlier. With travel time you may spend a morning or an afternoon in total.

Will taking part in this study cost me anything, and will I be paid?
Participation in this study will not cost you anything. Child minding will be provided and you will be given refreshments. If you take part in a focus group, you will be reimbursed for your time and reasonable travel expenses to the amount of $25.

What are the benefits / positives?
The study will provide the research team with an understanding of the reproductive and sexual health experiences of migrant and refugee women. This understanding will aid in the development of clinical services and programs of sexual health education available to women from migrant and refugee communities. The knowledge generated from this project will benefit migrant women, health educators, the Australian government, and the overall health and economic wellbeing of Australian people.

Are there any risks?
Talking about reproductive and sexual health issues may be uncomfortable topics for you. We will do whatever we can to make sure that you feel safe and comfortable. You do not have to answer any questions that make you feel uncomfortable and you can leave the group at any time. There is a possibility of males being present in the building where the focus group takes place (but not present in the focus group room). There is a potential risk that a male family member may be upset that their relative has participated in research on such a topic. However, we will not disclose any of your information to a family member or any other person.

Confidentiality and choice
All of the information is confidential and you will not be identified in any publication of the research. The information you provide will not be disclosed to any third party and will be securely stored. Translators will also respect your confidentiality and will not talk about who was in the group or anything that was said. As a member of the group, it is important that you respect the privacy and confidentiality of others. You must agree not to tell anyone the names of the other women in the group or what they said.

If you decide you want to take part in the research project, you will be asked to sign a consent form. You can tell the researchers if you would like a copy of the report explaining the outcome of the study. Participation is voluntary. If you decide not to be involved, it will not affect you in any way and it will not affect the relationships you have with any of the organisations involved. You can change your mind and quit the study at any time and you don't have to give any reasons if you don't want to.

Can I tell other people about the study?
Yes, you can tell other people about the study and give them the researchers' contact details if they would like to participate or would like information.

What if I know someone in the group?
You may recognise someone in the group, through family or community connections. If you do recognise someone and this is a problem or causes you concern, please ask to speak privately to a member of the research team before the discussions begin. You may want to be excused from the group and join another group if possible. We will not try to prevent you from leaving the group for any reason.

What will happen with the results?
We plan to talk about the results with other organisations (e.g., Family Planning NSW) so other people can learn about the reproductive and sexual health of recent migrant and refugee women. We will do this by presenting and discussing the results with people who look after migrant women. Whenever we present or discuss the results, your name will not be mentioned and no one will know that you participated in the study.

Complaints

This study has been approved by the University of Western Sydney Human Research Ethics Committee (Study ref H10352). If you have any concerns about the conduct of the study, or your rights as a study participant, you may contact the Ethics Committee through the Research Ethics Officer on 02 4736 0229 or humanethics@uws.edu.au

Contact details

If you would like to participate, would like to know more about the study or experience any problems while on the study, please contact a member of the research team on (02) 4620 3606 or email Christine Metusela c.metusela@uws.edu.au

This information sheet is for you to keep and thank you for taking the time to consider this study.

Appendix E: Consent Form

Sexual and Reproductive Health of Migrant and Refugee Women: Consent to Participate in Research

1. I acknowledge that I have read, or have had read to me the Participant Information Sheet relating to this study. I acknowledge that I understand the Participant Information Sheet. I acknowledge that the general purposes, methods, demands and possible risks and inconveniences which may occur to me during the study have been explained to me by _____ ("the researcher") and I, being over the age of 18 acknowledge that I understand the general purposes, methods, demands and possible risks and inconveniences which may occur during the study.

2. I acknowledge that I have been given time to consider the information and to seek other advice.

3. I acknowledge that refusal to take part in this study will not affect the usual treatment of my condition.

4. I acknowledge that I am volunteering to take part in this study and I may withdraw at any time.

5. I acknowledge that this research has been approved by the University of Western Sydney Human Research Ethics Committee.

6. I acknowledge that I have received a copy of this form and the Participant Information Sheet.

7. I understand that that the discussion will be digitally recorded and transcribed.

8. I understand my identity will not be disclosed to anyone else or in publications or presentations.

Name of Participant:	**Name of Researcher:**
Sign:	**Sign:**
Date:	**Date:**

Appendix F: Interview Schedule

Sexual and Reproductive Health of Migrant and Refugee Women
Interview questions for one-to-one interviews: Australia

Consent and opening statement

Thank you (name of participant) for agreeing to take part in an interview. The interview will take around 45-60 minutes and will be audio recorded to allow us to go over what is said in detail afterwards. Everything you say will be confidential. Your name will not be used and no one else will get the data or hear the recording. Feel free to stop the interview at any time if you need to take a break.

We'd like to find out about your knowledge, beliefs and experiences of growing up, life changes, sexual and reproductive health, relationships, marriage and having children. There are many things a woman has to deal with in her life that influence her health, such as managing monthly bleeding, sexuality, and having children. We are aware that this is not the same for all women. The beliefs and practices of our families, and the wider society we live in, can influence our experiences. Migration can also have an impact on women's views or experiences of these aspects of their health. We'd like to know if this is the case for you. In Australia there are special services for these aspects of women's lives, to help women optimise their health, and special programmes to help avoid women's cancers. We are also interested in finding out if these services would be useful for you, or how they could be improved.

Turn on recorder
Are you happy to be involved in the study and continue with the interview? (Wait for interviewee to say yes. If they don't say yes clearly, please ask them to so that we can record their consent to participate).

Background Questions

I'd like to start with some background information about you.

How old are you?

What is your religion?

Where did you live before migrating to Australia? (Is that where you were born?)

When did you arrive in Australia? (month/year)

What language do you speak at home? (Do you speak any other languages?)

How many years of schooling have you had?

What is your relationship status? (e.g. married/ de facto, partnered but not living together, widowed)

Do you have any children? (If yes: how many children?; ages of children?)

Becoming a Woman

Menarche and menstruation

To begin with I want to ask you a few questions about becoming a woman and having babies. One of the first signs of becoming a woman is when you start to bleed once a month. In Australia this is called menstruation. Did you know about bleeding/menstruation before it first happened to you?

When did you first find out anything about bleeding? What did you find out? How did you find out?

Changes after menarche

Did things change for you after you started bleeding? (e.g. by wearing particular clothes; by celebrating or having a feast?)

Is anything different in your life now when you bleed? (e.g. preparing food; washing your hair; social or work time; having sex?)

Premenstrual changes

Some women report changes before their period, which can be difficult, or can be positive. Is this something you're aware of? (Prompt: physical and psychological changes) Has it happened to you? In Australia this is called 'PMS'. Do you have a word for it?

Becoming a Mother

Knowledge about pregnancy

When you started bleeding did you understand that you were now able to have a baby? If not, when did you first find out anything about having babies?

Knowledge about contraception

Do you know about how to stop having babies? In Australia this is called contraception. Do you have a word for it?

Are you doing or using something to help you not have babies now? (e.g. traditional methods, withdrawal method, taking the pill, using condoms, IUD, etc.) (Why/why not?)
Are you able to talk about this with your husband/partner?

For women who use contraception: How do you find these methods? (positive/negative consequences; how happy are you with contraceptive choice?; any consequences in terms of changed menstrual cycle or changes in sexual desire?)

Do you worry about trying to have a baby or trying not to have a baby?

Knowledge about menopause

When women's bleeding has stopped, it is called menopause – do you use this word? If not, do you have a word for it?

Do you know what happens to women's bodies during menopause? What do you think about menopause? (e.g. any concerns?)
Has this happened to you? What was your experience? (e.g. what are your thoughts/experiences about 'hot flushes' or vaginal dryness?)

Being in love and having sex

Sex before marriage

In Australia, many people choose to have relationships and to have sex before they are married. What would happen if a woman in your culture met a man and wanted to have sex, but they were not married? Is this something you would do?

Some cultures allow certain sexual practices before marriage – as long as sexual intercourse does not take place, and the woman remains a virgin.
Are certain things ok in your culture, such as touching each other intimately, oral sex, anal sex, Skype sex, when you are not married? Would you engage in such practices before marriage?

Would you consider having hymen repair before you got married if you are not a virgin?

Choosing a partner

Is it ok for you to choose who you want as a partner/husband?
Did you choose your husband?

What would happen if a woman in your culture fell in love with another woman?

Sexual pleasure and desire

In your culture, are women allowed or expected to enjoy and want sex?
Do you ever feel like you want to have sex? What does this feel like?

Can you show this to your husband or is it always what your husband wants that counts? What happens if you show your husband that you want to have sex; do you ever worry about not wanting to have sex?

Talking about Sex

Now we are going to move on to talk about sexual desires and concerns. Do you ever talk about sex with your husband? (Do you talk about what you want and when you want it? Can you say no to sex? Can you say no to certain kinds of sex that you don't want?)

Changes over time

Women's experiences of their bodies and sexuality can change over time, or as our life circumstances change.
Have any things changed in relation to your sexual health since migrating to Australia? Since you had children? Since stopping bleeding [menopause]?; Can you explain what has changed?

Getting help about sexual health

Lastly, we would like to know what aspects of sex and having babies you would like more information about. Have you ever gone to a doctor to ask for help about sex or about having babies? If yes, who did you see? Is it important for you to see a female doctor?

Where else do you go to get information about sex? (e.g internet, friends)

What is the best way to get you the information you want about sex or having babies? (e.g. through a booklet; a dvd; a one-on-one talk; a group education session; the internet)

This is the end of the interview – thank you for taking part. Are there any other issues we haven't talked about that you would like to discuss?

Appendix G: Project Coding Framework

Coding Frame: Sexual and Reproductive Health in CALD Women.

Node Level 1	Node Level 2	Node Level 3	Description
Menstruation			
Construction and meaning	**Becoming a women**		Women who make reference to menstruation being associated with the 'girl to women' transition, growing-up and marriageability. Menstruation as a normal biological function, or simply onset of bleeding.
	Developing bodies		Physical changes following menarche. E.g. Developing breasts.
Menarche experience	**Experiences of first period**		Women's experiences of first menses. E.g. shock, shame, embarrassment, fear, disgust, relief. concealment.
	Celebration /Rituals		Cultural celebration/ non-celebration, rituals, meaning and feelings towards.
Menstrual knowledge	**Menstrual learning**		How women learn about menstruation, what information they know, from whom, at what stage, including no prior knowledge.
	Daughters		Information disclosure and comfort with daughters, experiences of daughter's menarche, preferences or worries about daughter's menstrual learning.
	Link to reproduction		At what stage women linked menstruation to reproductive potential.
Changes after menarche	**Socialisation and activities**		Changes in women's lives directly after first menstrual period.
	Presentation and clothing		Changes in social activities and people who they socialise with.
			E.g. Wearing hijab.
Changes during menstruation	**Socialisation and activities**		Changes in women's day-to-day lives when menstruating post-menarche.
			E.g. Not able to greet guests.
	Clothing		
	Food		E.g. Food preparation and eating.
	Hygiene		Changes in normal hygienic practices. E.g. Showering.
	Sex		
	Religious		E.g. Not praying, touching holy texts.
	Experiences of menstruating		Women describing their period. E.g. problems, pain during period.
Premenstrual changes	**Construction**		Cultural meaning/existence of PMS as a cultural phenomenon.
	Physical/psychological		
Fertility/Contraception			
Contraception experience	**General experiences**		Women's narratives of contraception use, including abortion. Experiences positive or negative.
Contraception choice	**Personal choice**		Choice of contraception based on previous use/non-use (non-use = not sexually active with no explicit link to culture or religion)
	Partner influence		
	Cultural and religious influence		Direct reference to contraception type or use as a reflection of culture or religion.
	Other factors		E.g. cost, physician recommendation.
Contraception knowledge	**Formal education**		Learning about contraception at formal institutes. E.g. school, group sessions.
	Informal education		Personal experience, family, friends.
	General knowledge		Women's knowledge (including nil) about contraception options with no reference to formal or informal education.
Contraception misconceptions and worries	**Physical or psychological**		Perceived impacts on reproductive potential and normal menstrual cycle. Perceived physical/psychological impacts on the body. E.g. blockages or changes in mood.
Cultural construction of fertility and motherhood	**Pressure to reproduce**		Pressures to reproduce. Including from self, partner, family, culture, preference for a boy child.
	Experiences of motherhood		Women's narratives of becoming/being a mother and impacting influence on health behaviours. E.g. prioritisation, choosing number of children.
Menopause	**Experiences and constructions**		Women's descriptions and meaning of menopause.
	Knowledge		Knowledge of biological changes during menopause.
Relationships			
Marriage	**Partner choice**	**Arranged marriage**	Arranged by family and agreed upon and forced marriage.
		Choosing own husband	Preferences in partnerships.
		Multiple wives	
		Dowries	
		Daughters	Preferences and experiences of daughters partner choice and marriage.

Coding Frame: Sexual and Reproductive Health in CALD Women.

	Divorce/relationships after	How divorce is viewed, women's preferences and experiences of relationships later in life.
Relationships before marriage		How dating, attraction and relationships before marriage is viewed, including intimacy boundaries.
Same sex relationships		Women's views on same sex relationships.
Sexuality		
Sex before marriage	**Virginity**	Meaning and importance.
	Preferences for daughters	What would you like for your daughters, feelings about daughters growing up in Sydney/Vancouver, include reference to sons also.
	Consequences	Outcomes for women who have sex before marriage. E.g. Stigma, hymen repair, hiding.
	Attitudes	How women feel about sex before marriage. E.g. personally or others.
Sexual pleasure and desire	**Sex initiation**	
	Sex consent	
	Sexual enjoyment and desire	Experiences and importance of sexual enjoyment, experiences of sexual pain (not wedding night) and disinterest, purpose of sex. Feelings about wanting sex.
	Talking about sex	Ability or inability to communicate with husband, friends, family, HCP about sex.
	The wedding night	Women's experience of first sexual intercourse, prior knowledge and information sharing.
Sexual health		
STI's	**Construction of disease**	How women perceive risk of disease.
	Knowledge	Women's knowledge of disease types, prevention and risk.
	Experiences of STI's	Women's descriptions of having STI's. Includes other sexual diseases e.g. UTI's and thrush.
	Worries	Concerns women may have regarding contracting STI's.
Pap Smears	**Constructions of disease**	How women perceive risk of disease.
	Knowledge	Knowledge of Pap test purpose and appropriate screening intervals.
	Screening behaviours/attitudes	What women think about Pap tests and their resulting behaviours.
	HPV Vaccine	Women's reference to knowledge, purpose and attitudes surrounding the HPV vaccine.
Sex Education		Learning about sex (formal/informal education) but not including menstruation, contraception, STI and pap smear knowledge.
Female Genital Cutting/Circumcision		
	Constructions of FGC	What it means to be circumcised/not circumcised.
	Experiences of FGC	Personal narratives or narratives of other women's experiences and decision to undergo FGC.
	Impacts on health	
Health Services		
Health Practices		Experiences, thoughts and health behaviours in accessing services and addressing SRH with HCP.
Preferences for information and resource delivery.		What information women would like, how they would like to receive it, and healthcare preferences. E.g. HCP gender.
General Experiences		
Changes over time		Women's experiences of change. E.g. isolation, stress, issues of migration, sense of community, friendships.

Appendix H: Overall Project Research Report and Recommendations

Sexual and Reproductive Health of Migrant and Refugee Women

Research Report and Recommendations for Healthcare Providers and Community Workers

Funding and research team
This research was funded by an Australian Research Council Linkage Grant LP130100087 to the Centre for Health Research, School of Medicine, Western Sydney University, in conjunction with Family Planning New South Wales (FPNSW), The Community Migrant Resource Centre (CMRC) and Centre for the Study of Gender, Social Inequities and Mental Health, Simon Fraser University, Vancouver, Canada.

The chief investigators on the project were Jane Ussher[1], Janette Perz[1] and Renu Narchal[1]. Partner investigators were Marina Morrow[2], Jane Estoesta[3], Jane Wicks[3] and Melissa Monteiro[4]. Christine Metusela[1] was the research co-ordinator, Alexandra Hawkey[1] a doctoral candidate, and Brenda Jamer[2] and Sevinj Asgarova[2] co-ordinated the Canadian data collection. The research was approved by Western Sydney University, Simon Fraser University, Vancouver Coastal Health, Fraser Health, and Family Planning NSW Ethics Committees.

[1]Western Sydney University; [3] Simon Fraser University; [3] Family Planning NSW; [4]Community Migrant Resource Centre

Acknowledgements
We thank our community interviewers: Salwa Alhag, Tabitha Ajak, Naima Abdullah, Mala Punnia-Moorthy, Nabila Qalandarzadah, Hela Jaffar in Australia, and Hoda Nassar, Rahma Abdullahi, Hala Habibi, Rima Hijazi and Adriana Paz in Canada, and also the following people and community organisations for assistance with recruitment: Conscila Emilianus, Faiza Shakori, Nuha Razaq, Nazifa Ali, CMRC, Options for Sexual Health, East Van Youth Clinic, Evergreen Community Health Centre, Burnaby New Canadian Clinic, Surrey New Canadian Clinic, and Healthiest Babies Possible, Vancouver Coastal Health. We also thank all the women who took part in interviews and focus groups to share with us their experiences of sexual and reproductive health. Finally, we thank all of the community stakeholders and service providers who gave feedback on the report.

Report prepared by Jane Ussher, Christine Metusela, Alex Hawkey, Janette Perz, and formatted by Melinda Wolfenden

Suggested formal citation:
Ussher, J.M., Perz, J., Metusela, C., Hawkey, A., Morrow, M., Narchal, R., Estoesta, J., Monteiro, M. (2017) *Sexual and reproductive health of migrant and refugee women. Research report and recommendations for healthcare providers and community workers*. Western Sydney University.

For further details about the research see:

Ussher, J. M., Perz, J., Metusela, C., Hawkey, A. J., Morrow, M., Narchal, R., & Estoesta, J. (2017). Negotiating Discourses of Shame, Secrecy, and Silence: Migrant and Refugee Women's Experiences of Sexual Embodiment. *Archives of Sexual Behavior*. DOI:10.1007/s10508-016-0898-9

Hawkey, A., Ussher, J. M., Perz, J., & Metusela, C. (2016). Experiences and Constructions of Menstruation Across Culturally and Linguistically Diverse Migrant and Refugee Women. *Qualitative Health Research,* DOI: 10.1177/1049732316672639.

An electronic copy of this report can be downloaded from:
www.westernsydney.edu.au/SRH_CALD_Report.pdf

Contents

Introduction

Sexual and reproductive health is a key component of quality of life, with utilisation of sexual and reproductive health services associated with positive mental health [1]. However, these services are underutilised by migrant and refugee communities [2-4]. This can result in a lack of information for informed decision-making and poor sexual and reproductive health outcomes among migrant and refugee women [4-6].

There are a range of reasons why migrant and refugee communities underutilise sexual and reproductive health services [2, 7]. Social and cultural norms sometimes make open discussion about sex and sexuality difficult [8-10]. Consequently, health concerns may not be addressed with family members and healthcare providers. As a result, women may have poor knowledge of, and access to, contraception, and feel ill equipped to articulate their sexual rights [11], exposing them to STIs and unwanted pregnancies.

Where premarital sex is discouraged, parental and community attitudes can influence women's contraceptive education and prevent access to the HPV vaccine [12, 13]. If it is seen as inappropriate and unnecessary for unmarried women to access sexual and reproductive health services [5, 6], such women may be ashamed to obtain contraceptives [14], or be fearful of parents or the community finding out they are using contraception [15]. Personal reputation or family honour may then be jeopardized if it is known that they are engaging in premarital sex [4, 9].

How diseases and treatment of illness are socially and culturally understood may be a barrier to accessing sexual and reproductive health services for some women. Infections and diseases may be seen to be determined by a god or by fate, therefore contributing to avoidance of sexual health screening behaviours.

There is a need for health providers to recognise the social norms and practices of sexual and reproductive health within migrant and refugee populations, in order to provide culturally safe medical care, health education, and health promotion, and to increase capacity to access sexual and reproductive services [10, 16-18].

The Research Study

The aim of our research was to examine how sexual and reproductive health is experienced and understood by recent migrant and refugee women, living in Sydney Australia and Vancouver Canada. This allowed us to identify unmet sexual and reproductive health needs and barriers to accessing information and services [19, 20]. We interviewed women from a range of recent migrant and refugee communities, including Sudan, South Sudan, Somalia, Iraq, Afghanistan, Sri Lanka (Tamil), India (Punjab) and Latin America. In this document we present participant accounts of experiences of sexual and reproductive health. This includes: menstruation and menopause; contraception; sexual relationships; female genital cutting; sexual health screening; and use of sexual health services.

We draw on these findings to outline implications for health services and provide recommendations to healthcare providers for culturally safe care of migrant and refugee women's sexual and reproductive health needs.

Research Methodology

A total of 169 women participated between July 2014 and March 2016. In-depth one-to-one interviews were carried out with 84 women. Additionally, 16 focus groups were held with a total of 85 women [20].

Women were aged between 18 and 70 years, with 35 being the average age. 54% were married, 2% living together but not married and 44% were single (including

divorced and widowed). Participants had arrived in Australia or Canada an average of 6 years before the interview. The majority identified with Islamic religion with 66% Muslim, 20% Christian, 7% Hindu, 2% Sikh, 1% Buddhist and 5% non-practicing (See Figures 1-4 for demographics).

Australia and Canada were chosen as the sites for the research as they are similar geographically, economically and politically, and have comparable migrant and refugee populations.

The specific cultural groups were chosen through consultation with community stakeholders who are involved with supporting or providing sexual and reproductive healthcare to migrant and refugee populations. The cultural groups selected (Figure 1) were recognised as being underrepresented in previous sexual health research, and were identified as underutilising current sexual health services, despite reflecting a significant proportion of the recent culturally and linguistically diverse[1] migrant population of Australia and Canada.

Interviews

Trained community interviewers within each of the language and cultural groups were involved in recruiting and interviewing the majority of women in both Sydney and Vancouver.

In Sydney, participants with conversational English had the option of being interviewed in English by one of the research team. Women gave informed consent and interviews and focus groups were digitally recorded. Topic areas focused on the reproductive lifecycle from menarche to menopause, and on sexual health practices, including sex before marriage, consent, pleasure and desire, contraception knowledge and use, and sexual health screening.

Data analysis

Interviews were translated by the community interviewers, and transcribed verbatim, with actual names replaced with pseudonyms. Thematic analysis was used to analyse the data. This is a qualitative method for identifying, reporting and interpreting patterns or themes within interviews [21].

Although differences were found within and between women from different cultural backgrounds there was no notable difference between accounts of women from Australia or Canada. Therefore, in our presentation of women's accounts below, we have identified cultural background but not country of residence post-migration. We acknowledge that the findings may also be applicable to women from other cultures including non-migrant women.

[1] The term "culturally and linguistically diverse" (CALD) is used in Australia to describe people who have a cultural heritage different from that of the majority of people from the dominant Anglo-Australian culture, replacing the previously used term of people from a "non-English speaking background" (NESB). As this term is not used in Canada, we are defining our sample as 'migrant and refugee women'.

Figure 1: Cultural background of participants

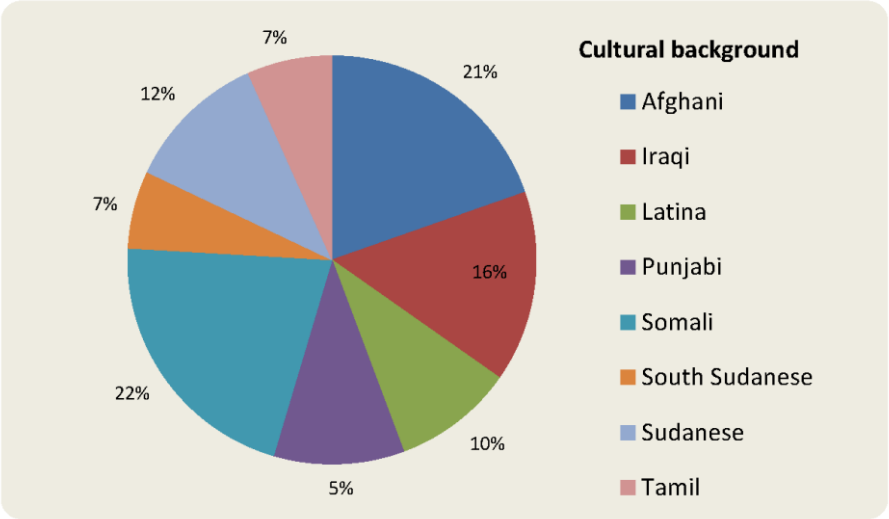


Figure 2: Religion of participants

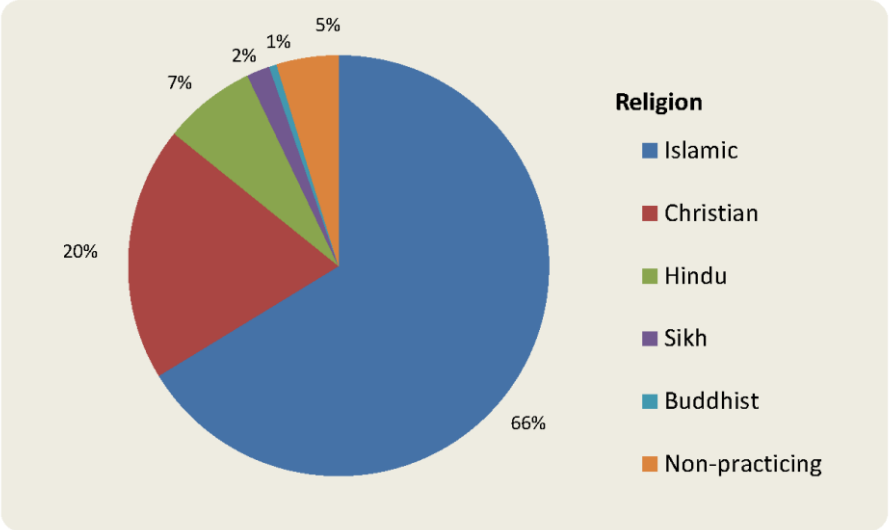


Figure 3: Relationship status of participants

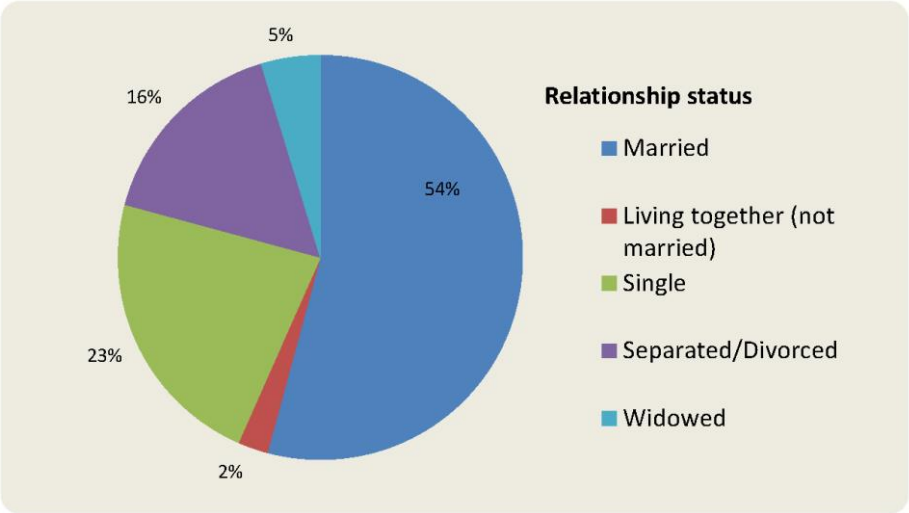
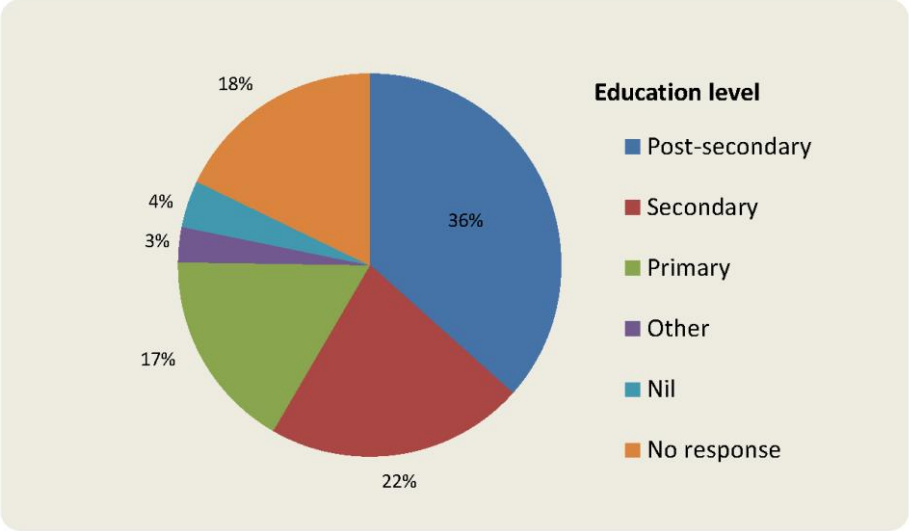


Figure 4: Education level of participants



Menarche, Menstruation and Menopause

Fear, shame and secrecy at menarche

Many women had received no information about menstruation prior to menarche and described the experience as being isolating, shocking and frightening. They often had no idea what menstrual blood was, where it came from or what it meant. Some women mistook menstrual blood for faeces or urine, thought they were sick or injured, or believed they were being punished for wrong doing [19].

Absence of communication about menstruation

Many young women concealed their first period and did not discuss it with anyone, because of feelings of shame. Menstruation was described as a forbidden topic in many families. If women had received information and support at menarche it was primarily from their mothers, or from female friends and relatives. Some women had received a biological explanation of menstruation at school. This information and education was often brief, and did not alleviate feelings of shame.

Mother-daughter communication

The majority of women wanted their daughters to avoid the negative experiences they had been through at menarche. However, some women felt embarrassed talking about periods with their daughters. This acted as a barrier to providing menstrual information and support. Women who had received help from community workers in providing menstrual education were more confident about talking to their daughters.

Limited knowledge of the function of menstruation

Menstruation symbolised a girl becoming a woman, and in some cultures resulted in an expectation of early marriage. However, the majority of women told us that they had no knowledge of the link between menstruation and reproduction before their first period. Some women only learnt about the function of menstruation when they became pregnant. Those women who did know the purpose of menstruation had learned through science classes at school, or through informal mechanisms, such as female friends and family.

Cultural and religious restrictions during menstruation

Menstruating women were commonly considered dirty and unclean. Some women from Afghanistan and Iraq were told not to shower during menstruation, as this was thought to increase pain and bleeding. In a few instances, women practiced shower avoidance for up to four days. Women who identified as Muslim or Hindu were prohibited from visiting holy sites, praying or touching holy books. Menstruating women were also exempt from fasting at Ramadan.

Most participants avoided sexual contact with their partners during menstruation. Blood was positioned as dirty and a waste product, and having sex during menstruation seen as unhealthy for women and their partners. Menstrual sex was religiously prohibited for Muslim women.

Menstrual difficulties

Many women reported menstrual difficulties, including severe pain, heavy bleeding, and extended bleeding. Only a minority of women had discussed such difficulties with a health care professional. Women who had experienced female circumcision were concerned about infection or build-up of menstrual blood.

Some women experienced negative premenstrual changes, both physically and psychologically. Social and cultural norms meant that premenstrual distress was often not recognised or discussed.

Menopause

Many participants had poor knowledge of menopause. It was commonly viewed as an illness or sickness resulting in negative physical and psychological changes to the body. Women wanted more information about menopause and how it might affect them.

Some women were married immediately following menarche

When the girls get their period they can be married to a man. (Somali Focus Group)

*In South Sudan, **when the girl has the first period**, that means you are considered as a woman . . . it's associated with marriage . . . **you're going to get married and you are going to have babies.** (Akoi, age 40, South Sudanese)*

*I remember **my uncle's wife told my dad [that I had my first period] and that is how I got engaged and married by 14**. Before knowing anything I was already a mother. (Minoo, age 32, Afghani)*

Talking about menstruation is considered shameful for some migrant and refugee women

*In Sudanese culture it is **shame to talk about it** [periods] (Saba, age 48, Sudanese)*

*I also **associate a period with shame…something dirty and something to feel bad [about], it's something to feel ashamed of**. (Latina Focus Group)*

Young girls may have poor knowledge of menstruation prior to menarche

***I had no idea what menstruation meant**, I had never even heard about the word. It was quite **scary** for me. I would say I was kind of **horrified** that something was **wrong** with me or I might have **hurt myself.** (Shiwa, age 23, Afghani)*

In some migrant and refugee cultures menarche is celebrated

*It's a **big ceremony** it's called a **saree party** here [Australia] (Tamil Focus Group)*

*During that time, people **celebrate**, and people **dancing** and people **killing this big cow to celebrate**, and **different types of foods** are cooked for the celebration (South Sudanese Focus Group)*

At menarche a girl becomes a woman, which can lead to restrictions

***You start bleeding and you become a woman.** (Amaal, age 42, Somali)*

*You need to change your manner, the way of sitting, **you can't play outside with your friends**, it's different. (Raana, age 43, Iraqi)*

*You can't play around like a child again . . . **I didn't like having to grow up**. (Lokoya, age 42, South Sudanese)*

Migrant and refugee women may have poor knowledge of menstruation as a reproductive function

*For me **I didn't know, I mean like that I will become pregnant, the first time I started bleeding**. Our parents were not educated. **They didn't know how to communicate with their children** because they were less educated (Somali Focus Group)*

Migrant and refugee women may need information and resources to help prepare their daughters for menarche

*I was **scared to tell her about the period** because my **daughter** might **misunderstand me**...But I went to a migrant resource centre and there was a lady talking about women's health. She talked about periods and how to tell daughters. **I learnt from that session and it encouraged me to tell my daughter**. (Sudanese Focus Group)*

*I **don't want my daughters to be shocked** like I was (Madina, age 45, Iraqi)*

Female circumcision (or genital cutting) may be associated with menstrual difficulties

*When you got periods, **that's why you got sick, because there is no space to come, the period.** (Hasina, age 25, Somali)*

*My cousin was in the countryside in Sudan and she had this bad circumcision which closed everything. So **when she has her period, it doesn't come out and it just stays in her tummy and poisons her body and she died**. That's why people are so scared. (Sudanese Focus Group)*

Menstrual and premenstrual difficulties were common, but rarely discussed with health care professionals

***I have a very strong constant pain** that was so bad and so strong that when I had my three miscarriages I didn't realize that those were [miscarriages] because **I've always had very heavy periods and a lot of blood and bleeding** for many days. (Latina Focus Group)*

***Whenever I have my PMS I'm very moody I'm very emotional** sometimes very aggressive as well...Well **my family doesn't know how to react to it** they just tell me to shush and go away... (Fahmo, age 23, Somali)*

Migrant and refugee women may have poor knowledge of menopause

*I **would not want my period to stop** because this makes me imagine that I will be **getting ill**, and **blood will be accumulated in my body** and I will not have any more energy (Arifa, age 48, Iraqi)*

*But **my heart says they [periods] should stop as I feel anxious.** I feel I will **feel better if they stop** (Zinat, age 45, Punjabi)*

Recommendations Regarding Menstrual Healthcare for Migrant and Refugee Women:

- Awareness of cultural sensitivities surrounding discussion of menstruation for migrant and refugee women
- Awareness of the association of menarche and marriageability
- Awareness of cleansing rituals post menstruation
- Information and resources for community workers on menstruation, premenstrual distress and menopause needs to be available
- Recognition of menstrual problems among migrant and refugee women (e.g. pain and heavy bleeding; menstrual difficulties following female circumcision or genital cutting (FGC); consult with FGC network
- Awareness that young women may have poor knowledge of the association between menstruation and fertility. This may have implications for unplanned pregnancy and contraception
- Encouraging schools to engage with parents in developing programs of education about menarche and menstruation

Menstrual Healthcare Resource and Support Needs of Migrant and Refugee Women:

- Menstrual education and information to help mothers prepare their daughters for menarche
- Information on menstrual health conditions such as painful or heavy bleeding and fibroids, pelvic inflammatory disease
- Encourage women to seek help if they have heavy menstrual bleeding; support the use of contraception for menstrual difficulties e.g heavy bleeding
- Menstrual education for prevention and early treatment of reproductive cancers
- Education on anatomy of menstruating body, from whole life body perspective and how bodies change e.g. female genitalia and what is 'normal'
- Menstrual and fertility education to prevent unintentional pregnancies; e.g. through Life Education NSW
- Menstrual education to include the use of sanitary products, including tampons
- Information on premenstrual change - what it is; what to expect; prevention and support
- Information on menopause - what it is; what to expect; support

Contraception and Family Planning

For the women in our study, the primary source of contraception information was female friends and relatives, followed by the media. Women described piecing together their knowledge through multiple sources, including formal and informal learning. Some women had little knowledge of contraception due to poor education in their countries of origin or personal disinterest.

Condoms and the contraceptive pill were the methods most women knew about. However, beliefs some women held about such methods were not always medically sound [22].

Culture and religion

Among some Muslim women the use of contraception was strictly forbidden as it was considered to be killing a 'child'. Many women were expected to reproduce until they were no longer fertile.

Christian women from Dinka tribes of South Sudan stated that it was culturally unacceptable for a husband to have sex with his wife while breastfeeding, thus acting as a birth spacing mechanism.

Unmarried women were forbidden from contraception knowledge or use. Many married women needed the agreement of their husband to use contraception. In some cases, parents and in-laws were involved in the decision-making. Contraception was mostly used after the first child was born.

Across all cultural groups there were expectations to have children, with a preference for boys. Amongst South Sudanese, Sudanese and Somali women large-sized families were expected. Smaller family sizes were desired among Punjabi and Tamil women, as long as there was at least one boy child.

Experiences of contraception use

The use of contraception was fraught with worry and concern due to feared side effects. Concern about these side effects resulted in some women avoiding use of any form of contraception. However, unplanned pregnancy was also a concern, and many women told us that they wanted contraceptive education for themselves and their community. Natural methods of cycle calculation and withdrawal were commonly used. However many women reported this ended in unplanned pregnancies.

The contraceptive pill was tried by a number of women, but was often discontinued due to negative side effects. These included headaches, weight gain, and changes in mood. Women also worried about the impact of the pill on future fertility. Women reported mixed experiences with IUD's, contraceptive injections and implants with many reporting heavy or irregular bleeding as a side effect contributing to discontinued use. Few women used condoms and those who did described a negative impact on sensation.

Abortion

A number of women had undergone abortion before and after migration. Although religiously forbidden, some women and their husbands considered abortion acceptable in the case of financial pressure or in very early pregnancy. Discussing abortion with others was taboo, so it was conducted in secret.

Many migrant and refugee women have limited or inaccurate knowledge of contraception and fertility control

*I have **no idea** about **contraception** (Akeck, age 30, South Sudanese)*

*The **two sides of the IUD close the two passages to tubes** that take you to the eggs...**sperm can't get through** and they have to return back (Sharifa, age 43, Iraqi)*

*Just the condom for prevention...**I don't know anything else** (Ara, 34, Afghani)*

***I wanted to know more about contraception** but at that time **there was no internet and nobody was around to give me any kind of knowledge** and no books that I could rely on. (Wafa, age 40, Sudanese)*

Due to poor knowledge of contraception, migrant and refugee women may have unplanned pregnancies

*My husband would **try to pull out to not get pregnant**, but despite that...**I got pregnant** with my son (Afghani Focus Group)*

*After my first baby **I took pills, while I am using them I fell pregnant five times. I did abortion** because I didn't want more children. (Najiba, age 64, Iraqi)*

*I didn't use any pills or condoms, **I made a mistake on the day's calculation** and fell pregnant with my second child (Zarina, age 32, Tamil)*

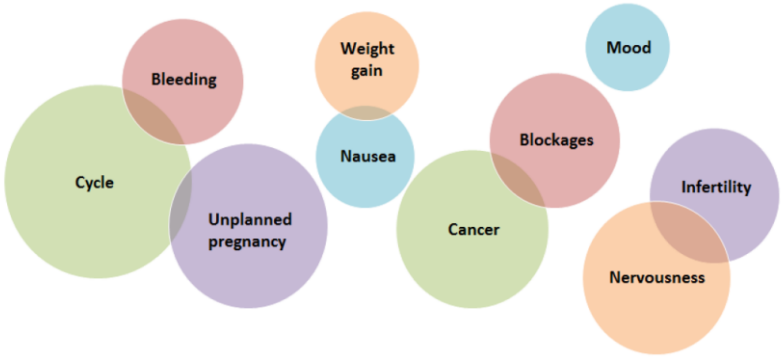
Many migrant and refugee women have fears and negative past experiences using contraception (Figure 5)

*They gave me shots...and **my period has completely stopped...** I just wonder if it **later on will create complications. So all those periods just stay in and they gather up**, right? (Anosha, age 30, Afghani)*

*Contraceptives will **cause a lot of problems**, sometimes they say **you will have a blockage**, sometimes they will say, **you will bleed to hell** after that (Akoi, age 40, South Sudanese)*

*If they take that birth control...**it might make them not to have kids anymore**, that's the big issue (Arliyo, age 26, Somali)*

Figure 5: Negative Experiences and Misconceptions Surrounding Contraceptive Use



Religious and cultural beliefs may be a barrier to contraception use for married and unmarried women

*No the **religion does not allow** women to use contraceptives (Hido, age 68, Somali)*

*...**there is no need to stop pregnancy because you're not even supposed to get pregnant** before you are married and **a woman is not supposed to have sex before she is married.** (Maano, age 19, Somali)*

***No I never use it** [contraception], **my religion and culture allow it only if the woman is sick**...women don't normally use contraception, maybe one in one hundred would use it (Saafi, age 43, Somali)*

There are cultural and family pressures for women to have children

*If you **don't have baby**, you **can't be in the culture** (Tamil Focus Group)*

*Sometimes you don't have a choice [about having a baby]... **the family, they're controlling**. You are not you and your husband only (Somali Focus Group)*

Some women wanted contraception information and education

*So this is a **real education that women need to know**, they **need to learn that you have to stop having babies, using contraception** (Akoi, age 40, South Sudanese)*

*That's **something that I want to know about - if you don't want to have kids** ... so let's say safe sex and usage of contraceptives (Setara, age 23, Afghani)*

Recommendations Regarding Contraception and Family Planning for Migrant and Refugee Women:

- Language and culturally appropriate information and education about various methods of contraception
- Addressing misconceptions about methods of contraception during consultations
- Where appropriate, involving husbands in discussions of available methods of contraception
- Using the term 'women's health' instead of 'family planning' can may be more culturally acceptable
- Awareness of the social and cultural sensitivities that migrant and refugee women may have regarding contraception use and not to assume knowledge on the part of patients
- Recognising that unmarried women, and married women wanting to use contraception before the birth of their first child, may experience difficulties in requesting contraceptive information and support
- Giving information to women at antenatal classes and following childbirth while they are engaged with health providers
- Consulting with community and religious leaders to receive their support on contraception education
- Contraception and family planning education for men by male educators
- Contraception and family planning education for community workers to prevent misconceptions being passed on
- Up-skilling general practitioners on methods of contraception, including natural methods and on how to handle conversations with migrant and refugee women

Contraception and Family Planning Resource and Support Needs of Migrant and Refugee Women:

- Information on different types of contraception, to counter worries and misconceptions; e.g. about the effect on bleeding and future fertility, and the level of risk
- Information on low cost contraception options, including what is available for those without Medicare cover
- Information on natural methods of birth control to increase efficacy for women who choose not to use other methods of contraception
- Information on emergency contraception and abortion
- Information on pregnancy options such as adoption and IVF
- Development of a contraceptive decision-making tool targeted at CALD women
- Information and support services following abortion

Sexual Knowledge and Communication

Premarital sexual knowledge and communication

Across most of the cultural groups, unmarried women were not permitted to discuss sex, or be part of a conversation that made reference to sex. To break this taboo was culturally shameful. Sex and intimacy was only acceptable within married heterosexual relationships [20].

As a result, premarital sexual knowledge was limited. Some women had received basic sex education at school and a few women had talked about sex with their friends. Very few women received sexual information from their parents. A number of women were wary about their children receiving sex education in school in Australia or Canada, for fear it would encourage premarital sexual activity. Conversely, some women wanted information and support in order to educate their children about sex.

Premarital sex and relationships with men

Women's contact with men was restricted in some instances, and entwined with rules, regulations and repercussions. Premarital physical contact such as hugging, hand holding and kissing was forbidden for some. Women made a conscious effort to avoid association with men because of the potential for condemnation by family and the wider community. Even thinking about sexual intimacy before marriage was considered as "harming your religion". If women did have sex before marriage, it was kept secret.

Women who were known to have had sex before marriage were at risk of social exclusion, no longer being seen as a desirable partner, or were forced into marriage to protect family honour. Women who became pregnant as a result of premarital sex were often isolated and rejected by their family, and wider society.

Many women felt anxious about raising daughters in a Western context, given the different cultural value placed on virginity. Mothers worried about the influence Western education and peer pressure may have on their daughter's choices, as they wanted their daughters to be virginal at marriage.

Marital sexual communication and consent

Open communication about sex within marriage was also uncommon. Women who openly discussed sex were commonly seen as 'bad women' and vulgar.

Women's expression of sexual desire within marriage was associated with embarrassment and shame, and considered offensive. Women disclosed shyness and shame at the prospect of initiating sex with their husband. A few women acknowledged a woman's right to sexual pleasure; however, the majority believed the focus of sex was on male pleasure and childbearing.

Refusing sex was unacceptable and seen as a "sin" across cultural groups. Many married women felt they did not have the "right" to say no to their husband and some women feared that refusal of sex could result in their husband "looking elsewhere". This resulted in frequent unwanted sex for many women. Some women however, could discuss sex, express desire and say no to sex.

Accounts of painful sex were common. Women frequently did not disclose sexual pain to their husband. Vaginal dryness was commonly associated with sexual pain. Few women had knowledge of lubricants, or means of increasing sexual pleasure. Many women saw addressing sexual issues or concerns with a doctor as too embarrassing.


Some women have limited knowledge about sex prior to marriage
You don't get enough information about sexual relationship especially if a girl is not married...no-one will talk to you about these things (Ara, age 34, Afghani)
I had no idea what was going to happen. One of our friends told me about marriage and what is going happen to me when I have sex for the first time...When she told me about sex I was scared and shivering... I got married when I was 16 years old (Najiba, age 64, Iraqi)
It was a complete surprise to me if I am honest with you...I was really scared (Banoo, age 28, Afghani)
For many migrant and refugee women, talking about sex is culturally and religiously forbidden
We are not allowed to talk about sex, not even in our bedroom... it's a taboo (Arifa, age 48, Iraqi)
It is shame to talk about sex with anyone in my culture and I feel embarrassed to talk about it (Hooria, age 35, Sudanese)
Your mother would kill you if she heard that word [sex] (Arliyo, age 26, Somali)
Sexual relationships before marriage are forbidden and stigmatised
...it's not permissible for unmarried men and women to be together like having a relationship, so it's absolutely wrong (Hoodo, age 29, Somali)
They say sometimes when you have sex before marriage sometimes you can't get kids, you're going to be addicted to sex all the time until you going to come like a prostitute (Suz, age 42, South Sudanese)
To even think about sex is wrong before marriage (Afghani Focus Group)
Women expressing sexual desire is considered to be culturally inappropriate by some women
So actually we don't talk about sex at all, so I have no idea whether we're meant to enjoy it or not to be honest (Anu, age 35, Punjabi)
Not acceptable at all, never ever... As a Sudanese it is impossible for women to ask for sex" (Saba, age 42, Sudanese)
Many women believe they do not have the right to say no to marital sex
Well, if your husband wants to have sex, I don't think our religion would allow us to say no...if you say no...and you happen to die the same night, we used to hear that you would go to hell (Hani, age 32, Somali)
If she says no, he might go outside and make another relationship (Sudanese Focus Group)
The culture sees that a woman is there to give joy to her husband and bear children (Nasima, age 43, Iraqi)

Some women *could* discuss sex with their husbands, express desire, and say no to sex

When I don't have sexual desire ***I say no****. (Somali Focus Group)*

There is no shyness between husband and wife, ***I can talk to him about sex,*** *it's normal (Kamelah, age 36, Sudanese)*

There was always good communication. ***I would feel free to ask for certain things and to communicate my needs and pleasures… and when it was painful*** *(Mariana, age 38, Latina)*

Your society is opened so we learnt a lot from your society [Canada] so I see that it's ***my right to tell him what I enjoy and what I don't enjoy in the sexual relation.*** *(Sudanese Focus Group)*

Same-sex relationships were forbidden or taboo

It's ***not in our culture, it's not in our religion****, it's not something we chose (Somali Focus Group)*

We don't have this (Amer, age 34, Sudanese)

In my opinion ***it is religiously illegal 'haram' (sinful)*** *and for my opinion it is completely totally refused (Iraqi Focus Group)*

Experiences of sexual pain or discomfort are common

It was painful every night *and I hated sex (Najiba, age 64, Iraqi)*

I feel ***pain in my vagina*** *in the hours after the sex. In my culture it's* ***shame to talk about this pain****. It is considered* ***normal*** *[part] of having sex (Hooria, age 35, Sudanese)*

It just ***hurts every time****, sometimes it lubricates, sometimes it doesn't (Darya, age 24, Afghani)*

Migrant and refugee women want support in educating their adolescent children about sex

I would like to have information about ***sexual education for kids and young people****. I would like to have some advice or guidance on* ***how to approach these kind of issues with my daughter*** *(Mariana, age 38, Latina)*

Here in Australia… when she was in Year 5 the ***sex education I participated in that session. I told myself, me and my child learning at the same time*** *(Tamil Focus Group)*

Some women could discuss sex and their sexual health needs with health providers post migration

The good point is that here ***I feel really comfortable about obtaining any kind of information related to my sexual health****, but in Sudan and Saudi Arabia, I feel embarrassed to ask for this kind of information (Wafa, age 40, Sudanese)*

Recommendations Regarding Sexual Knowledge and Communication for Migrant and Refugee Women:

- Understanding of the social and cultural sensitivities that some migrant and refugee women have regarding talking about sex or sexual concerns
- Awareness that some migrant and refugee women have limited knowledge about sexuality and sexual practices
- Recognition that migrant and refugee women may not be aware of their sexual rights, including the right to say no, and the right to pain-free sex
- Adopting a comprehensive human-rights based approach, that treats migrant and refugee women and their sexual and reproductive health needs holistically, taking into consideration the wider socio-cultural context
- Education for men as well as women around sexual rights, e.g. embed education in culturally acceptable programs such as marriage counselling
- Awareness of the cultural difficulties facing same-sex attracted girls and women

Sexual Knowledge and Communication Resource and Support Needs of Migrant and Refugee Women:

- Sexual rights and sexual consent
- Different types of sex, and the value of sexual pleasure and desire, including same-sex attraction, using a rights-based approach
- How to talk about sexual concerns with your partner and health professional
- How to avoid or treat sexual pain and discomfort
- Talk about use of lubricants e.g. during cervical screening and menopause education
- Sexual education for young people
- Information about respectful relationships

Premarital Virginity and Female Circumcision or Female Genital Cutting (FGC)

Across all of the cultural groups women were expected to be identifiable as a virgin on their wedding night. For women from Islamic cultures, virginity was traditionally demonstrated through the collection of blood stained bed sheets. The possibility of absence of blood on their wedding night was a cause of concern for some unmarried participants. They wanted greater community recognition that women could be virgins and not bleed after first sex. Hymen repair was discussed as being available to mimic virginity. However, this was considered unacceptable, unless rape had occurred.

Infibulation and female genital cutting (FGC) was customarily used to ensure virginity before marriage among Sudanese and Somali participants. A woman who was not circumcised was considered "not a virgin" and traditionally was not marriageable [23].

Meaning of Female Genital Cutting (FGC)

The meaning of female genital cutting (FGC) varied among individual Sudanese and Somali women, with some accepting and others rejecting it. There was general agreement that FGC was not a religious practice, but one of culture and tradition. The majority of women linked it to proof of virginity at marriage, or to the removal of a woman's sexual desire, to ensure family honour.

The prevalence of FGC in women's birth countries was said to be declining, with the practice happening mainly in rural areas. Participants who supported the abolition of FGC focused on the trauma of the procedure both physically and mentally, and said they would never consider it for their daughters. There were a small number of women who supported the ongoing practice of 'sunna' or clitoral removal/nicking for their daughters. How this would be undertaken in Australia or Canada was not disclosed. Women were aware that any form of FGC practice is illegal in these countries.

Experiences of FGC and impacts on health and sexuality

Women who had been circumcised had the procedure carried out prior to migration. Participants had received a range of FGC, including clitoridectomy and full infibulation. Accounts of the experience included being held down and cut with a razor, absence of anaesthetic, significant blood loss, pain, and distress. In a number of cases, fathers did not want their daughters to receive FGC, but mothers and older female relatives insisted and carried out the procedure while husbands were away.

Women reflected on the implications of FGC for women's health and wellbeing. This included infection and pain following the initial procedure, which sometimes led to death. Severe pain or difficulties could be experienced during childbirth, especially for women who were continually being de-infibulated and re-infibulated. Painful menstrual periods were also a major problem for women who had undergone FGC, as were repeat infections.

Women reflected on the negative impact that FGC has on a women's sexual life. Some women were de-infibulated immediately prior to marriage. The majority experienced severe pain on their wedding night, due to the tiny hole remaining after infibulation. This pain was ongoing, sometimes over months, until the husband had fully penetrated the opening. Women also reported a disinterest in sex due to the inability to feel pleasure.

Migrant and refugee women are expected to be virgins, and traditionally, bleed on their wedding night

The second day of the wedding ***they took that cloth with blood to the bride's mother to show her the cloth*** *and her daughter is still virgin, that means she raise her in a good manners and is proud of her daughter. (Saba, age 48, Sudanese)*

In the morning…they expect a bed-sheet, like normally it's a white bed-sheet that is spread on the bed, and ***they expect blood on that thing*** *(Akeck, age 31, South Sudanese)*

Some women were concerned that they may not bleed on their wedding night

I am ***very frightened*** *because* ***I do want to bleed, it's very important*** *(Suhaira, age 20, Afghani)*

My experience is that we ***needed to prove that we are a virgin****. That was the main concern, even* ***my mother and whole family were worried****. (Afghani Focus Group)*

OMG ***the most important thing*** *[to bleed], that is pretty much* ***your life and your future****, you could get bashed, or even killed in some families (Afghani Focus Group)*

Some women want their communities to be educated about the hymen and bleeding following first intercourse

I want our older women, our mum and dad to be ***taught*** *that sometimes it's okay, like that* ***girls is virgin but sometimes it's okay not to bleed*** *(Suhaira, age 20, Afghani)*

They ***don't know*** *that if* ***blood doesn't come*** *a girl* ***still could be virgin*** *(Afghani Focus Group)*

Women had polarising opinions about the practice of hymen repair

You are born with virginity, people think they can make it, but it is not so. It is ***something God made…it's only one chance, I am sorry, but it's not repairable*** *(Safi, age 43, Married, Somali)*

If the girl had ***hymen rupture by raping or accident****, this type of* ***hymen repair operation is good*** *(Iraqi Focus Group)*

She is deceiving the person that she is going to marry. *I don't agree with this (Wafa, age 40, Married, Sudanese)*

*If I wasn't a virgin yes I would [get a hymen repair]…****because of the stigma…if you get married and you're not a virgin your in-laws will not respect you nor will your husband*** *respect you (Iraqi Focus Group)*

Female genital cutting (FGC) is culturally undertaken to ensure premarital virginity and control women's desires

Our mothers used to say that ***if girls are not circumcised they become hyperactive****, they look for men but if they get circumcised they will cool down and just stay home, [it's]* ***just to kill their sexual desire*** *(Nafiso, age 28, Somali)*

The ***clitoris is the one that makes you want to have more sex****, I think if it was left…I'll be just all over men and having sex like crazy…* ***I would just have babies before the age of 15*** *because I would just engage in sex, that's my belief (Somali Focus Group)*

In order to ***decrease her sexual desire****, they do this female circumcision (Habibah, age 43, Iraqi)*

*There's two types of circumcision, one of them is just the bad one which is they do everything…****the other one is just a small thing, so the small thing is not bad****, because you move quickly they cut a small part of the body (Sudanese Focus Group)*

FGC can have severe negative impacts on women's health

Circumcision *is* ***killing off*** *a part of a* ***woman's life****. (Kamelah, age 36, Sudanese)*

This [FGC] is ***why my sexual experience with my husband was very painful and a lot of bleeding happened****. (Wafa, age 40, Sudanese)*

Sometimes the ***husband take her to the doctor to open.*** *Sometimes* ***suffering for two or three weeks****. It's really bad (Sudanese Focus Group)*

No space for the blood *to come out at menstruation (Amran, age 47, Somali)*

I ***born nine kids, seven times*** *I have the* ***procedure again****. (Somali Focus Group)*

… every time she delivered the baby, ***they had to open it and sew it back again****. She was really tired because she had five babies and* ***during her fifth birth, she passed away.*** *(Hawa, age 30, Sudanese)*

Most migrant and refugee women are strongly against their daughters being circumcised

So I know, I've been there. ***I've gone through this horrible experience****, so* ***I don't want my daughters to go through the same experience.*** *This is not a religion, this is not a culture,* ***it's a barbaric culture*** *(Somali Focus Group)*

Never, ***I would not do this at all for my daughter****… this is* ***wrong****, because if you imagine when you are 8 years old and you get to experience this, it's* ***very traumatic****, it's* ***very scary****…This is something completely wrong and it's a wrong tradition, and it has nothing to do with religion. (Wafa, age 40, Sudanese)*

I think it's very cruel. ***It shouldn't happen to young girls*** *(Fahmo, age 23, Somali)*

I think ***it's wrong and barbaric*** *and something that* ***doesn't have a base in Islamic religion. It's just a cultural thing*** *that we have adapted from other countries and* ***it's really unfair to the girls*** *(Hoodo, age 29, Somali)*

Recommendations Regarding Premarital Virginity and Female Circumcision for Migrant and Refugee Women:

- Understanding of the importance of virginity for the majority of women from migrant and refugee backgrounds
- Recognising concerns surrounding proof of virginity status and requests for hymenoplasty
- Awareness of the cultural context and different types of female genital cutting (FGC)
- Attentiveness to beliefs that some forms of FGC are deemed more acceptable than others, and provision of information to counter these beliefs
- Provision of culturally safe care for women who have undergone female genital cutting (FGC)
- Development of information and resources on hymen repair and female genital cutting for health and community workers
- Education and information for community and religious leaders on virginity, the hymen and female circumcision

Premarital Virginity and Female Circumcision Resource and Support Needs of Migrant and Refugee Women:

- Education and materials for women and men on virginity status and the hymen including:
  - The fact that many women don't bleed at first intercourse
  - The hymen is not proof of virginity
- Puberty talks with mothers about virginity, the hymen and bleeding
- Educational talks in a safe place about female genitalia and what is 'normal'
- Information on female genital cutting (FGC) including:
  - Legal position of FGC in Australia or Canada;
  - Implications for women's health and wellbeing, including recurring infections;
  - Support and health care for women who have undergone FGC with referral to programs such as the 'NSW Education Program on Female Genital Mutilation';
  - Information and support for mothers to encourage them to refuse FGC for their daughters using a rights-based approach

Sexual Health Knowledge and Practice: Cervical Screening, HPV and Sexually Transmitted Infections (STIs)

The majority of women, across cultural groups, had limited knowledge about women's sexual health or prevention of sexual health problems.

Knowledge of cervical screening, HPV and STIs

Most women had very little knowledge about cervical cancer, or the need for cervical screening. One woman reported learning about pap smears at a migration information session while another gained information through her school-aged daughter. Likewise, there was a general lack of knowledge and awareness of the HPV vaccine. Women or their daughters who had received the vaccine were often not sure what it was for.

Women also had little knowledge about sexually transmitted infections (STIs) - the different types, different ways they are contracted and how they are prevented or treated. Most women only knew of HIV/AIDS. There was a belief that women were not at risk of STIs if they were monogamous. Some women held a fatalistic view that it was up to fate or a god to determine whether or not they contracted a STI.

Barriers to cervical screening and HPV vaccination

A number of explanations were given for why women did not engage in sexual health screening. Women reported being "scared", "embarrassed", "shy", "lazy", "too busy", fear of "an intrusion of privacy", or being "not aware" as reasons for avoiding cervical screening. Some did not think it necessary for unmarried women to have cervical screening, due to social and religious norms forbidding premarital sex. Cervical screening was also believed to affect the hymen, and therefore virginity status. The HPV vaccine was not considered important for young unmarried women. There were also misconceptions around the HPV vaccine, with a few participants believing it caused cancer.

After migration several women across cultural groups reported regular cervical screening, attributing this to healthcare providers who sent out reminder letters or spoke to them personally. A number of women were keen for their daughters to be protected from cervical cancer through HPV vaccination. Participants wanted information on cervical screening and the HPV vaccine.

Experiences of and worries about STIs

A number of participants reported experiences of STIs and other reproductive infections, or gave accounts of experiences of family members or friends. Husbands were seen as the source of the infection, leaving their wives to deal with the consequences.

Many women were unable to ask their husbands to be tested, if they suspected a STI. Some women were also worried about beginning a relationship due to not knowing if the potential partner had an STI, as well as being concerned about their adult children contracting STIs. Women told us that they wanted information on STIs.

Many participants reported having experienced urinary tract and yeast infections. However, seeking help from health care providers was sometimes delayed, because of lack of understanding of the infection, or use of home remedies. Other women described having regular GP check-ups and receiving good sexual health care.

Many migrant and refugee women have poor or incorrect knowledge about cervical screening and HPV vaccine

***We don't know what it is [cervical screening]**, what is that, how much is that important for us? (Tamil Focus Group)*

*If my daughter said that **she has no sexual relations, why should I give her this vaccine**? (Iraqi Focus Group)*

Many migrant and refugee women have poor or incorrect knowledge about sexually transmissible infections

***I don't know much about that (STIs) but I try to keep myself very clean** (Banoo, age 28, Afghani)*

*In **my culture, we don't know anything about that**, I've never come across that… no (Janni, age 32, Tamil)*

*The belief is that people who came here, they think they don't have any sickness in their body, so whoever you are dating, **you can have sex without condom or any protection** (Akoi, age 40, South Sudanese)*

Cultural barriers to sexual health screening or prevention

***If she's not married, no reason for that** [cervical screening] **(**Iraqi Focus Group)*

*It can **affect the virgin state** and the **hymen** [cervical screening] (Bashira, age 44, Iraqi)*

*We spend our lives, nearly 20 years back home… **maybe it takes time to change**, because I'm here just only three years [regarding cervical screening] (Andrea , age 26, Tamil)*

*Yes **it is not important to give this vaccine** at that time [when unmarried] (Iraqi Focus Group)*

*If you're meant to have it in you, you know, **if it is meant to end your life then it will, nothing can prevent that** (Hoodo, age 29, Somali)*

Advice and providers can encourage regular cervical screening practices reminders from health

*I wasn't aware of it before I came to Australia, **my family doctor told me about it**. I got all the information and **I do it on regular basis** (Hooria, age 35, Sudanese)*

***GP** has been **really good at reminding me** (Punjabi Focus Group)*

Women want access to sexual health information

*I think in regards to different diseases, **sexually transmitted diseases** I think, **I usually get scared about them, I want to know about them** (Setara, age 23, Afghani)*

*I would like women or girls to **be informed about this free injection** [HPV vaccine]…like girls in my age group they don't know these things (Maano, age 19, Somali)*

Recommendations Regarding Sexual Healthcare for Migrant and Refugee Women:

- Recognition that migrant and refugee women may not have adequate knowledge about STIs, cervical screening and HPV vaccination
- Acknowledgment of cultural sensitivities associated with cervical screening and HPV vaccination particularly for unmarried women
- Clear information that cervical screening and HPV vaccination are part of prevention of cancers in women
- Development of cervical screening and HPV vaccination information and resources for community workers
- Culturally appropriate reminder systems for cervical screening along with the new 5 year protocol
- Using Cervical Cancer Day to spread awareness
- Development of sexual health information and resources for community workers on STIs and urogenital tract infections
- Provision of sexual health literacy workshops for community workers
- Empowerment of young people to take the lead in sexual and reproductive health education and in turn feedback into their own communities

Sexual Healthcare Resource and Support Needs of Migrant and Refugee Women:

- A directory of women's services including services for LGBTI and intellectually impaired women, as well as access to low cost services
- Sexual health literacy workshops and ongoing education for migrant and refugee women and men, including:
  - Cervical screening: including current guidelines; an explanation for why cervical screening is needed; potential implications of avoiding cervical screening
  - HPV vaccinations: what they are; what they prevent; any side effects, with emphasis on the vaccine given to all young women not just those who are sexually active
  - STIs and urogenital tract infections: what they are in women and men; how they are contracted; how they can be prevented and treated; implications of an untreated STI; address myths about STIs
  - Negotiating safe sexual relationships

Sexual Health Information and Support – Experiences and Preferences

Many of the women in the study placed a low priority on their own sexual health needs, resulting in putting others' health needs before their own. This was often due to stress or responsibilities at home. Other barriers to accessing professional healthcare that women raised included lack of education, illiteracy, lack of internet access, poor health promotion in country of origin, cultural and religious constructions of health, and the impact of migration [20].

Some women reported relying on cultural remedies for infections, as well as leaving their health up to fate or god's will, rather than seeking professional help. Several women also faced financial barriers to accessing healthcare, or were uncertain about their rights to healthcare due to their residency status.

Women who migrated without their extended family described their new environment as very physically demanding and isolating, with their own sexual health low on the agenda. Some women reported negative attitudes and lack of support from their husbands as a barrier to seeking professional sexual healthcare. Several Sudanese participants reported that men in their culture resisted adapting to western culture because it would mean they would lose 'control' over their women.

Experiences of consultation with health care professionals

Many women considered discussion of their sexual health needs and exposure of their body for examination by a health care professional (HCP) as inappropriate. For this reason, women healthcare providers were preferred when discussing 'sensitive' matters, or when being examined physically.

Some women described difficult experiences when they sought sexual or reproductive healthcare. This included difficulties in communication with HCPs, perceived disinterest in the part of HCPs, absence of tangible solutions to their problems, and consultation times that were too short to address their concerns. In contrast, other women had positive experiences of sexual health screening and support for sexual and reproductive health from GPs, specialists, and community workers.

Preferences for sexual health information

Women varied in their preferences for sexual health resource delivery. While some participants preferred to receive sexual health material that could be read or viewed in private, others indicated they preferred group discussions or one-to-one talks. Various barriers to receiving information were highlighted, including issues of confidentiality, and the shame and stigma associated with talking about sex.

Women highlighted their need for information on sexual and reproductive health. Broad topics participants wanted more information on included:

- Menstruation
- Menopause
- Contraception
- Sexual health screening
- STIs
- Sexual education of young people
- Painful sex

Due to cultural beliefs some women are reluctant to be examined, particularly by a male health professional

*...they **don't want to expose the body**. So even if they know that they are going to die, they don't want it (Andrea, age 26, Tamil)*

*I was **scared to see the doctor**... that it is a man... **I felt the some anxiety as one feels on the first night of the wedding**... I was relieved that my husband said that the doctor did not see much, never mind (Zinat, age 45, Punjabi)*

*...**even a specialist, no, not to a man** (Iraqi Focus Group)*

Migrant and refugee women may place low priority on sexual healthcare

*We always think about the kids and husbands but **we forget about our self** (Faaiso, age 32, Somali)*

Migrant and refugee women prefer a variety of sexual and reproductive health resource delivery options

*I think one of the good ways to get that information could be in the **community centres, in the neighbourhood houses**...for example, groups, **parenting groups**, and there will be one of the **good spaces to take advantage and to talk about sex education** (Catalina, age 45, Latina)*

***Reading.** Because we are **very private people** (Tamil Focus Group)*

*I would like to see little information books in doctor clinics, so we could read and could speak about it... **we can't talk in our community in a group** (Azita, age 38, Afghani)*

***One-on-one chat is probably more comfortable** for people because it's **more personalised** (Manjit, age 33, Punjabi)*

***Group sessions would be fantastic**...because it's nice to hear what other people are going through too (Geet, age 30, Punjabi)*

Migrant and refugee women want access to appropriate sexual health education on a wide range of topics

*I concerned about parenthood advice, how to teach **sexual education to your kids**. My daughter, she already asks me about how my son was made, how babies are done, why you and my dad kiss each other. **I'm not sure what will be the right way to engage in that kind of conversations** with her (Isabella, age 46, Latina)*

*I want women to be taught about girls, about [how] **young girls don't bleed sometimes** [at first sex] (Suhaira, age 20, Afghani)*

*I think **I should start getting more information about ways to get a lubricant**... so that I am **not experiencing painful sex** (Mariana, age 38, Latina)*

*More with the **contraception, talk about them**, it's something that I would actually like more information (Akeck, age 31, South Sudanese)*

Recommendations Regarding Sexual Heath Information for Migrant and Refugee Women:

- Understanding sexual and reproductive health as central to 'women's health and well-being'
- Education for health and community workers on how to work collaboratively with migrant communities
- Incentives to address sexual and reproductive health in migrant and refugee communities
- Building partnerships within migrant and refugee communities and services to implement culturally safe sexual and reproductive health education programs, including peer support groups for connecting with women who may be isolated
- Consulting with migrant and refugee communities about appropriate strategies to increase capacity to access sexual and reproductive health services
- Developing specific sexual and reproductive health resources tailored for different cultural backgrounds in consultation with communities
- Developing resources for women with low levels of literacy, i.e. material that is highly visual with simple language and use of diagrams and images
- Resources on sexual health to be disseminated as part of the resettlement process
- A collation of available resources to know what information exists and in what languages
- Providing information for women at events such as Women's Week, Refugee Week and the media
- Availability of information and support in a range of modalities to suit women's preferences: written, one to one, group discussion, peer education, video
- Availability of sexual and reproductive health information and resources at services and places frequented by migrant and refugee women including: migrant centres, doctors' surgeries, social security and government agencies for housing and education, community centres and clubs

Migrant and Refugee Women Want Information on:

- Menstruation
- Menopause
- Sexual health screening
- Contraception
- STIs
- Sexual education

Moving Forward and Future Research

A Stakeholder Forum was held at the Community Migrant Resource Centre in Sydney on October 11th 2016, where 61 participants, made up of healthcare providers and community workers, provided feedback on the report. Key research findings were discussed, report recommendations were evaluated, and research priorities and opportunities for collaboration in future research were raised. The stakeholders discussed steps on how to move forward with the current report and recommendations. This included provision of feedback on the overall content of the report and advice on the recommendations given for each section; how to disseminate the findings; and how to move forward in addressing sexual and reproductive health needs of migrant and refugee women. One of the main points the stakeholders highlighted was the need to make sexual and reproductive health a higher priority within multicultural health, and health in general. The following are suggestions they gave on how to go about this:

- Engage with policy makers to ascertain who is responsible for providing sexual and reproductive health education, particularly as there have been structural and organisational changes in women's health services and their connections with community migrant health services
- Provide policy makers with evidence-based research such as this current report to help put sexual and reproductive health on their agenda
- Align the findings of the current report with the NSW Department of Health's 'women's plan' to help set priorities in sexual and reproductive health
- Take the opportunity to be involved with the NSW Department of Health's tender for mapping women's health service provision, e.g. to produce a directory of sexual and reproductive health information and services
- Collaborate with health providers so that the same message is communicated across the service sector and that sexual and reproductive health services are available for migrant and refugee women at all services
- Partner with disability organisations and the NSW Council for Intellectual Disability to provide appropriate sexual and reproductive health information for migrant and refugee women with disabilities
- Involve the media in promoting and sharing sexual and reproductive health information
- Use the report to help upskill healthcare providers and community workers in migrant and refugee sexual and reproductive health
- Use findings of the current report to help the Australasian Sexual Health Alliance (ASHA) and health promotion teams in the public and private sector in developing and producing tools (i.e. fact sheets, apps, decision tools) to reach all migrant and refugee women including those who don't use services.

Stakeholders Provided Recommendations for Future Research Topics:

- Breast screening
- Antenatal care
- International students and sexually transmissible infections
- Attitudes to HIV/AIDS
- Sexual violence
- Needs of same-sex attracted women from migrant and refugee backgrounds
- Migrant and refugee women with disabilities, including cognitive and intellectual disabilities
- Men's perspectives on sexual and reproductive health
- Other cultures

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Appendix 1

Sexual and Reproductive Health of Migrant and Refugee Women Interview and Focus Group Schedule

Becoming a Woman

Menarche and menstruation

To begin with I want to ask you a few questions about becoming a woman and having babies. One of the first signs of becoming a woman is when you start to bleed once a month. In Australia this is called menstruation. Did you know about bleeding/menstruation before it first happened to you?

When did you first find out anything about bleeding? What did you find out? How did you find out?

Changes after menarche

Did things change for you after you started bleeding? (e.g. by wearing particular clothes; by celebrating or having a feast?)

Is anything different in your life now when you bleed? (e.g. preparing food; washing your hair; social or work time; having sex?)

Premenstrual changes

Some women report changes before their period, which can be difficult, or can be positive. Is this something you're aware of? (Prompt: physical and psychological changes) Has it happened to you? In Australia this is called 'PMS'. Do you have a word for it?

Becoming a Mother

Knowledge about pregnancy

When you started bleeding did you understand that you were now able to have a baby? If not, when did you first find out anything about having babies?

Knowledge about contraception

Do you know about how to stop having babies? In Australia this is called contraception. Do you have a word for it?

Are you doing or using something to help you not have babies now? (e.g. traditional methods, withdrawal method, taking the pill, using condoms, IUD, etc.) (Why/why not?)
Are you able to talk about this with your husband/partner?

For women who use contraception: How do you find these methods? (positive/negative consequences; how happy are you with contraceptive choice?; any consequences in terms of changed menstrual cycle or changes in sexual desire?)

Do you worry about trying to have a baby or trying not to have a baby?

For women who do not use contraception: What are you beliefs surrounding contraception use? (e.g. religious, cultural)

If you want to stop having a baby in the future, what methods of contraceptives would you use? What methods wouldn't you use? Why? (e.g. concerns or worries)

Knowledge about menopause

When women's bleeding has stopped, it is called menopause – do you use this word? If not, do you have a word for it?

Do you know what happens to women's bodies during menopause? What do you think about menopause? (e.g. any concerns?)
Has this happened to you? What was your experience? (e.g. what are your thoughts/experiences about 'hot flushes' or vaginal dryness?)

Being in love and having sex

Sex before marriage

In Australia and Canada, many people choose to have relationships and to have sex before they are married. What would happen if a woman in your culture met a man and wanted to have sex, but they were not married? Is this something you would do?

Some cultures allow certain sexual practices before marriage – as long as sexual intercourse does not take place, and the woman remains a virgin. Are certain things ok in your culture, such as touching each other intimately, oral sex, anal sex, Skype sex, when you are not married? Would you engage in such practices before marriage?

If a woman in your culture were to have sex before marriage, is there anything she could do to regain her virginity? For example having a hymen repair?

Choosing a partner
Married women: Is it ok for you to choose who you want as a partner/husband?
Did you choose your husband?

Unmarried women: Is it ok for you to choose who you want as a partner/husband?
What do you consider to be important when considering a man for marriage?

What would happen if a woman in your culture fell in love with another woman?

Sexual pleasure and desire

For women who have sex: In your culture, are women expected to enjoy and want sex?

Do you ever feel like you want to have sex? What does this feel like?

Can you show this to your husband or is it always what your husband wants that counts? What happens if you show your husband that you want to have sex; do you ever worry about not wanting to have sex?

For women who have not had sex: Despite not being married/sexually active, is sex something you think about? Do you ever feel like you want to express your sexual desire?

Do you ever explore your body in a sexual way? Did you feel pleasure from this?

Do you ever feel attracted to another person (e.g. physically/emotionally)? What does this feel like? Can you express your desire towards that person?

Do you think it is important to be sexually attracted to a potential partner/husband? (Why/why not?)

Do you think your views on sex have changed at all across your time in Australia?

Talking about Sex

Now we are going to move on to talk about sexual desires and concerns. Do you ever talk about sex with your husband/partner? (Do you talk about what you want and when you want it? Can you say no to sex? Can you say no to certain kinds of sex that you don't want?)

If you can't talk about sex with your husband/partner, what is stopping you?

Do you ever talk about sex with anyone else? (daughters, friends, fiancé, partner, doctor)
If yes, what do you talk to them about?

Worries about Sex

Sexually transmitted infections (STIs)
Some women have worries about their sexual health. One worry that women sometimes have is getting an infection, medically called a sexually transmissible infection, or STI.
Do you know what this is? What would you do if you thought this had happened to you?

Pap tests and cervical cancer
In Australia, women are encouraged to have a test, called a Pap test, to make sure that they don't get cervical cancer. Do you know about Pap tests? Is this something you have on a regular basis (if not, why not?)

Young women can now have a free injection to prevent the virus that leads to cervical cancer. Do women in your community normally have this injection? (For younger women: Is this something you have had; if not, why not? For older women with daughters: did your daughter have the injection; if not why not?)

Painful and unwanted sex
Some women say that sex can be painful. Is this a concern for you? What would you do about it if it happened? Can you talk about it with your husband?

Some women have sex when they don't want to, which can cause distress or pain. Have you ever had sex when you don't want to? Have you been forced to have sex? How was this for you?

Worries about daughters and sex
Do you worry about your daughters or female family members when it comes to sex? What concerns do you have? (e.g. having sex before they are married)

Female circumcision
In some cultures it is common for girls to be cut down below. Is this an issue for you or your daughters? What do you think about this?

Changes over time

Women's experiences of their bodies and sexuality can change over time, or as our life circumstances change.
Have any things changed in relation to your sexual health since migrating to Australia? Since you had children? Since stopping bleeding [menopause]?; Can you explain what has changed?

Getting help about sexual health

Lastly, we would like to know what aspects of sex and having babies you would like more information about. Have you ever gone to a doctor to ask for help about sex or about having babies? If yes, who did you see? Is it important for you to see a female doctor?

Where else do you go to get information about sex? (e.g internet, friends)

What is the best way to get you the information you want about sex or having babies? (e.g. through a booklet; a DVD; a one-on-one talk; a group education session; the internet)

This is the end of the interview – thank you for taking part. Are there any other issues we haven't talked about that you would like to discuss?

Appendix I: Menarche and Menstruation Published Journal Article

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Experiences and Constructions of Menarche and Menstruation Among Migrant and Refugee Women

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Abstract

Experiences and constructions of menarche and menstruation are shaped by the sociocultural environment in which women are embedded. We explored experiences and constructions of menarche and menstruation among migrant and refugee women resettled in Sydney, Australia, and Vancouver, Canada. Seventy-eight semistructured individual interviews and 15 focus groups comprised of 82 participants were undertaken with women from Afghanistan, Iraq, Somalia, South Sudan, Sudan, Sri Lanka, and varying South American countries. We analyzed the data using thematic decomposition, identifying the overall theme "cycles of shame" and two core themes. In "becoming a woman," participants constructed menarche as a marker of womanhood, closely linked to marriage and childbearing. In "the unspeakable," women conveyed negative constructions of menstruation, positioning it as shameful, something to be concealed, and polluting. Identifying migrant and refugee women's experiences and constructions of menarche and menstruation is essential for culturally safe medical practice, health promotion, and health education.

Keywords

focus groups; health care, transcultural; health promotion; interviews, semistructured; refugees; reproduction; research cross-language; research, qualitative; sexuality/sexual health; women's health; thematic decomposition; qualitative; Australia; Canada

Despite menstruation being an internal bodily process, the way in which women experience and construct menarche and menstruation is influenced by the wider sociocultural milieu in which they live. Understanding how cultural, societal, religious, and other intersections of difference might influence a woman's experience in this sphere is essential, given the prevalence of negative attitudes and representations of menarche and menstruation (Rembeck, Möller, & Gunnarsson, 2006; Ussher, 2006). Within a Western context, dominant cultural discourses portray menstruation as a "hygienic crisis" that needs to be managed and concealed, as well as a bodily function loaded with shame and embarrassment (Beausang & Razor, 2000; Jackson & Falmagne, 2013). Consequently, women are required to conform to rules and regulations associated with menstrual management, reinforced through mainstream media and menstrual education (Erchull, Chrisler, Gorman, & Johnston-Robledo, 2002; Kissling, 2002). In contrast, menstrual activists, artists, and poets have challenged negative representations of menstruation, to contest derogatory discourse and empower menstruating women (Bobel, 2010). Menstruation is also positioned positively when it is associated with privileges of adulthood, or where the focus of the menarcheal transition is not solely on sex and reproduction (Lee, 2009; Teitelman, 2004).

Menstruation in many non-Western contexts, however, is strongly associated with dirt, taboos, and restrictions (Garg, Sharma, & Sahay, 2001; Sommer, Ackatia-Armah, Connolly, & Smiles, 2015). These representations are often shaped by major religions such as Judaism, Hinduism, and Islam where we see strict prescriptions and prohibitions which menstruating women must adhere to (Crawford, Menger, & Kaufman, 2014; Dunnavant & Roberts, 2013; Guterman, 2008), such as the exclusion of women from religious ceremonies because they are considered polluting, dirty, or impure. Such ideologies position the menstruating body as unclean and a source of pollution (Ussher, 2006), contributing to stigma and women feeling ashamed

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of their reproductive bodies (Chrisler, 2011; Johnston-Robledo & Chrisler, 2011). This has implications for women's health. For example, women who have negative attitudes toward menstruation are more likely to support suppression of menstruation through long-term oral contraception use (Andrist, 2008; Johnston-Robledo, Ball, Lauta, & Zekoll, 2003). Furthermore, menstrual shame has been linked to increased sexual risk-taking (Schooler, Ward, Merriwether, & Caruthers, 2005) and embarrassment toward other reproductive functions, such as breastfeeding (Bramwell, 2001; Johnston-Robledo, Sheffield, Voigt, & Wilcox-Constantine, 2007) and childbirth (Moloney, 2010). Mother's attitudes toward menstruation also shape the menstrual education girls receive, which might negatively affect their experiences of menarche and ongoing perspectives toward menstruation and sexuality (Beausang & Razor, 2000; Cooper & Koch, 2007; Costos, Ackerman, & Paradis, 2002).

The majority of research studies that have examined the impact of cultural constructions of menstruation have focused on experiences of girls and women within a White Western context (Beausang & Razor, 2000; Burrows & Johnson, 2005; Lee, 2009). There have been a small number of studies that consider cross-cultural experiences of women currently residing in the West (Chrisler & Zittel, 1998; Orringer & Gahagan, 2010; Uskul, 2004). However, such studies were predominantly undertaken in the United States, conducted with university students, and required spoken or written English for participation, considerably limiting those who can be involved. There is a growing body of research considering the experiences of menarche and menstruation of women within a range of non-Western cultural settings, such as Middle Eastern, Asian, and African countries (e.g., Crawford et al., 2014; do Amaral, Hardy, & Hebling, 2011; Liu, Chen, & Peng, 2012; Mason et al., 2013; Sommer, 2010; Sommer, Ackatia-Armah, et al., 2015). These studies highlight that although there are many similarities in the way menarche and menstruation are experienced across cultures, such as lack of menarche preparation and difficulty managing menstruation from a hygiene perspective, there are also a number of differences, including specific beliefs and practices (Sommer, Ackatia-Armah, et al., 2015) and restrictions placed on women during menses (Crawford et al., 2014). This suggests that researchers need to pay attention to commonalities and differences across cultures when examining the sociocultural meaning and construction of menstruation.

Despite the importance of menarche and menstruation in women's wider sexual and reproductive health, few studies have considered the experiences and constructions of menarche and menstruation in culturally and linguistically diverse (CALD) migrant and refugee women[1] settled in their new countries of residence. Understanding migrant and refugee women's experiences and constructions of menarche and menstruation are important given women have transitioned between two differing cultures and might need to negotiate conflicting cultural ideals associated with reproductive health (Salad, Verdonk, de Boer, & Abma, 2015; Ussher et al., 2012).

Acculturation in Western contexts has been found to affect women's sexual and reproductive health, such as increased reporting of premenstrual stress (Pilver, Kasl, Desai, & Levy, 2011) and engagement with sexual risk-taking behaviors (Lee & Hahm, 2010). To date, migrant and refugee women's attitudes and experiences of menarche and menstruation have largely been ignored despite being intimately linked to fertility, sexual health, and a women's identity (Brantelid, Nilvér, & Alehagen, 2014; Sommer, Sutherland, & Chandra-Mouli, 2015; Teitelman, 2004). The focus of past research on migrant and refugee women's reproductive health has predominantly been on pregnancy outcomes, childbirth, postpartum experiences (Tran, Young, Phung, Hillman, & Willcocks, 2001; Tsianakas & Liamputtong, 2002), or sexual health (Ussher et al., 2012; Wray, Ussher, & Perz, 2014). Furthermore, past research either has conceptualized migrants as a homogeneous population, which negates variations which occur within and between cultures (Beiser, 2005; Rawson & Liamputtong, 2010), or has been focused on migrant women's experiences from predominantly Vietnamese or South-East Asian backgrounds (Gagnon, Merry, & Robinson, 2002; Garrett, Dickson, Whelan, & Whyte, 2010). Identifying how menarche and menstruation is experienced and constructed by migrant and refugee women is essential for the provision of culturally safe reproductive health care, health promotion activities, school-based education, and is important for the development of wider sexual and reproductive health education for women who have newly migrated (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003; World Health Organization, 2010).

The aim of the present article is to address these significant gaps in the research literature by examining constructions and experiences of menarche and menstruation among women who had recently migrated or arrived as refugees in Australia or Canada, across a range of cultural groups. The research questions were as follows:

Research Question 1: How do migrant and refugee women construct and experience menarche and menstruation?

Research Question 2: What are the implications of these constructions and experiences for the broader sexual and reproductive health of migrant and refugee women?

Method

Research Design

This article is part of a larger program of research examining the sexual and reproductive health of migrant and refugee women who were currently living in Australia and Canada. Although the broader project covers topics of menstruation, fertility, contraception, sexuality, sexual health, and access to health services (Ussher et al., 2016), the current article will only present on data relevant to menarche and menstruation. Seventy-eight individual interviews and 15 focus groups with 82 participants were conducted primarily by community interviewers in Sydney, Australia, and Vancouver, Canada. To enhance data richness, individual interviews were used to elicit personal in-depth accounts that might not be disclosed in a group setting, while focus groups provided a synergistic setting to gather insight into cultural and community norms (Creswell, 2009). Participants originated from multiple countries, including Afghanistan, Iraq, Somalia, and Sudan. Sri-Lankan (Tamil) and South Sudanese women were included in the Australian sample and women from varying South American countries (Latina) in the Canadian sample. Migrant groups were chosen through a process of consultation with the project advisory committee established with major stakeholder groups whose roles included migratory support to new migrant and refugee populations, as well as agencies who provide sexual and reproductive health care to women. Women from the countries selected for this study were recognized as being underrepresented in previous research, and were identified by stakeholder groups as being absent or poorly served within current sexual and reproductive health services, despite making up a substantial proportion of recent arrivals to both countries. Australia and Canada were chosen for this research as both countries are similar geographically and have comparable migrant populations. Data were collected from July 2014 to November 2015.

Participants

Participants were women who had migrated in the last 10 years, with the average time since migration being 7 years. Women identified as practicing a range of religions, including Christianity, Hinduism, and Islam. Interviewees and focus group participants included women with varying migratory experience, including humanitarian, family reunion, refugee, and women seeking asylum. Participants ranged from 18 to 70 years old, with a mean age of 35. Except for one Latina woman who identified as being in a same sex relationship, all identified as being heterosexual. Supplemental Table 1 provides the socio-demographic information for each cultural group.

Procedure

At the onset of this project, the advisory committee was contacted to provide cultural guidance, establish appropriate research methodologies, refine the research aims of the study, and provide guidance on the research interview schedule. Following this, women were recruited through the distribution of flyers by community support staff working at migrant resource centers and the community interviewers themselves. Furthermore, women were invited to participate through visits to preexisting cultural community groups, through flyers displayed in health centers for migrant women, and snowballing. Before taking part in the interview or focus groups, women were informed participation would involve discussion of sexual and reproductive health. Consent forms were provided in English; however, any queries about participation were addressed verbally in their first language with a community interviewer to ensure understanding. Informed consent was gained from all participants.

Community interviewers, who received training by members of the research team (Jane Ussher and Janette Perz), in how to conduct interviews and focus groups, conducted the majority of the interviews, a methodology that has been successfully adopted in previous sexual and reproductive health research with non-English speaking women (Go et al., 2002; Morrow, Smith, Lai, & Jaswal, 2008). In most instances, interviewers were of the same ethnic background to the women they interviewed; however, in three cases, the interviewers spoke the participant's first language but identified as having a differing ethnic background. Each community interviewer was responsible for conducting approximately five interviews and one or two focus groups. Focus groups were either conducted in participants' first language, or in some instances facilitated in English, with the option of interpretation through the presence of the trained community interviewer. Members of the research team (Alexandra Hawkey and Christine Metusela) conducted the remaining interviews and focus groups with women who preferred to speak English or wanted to be interviewed by someone who was not a community member. Interviews and focus groups took place at venues elected by participants, including their home, local libraries, or community centers; child care was provided when necessary. The interviews and focus groups were semistructured and lasted on average 90 minutes. With the exception of one individual interview, where the participant declined to be audio-recorded and extensive notes were taken, all interviews and focus groups were audio-recorded with permission from participants. The interview schedule included the open-ended questions: Did you know about menstruation before it first happened to you? When did you first find out anything

about bleeding? Did things change for you after you started bleeding, for example, celebrations or prohibitions? Is anything different in your life now when you bleed? How have you/will you address menarche with your daughters? The same interview schedule was utilized in individual interviews and focus groups across all cultural groups; however, the wording and formatting of questions was used flexibly to suit the specific context of the participants. This research was approved by the Western Sydney University Human Research Ethics Committee, and by the ethics committees of community stakeholder organizations.

Analysis

Audio-recordings of non-English interviews were either translated verbally into English and then transcribed, or transcribed directly into written English by the bilingual community interviewers. This process involved a systematic approach by which a small segment of data were listened to multiple times and then translated. Translation was conducted in a manner that was as close as possible to the participant's accounts while taking into consideration the subtleties of language. Interviews and focus groups in English or with English spoken sections were professionally transcribed verbatim, and then integrity was checked by listening to the audio- recording and reading written text to ensure authenticity and accuracy. To improve readability filler words such as "um" and "ah" were removed. Participants' names were replaced with pseudonyms.

Our epistemological standpoint was critical realism, which recognizes the materiality of somatic, psychological, and social experience, but conceptualizes such materiality as being mediated by culture, language, and politics (Bhaskar, 2011). In this light, to both acknowledge the biological materiality of menarche and menstruation, and recognize women's constructs and subjective experience of these events, we adopted a material-discursive theoretical framework (Ussher, 2008). Our analysis also drew on intersectionality, a concept which examines how mutually constitutive categories of difference, such as gender, culture, and religion, shape individual lives, social practices, and cultural ideologies (Davis, 2008). Intersectionality moves away from an additive approach of single variables, to consider experience in the light of multiple influential factors that are continuously interacting (Bowleg, 2008).

Participant's transcripts were analyzed using a process of thematic decomposition, a form of analysis which identifies participant subjectivity or discourses across themes within data (Parton, Ussher, & Perz, 2015; Stenner, 1993). Analysis was inductive, whereby the development of the themes was driven by the data and less by existing theory, research, or hypothesis. A subset of interviews and focus groups were read and reread independently by two members of the research team who were experienced qualitative researchers. First order concepts or codes, such as "menarche celebration," "link to reproduction," and "menstrual rules," were identified. Following this, the entire data set was then coded utilizing the computer software NVivo, a program to facilitate in the organization and coding of qualitative data. Codes were then grouped through a process of continuous and vigilant decision making, creating a smaller number of more distinct categories as the process continued. Subsequently, each coded set of data was summarized with reference to specific accounts from individual participants or focus groups. Participant accounts in the coded summaries were then color coded to represent women from differing cultural groups and accounts from Canada were bolded to allow for a cross-country analysis. Through the process of coding, summarizing, and highlighting, we were able to identify commonalities across women's accounts, between individual interviews and focus groups, as well as unique stories specific to women or their cultural group. This process was important to identify how women discursively experience and construct menarche and menstruation in respect to their wider sociocultural contexts. Any discrepancies with coding data or data analysis were resolved through consultation and discussion with the wider research team.

Across all cultural groups, the positioning of menarche and menstruation as shameful was central to women's accounts. The majority of participants retrospectively described being immersed in cultural discourses of shame shaping both their experiences of menarche, and ongoing behaviors toward menstruation. Through our analysis, we observed how women resist and negotiate discourses of shame toward menstruation, in their own experiences, and with their daughters today. Thus, "cycles of shame" became the overarching theme of this article. "Becoming a women" and "the unspeakable" are the two core themes that fell beneath the central idea of shame. See Figure 1 for full thematic map.

Within participants quotes presented in this article " . . . " are used to identify sections of discussion that were not relevant to the analytical context and "[ ]" signifies text that have been added by the authors to improve readability and retain meaning of the verbal passage. Quotes are substantiated by ethnic background to enable comparisons within and between cultural groups. Through our analysis, no significant difference was found between the accounts of women from Australia or Canada, or individual interviews and focus groups. Consequently, there is no distinction made with regard to these variables when presenting participant accounts.

Results

Cycles of Shame: Becoming a Woman

The discursive theme "becoming a woman" explores women's constructions of menarche and the implications this developmental milestone has on women within the context of their wider cultural milieu. Three subthemes were identified under this theme: "The girlhood to womanhood transition," "the perilous pubescent," and "celebrations and rituals at first blood."

"Yesterday you were a girl, but today you're a woman": The girlhood to womanhood transition. A majority of women across all cultural groups described the sudden onset of bleeding as being a distinct point at which they transitioned into womanhood. For example, participants told us, "you start bleeding and you become a woman" (Somali), "the day when the period comes, like she becomes a woman" (Iraqi). This transition affected the gender identity position participants adopted, as one woman commented, "I thought I was a boy, when I got my period . . . I became a woman" (Somali). A number of participants positioned this as a positive transition they had been waiting for, with one woman saying, "finally I am a woman" (Afghani). Others positioned menarche positively as it signified fertility:

> When I started bleeding, I kind of felt happy . . . I was really waiting because it kind of lessened my anxiety because I was asking myself, oh my goodness, I'm not going to have children . . . it was kind of a relief. (Somali)

In another account, a participant said, "[When] the period, it come to me, I was very happy, now [I] was thinking I'm going to have kids because I have period" (Sudanese). For many participants, however, the putative status of "womanhood" following menarche was rejected:

> When you get your period . . . [You're] not running around anymore, just being like a woman, act[ing] like a woman. Actually you are not . . . because, when you are 11 like my age when I got period, 11 is not woman it's just a young girl, but you act as you are a woman. (Somali)

This account suggests that although menarche might mark the materiality of achievement of a woman's reproductive body, it can occur at a time when a girl still discursively positions herself as a child and wants to engage in childlike behavior, such as "running around." As such, it was common for women to describe feeling resentment toward their newly ascribed adult positioning. For example, participants told us, "I don't want to be . . . a big girl, I want[ed] to stay as a child . . . you need to change your manner, the way of sitting . . . you can't play outside with your friends" (Iraqi) and "you can't play around like a child again . . . I didn't like having to grow up" (South Sudanese).

When further questioned about what being a woman meant, a number of participants disclosed constructions centered on marriageability and childbearing: "when the girls get their period they can be married to a man" (Somali):

> In South Sudan, when the girl has the first period, that means you are considered as a woman . . . it's associated with marriage . . . you're going to get married and you are going to have babies. (South Sudanese)

Consequently, for a number of women, a direct outcome of menarche was immediate marriage and childbearing. As one woman told us,

> I remember my uncle's wife told my dad [that I had my first period] and that is how I got engaged and married by 14. Before knowing anything I was already a mother . . . I didn't get a chance to know when I was a girl, when I was a woman and when I was a mother. (Afghani)

As is evident in the above account, the majority of women did not position cultural norms of early marriage and childbirth positively. One participant reported that it caused her great anxiety: "I was scared because I knew that they are going to be forcing me to get married, and I wasn't prepared for it, I was scared to be a mum" (South Sudanese). Early marriage and childbearing also had consequences in the formation of a woman's identity and the opportunities available to her. The above participant went on to say, "I had my first one [child] when I was 17 . . . you spend your time looking after the children, nothing else, [it's] not about you" (South Sudanese). Similarly another woman said,

> I got married so young that I feel like all my opportunities were really taken away from me. I wanted to be a dentist for example . . . but then the moment I got married, I got pregnant and I had kids . . . I could have been a person, and instead I'm just a mother and a wife. (Afghani)

The perilous pubescent. "Becoming a woman" was aligned with women's nascent sexuality, and fear of pregnancy in those who were not married. Participants repeatedly disclosed being warned to "avoid boys," "be more careful," and "watch your steps" after menarche. Such cautionary advice was predominantly delivered by mothers and was frequently at the forefront of girls' menstrual education, as one participant said,

> My mum always told me . . . when you get the period, don't come closer to the men, don't sit with the men . . . if you sit

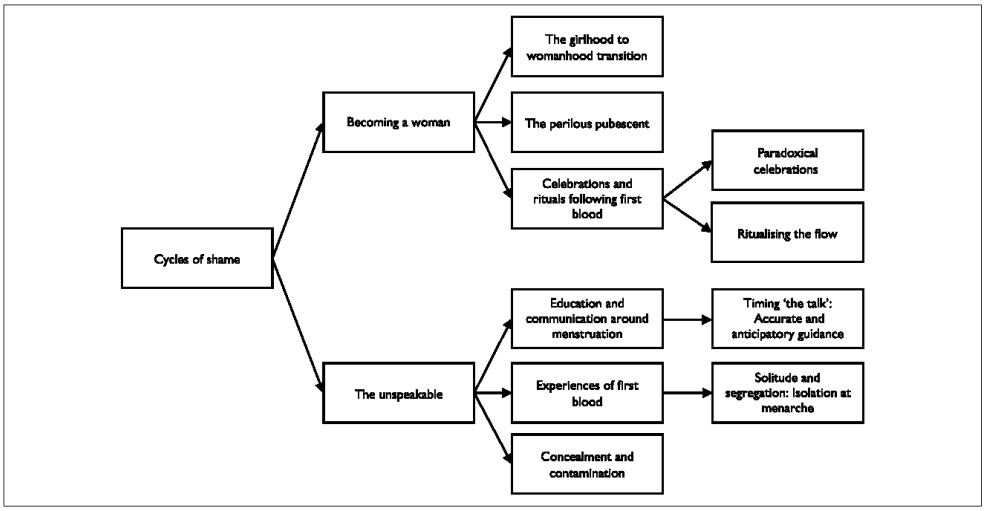

Figure 1. Thematic map.

> with the men or talk closer to the men, you're going to fall pregnant . . . once I got it, I was scared of men because my mum always told me these stories. (Sudanese)

When another participant was asked what would happen if you "get closer" to men following menarche, her response was, "men can rape you and you can get pregnant and in my religion a woman is not supposed to get pregnant before she is married" (Somali). The urgency of marriage following menarche was also positioned as a way to maintain family honor: "they are afraid for their honor on your own" (Iraqi); "after I got my period I have to get married because I might get pregnant" (Sudanese). Without the protection of a husband to "take care of sexual things" women were deemed "at risk" of being tempted into premarital sex and falling pregnant, a culturally intolerable act. However, warning messages received by menarcheal girls were often difficult to understand, given absent or incomplete information about the association between menstruation, sex, and pregnancy, as one woman commented, "they don't give any information . . . like any sexual relationship or anything . . . they won't tell" (Tamil). For in being told not to "go around with," "do a mistake," or "play with" boys, young women were given the erroneous impression that any contact with men can make you pregnant.

Although women could attempt to conceal their menstruating bodies to avoid pubertal sexualization, breast development is an overtly visual signifier of pubertal womanhood. Across most cultural groups, women reported being self-conscious of their developing breasts and inherently positioned them as something that they must conceal from the public eye, as one woman told us, "I was mainly concerned about my breasts, I was very shy, and I was wearing loose clothes and was careful about that" (Afghani). In societies where women are encouraged to be sexually invisible to men other than their husband, the prospect of their breasts being an object of male desire can be experienced as shameful. This was reflected in accounts of women describing the pubertal growth of their breasts as anxiety provoking. For example, "I used sticky tape, scarves, and other things to tightly wrap my breasts close to my body in order to flatten them; I also used to hunch my back so they don't show" (Iraqi); "I was really embarrassed . . . when my breasts was coming, I was very shamed" (South Sudanese). These accounts highlight how participants did not want to be in the sexual gaze of others, particularly men, and consequently went to great lengths to cover their developing reproductive bodies.

Celebrations and rituals following first blood

Paradoxical celebrations. Although most women we interviewed reported having experienced menarche as a private and personal affair, menarche celebrations did occur within some cultural groups, predominantly the Tamil and South Sudanese context. Traditional celebrations practiced included prayer, ceremonies, parties, and animal sacrifice. For example, participants told us, "the 30th day we celebrate and invite our cultural people, relatives and friends" (Tamil); "they call adults and girls like

you to come . . . they cut a cow or a sheep for people to eat" (South Sudanese);

> When you have the first period, you don't keep it as private. You have to tell your family . . . they celebrate it . . . young girls my age will come and you will be treated like you are getting married . . . sometimes it can go for seven days [of] celebration. (South Sudanese)

Most participants positioned menstrual celebrations as a public recognition of their entry into womanhood: "just marking that she has become a woman" (South Sudanese); "it's welcoming to adulthood" (South Sudanese). In other cases, participants disclosed that they "don't know" the reason for menstrual celebrations or believed their purpose has changed over time:

> Now it's like they do these things for fun . . . before, I think my parents' time . . . they do this sort of celebration to show the other people, I've got a girl . . . whenever you are ready, you can marry that girl. (Tamil)

Participants' revealed obvious discomfort in the role that menstrual celebration played in announcing to the wider community that they were now "menstruators." For example, when asked about their emotional responses during menstrual celebrations, embarrassment was a common response: "I was really shy you know it's not good when people come over and say oh, she got [her] period, now she's a big girl" (South Sudanese); "I felt embarrassed . . . in our country . . . they think she become like a menstrual girl . . . [they] look at you in like a different way" (Tamil). In an Australian or Canadian context, celebrations were largely positioned as being redundant, outdated or inappropriate, with no sense of loss. For example, one participant said, "now, no one actually prays or cares, like, if you don't tell anyone, who cares" (South Sudanese). Other women told us,

> My daughter . . . she said, why do you want to have a function for getting a period . . . I also realized that it's true. It's the normal process in the body, so why should we have [a] party . . . I'm not going to follow it. (Tamil)

"They grow up in Australia and they see it's not [an] appropriate thing to announce" (South Sudanese). In another account, a woman living in Australia said, "they call it a Saree Party here" (Tamil), referring to the "coming of age" party in a Western context where a girl wears a saree for the first time. These findings suggest that for a minority of women, where menstrual celebrations do continue to occur, they might do so in an adapted form.

Ritualizing the flow. Across most cultural groups, women could describe traditional rituals that took place at menarche and during menstruation. These included ceremonies with leaves, dirt and water, slapping, dietary changes, flour hand dipping, changes to showering, and wearing of new clothing. For example, participants told us, "the mother should put her daughter's hand in the bag of flour. They believe that if I didn't do that . . . something bad will happen to me" (Iraqi); "they put some tree leaves around her hand . . . to wish the girl luck to get married and have children" (Sudanese); and "they made me sit on a heap of dead leaves and poured water on my head" (Tamil).

Although most participants said the practice of restrictive bathing during menstruation was considered something of the "old days" and of their "grandmothers" era, there were still a small number of Iraqi women in this research who changed hygiene practices during their monthly menstruation. For example, "by three or four days I take a shower. When the bleeding is little I take shower . . . it is not good for the back" (Iraqi). In such accounts, women attribute increased menstrual flow and menstrual pain to showering, thus avoiding the practice during menstruation. Similarly, Afghani women described avoidance of cold drinks to prevent menstrual pain: "[avoid] cold water . . . if a woman watches out for these things she won't have any bloating, she won't have any cramps" (Afghani). Although some food avoidances continued with monthly bleeding, Tamil women also reported specific dietary changes associated with menarche:

> They don't give any spicy food, no chilli . . . first they give us the raw egg, not the boiled, raw egg and the sesame oil. That's what I did with my girls here in Australia . . .[in] our culture they believe there's a wound inside because of the new eggs produced and it [has to] come out, the blood and all that, to heal. This helps the changes to loosen that blood to come out. (Tamil)

This account illustrates the cultural construction of menarche as a time when women have an internal wound that needs healing. Dietary changes were also positioned as a means to strengthen the reproductive system and avoid menstrual pain: "they think that it directly works with the womb you know the reproductive system will get the strength" (Tamil); "I had everything [special foods] because I was told I will have less stomach pain" (Tamil). One participant described continuing to give her daughter raw eggs during menstruation: "here I give my children only one egg a day, over there three eggs a day" (Tamil). However, another stated, "just a fresh egg . . . they think it's healthy, but after I came here I know it's bad, because it's not even boiled, it's not good for the health" (Tamil). These accounts highlight how women might continue adapted versions of traditional rituals with their daughters, or dismiss certain rituals on arrival to their new countries of residence.

Cycles of Shame: The Unspeakable

"The unspeakable" dually describes women's inability to talk about menarche and menstruation, and its discursive positioning as disgusting and polluting. "Education and communication around menstruation," "experiences of first blood," and "concealing the contamination" are three subthemes beneath the dominant discourse of "the unspeakable."

Silence and secrecy: Education and communication around menstruation. Throughout the interviews, women commonly described an absence of discussion surrounding menstruation, as evidenced by the following accounts: "nobody tells us, nobody talk about it" (Somali); "we don't really talk about stuff like that" (Afghani). A number of participants stated that the reason menstruation was not discussed was because of shame and wider disapproval from family and friends: "they think it is shameful, it's disrespectful, you don't have respect for yourself" (Afghani); "women's monthly period . . . people don't talk about. In Sudanese culture it is shame to talk about it" (Sudanese). In one account, a participant described how those who do choose to discuss menstruation are considered deviant: "if we share these things those girls are like naughty girls, so we never share anything" (Tamil). Women also positioned menarche as something they were "not allowed" to talk about, and in some instances were shocked to learn about it: "it was shameful for me to even listen to this kind of stuff" (Afghani). In this vein, some women engaged in self-policing to regulate their own reproductive health knowledge:

> When topics like this came up, we would generally keep away from it and not involve ourselves too much in these talks . . . it's not very good for women or girls to be focused on this kind of gossip. (Afghani)

For nearly a quarter of women interviewed, school was where they had first learnt about menarche, and for some women, this remained their only source of menstrual education and information:

> I did not have enough information, they taught us at school basic information not in details to understand or learn about bleeding . . . information about a woman's body in general, woman body diagram, and how the women bleed every month, it was very simple, at home no one told me about it. (Sudanese)

As illustrated by this account, women commonly disclosed being dissatisfied with the explanation and support they received from school. In the above account, it was described as "very simple," others stated information "wasn't clear," was "very brief," and "corporate." Nearly half of the women interviewed in the present study also received little or no preparatory menstrual education or support from their mothers, in most cases because it was considered too shameful a topic to discuss. For example, "nobody tell me nothing . . . it's not only my mother . . . all mother[s], they didn't share" (Somali); "our mother's from the old generation so she didn't give me any information about it" (Iraqi). In another example, when one woman questioned her mother about menstruation, her mother's response was, "don't worry about these stuff and never ask me questions like this again, it is not your business" (Afghani). Women were further denied information by being excluded from adult conversations that might have imparted menstrual knowledge, as one woman told us, "she [mother] said it is shame . . . when they speak about pregnancy or menstrual period, she said, go to other room" (Iraqi). When asked the reason for such reluctance on the part of mothers, it was described as a "cultural thing" which could not be challenged, as one woman said,

> They are very secret about this stuff, they don't talk about that to us . . . I don't know why it is that belief, but still my mum doesn't talk about that, yeah, about periods or childbirth or anything, we don't talk openly. Maybe it's a cultural thing. (Tamil)

At the same time, many women described having felt discomfort in approaching their mothers with regard to information about menstruation: "I would be very embarrassed to talk with my mum" (South Sudanese); "out of shame I couldn't, [I] didn't know how to approach her about it" (Afghani). Consequently, a number of women did not seek information about menstruation at all: "No, I did not ask anyone. I decided to deal with myself, I was shy to ask, I feel shame" (Somali). Other participants described accessing information from other women family members, such as sisters or aunts, or close girlfriends: "I couldn't talk to my mum . . . that was a very hard topic . . . but I can talk to my friends" (Sudanese); "my older sister was more playing the role of a mother" (Latina).

Timing "the talk": Accurate and anticipatory guidance. When information about menstruation was provided, it predominantly occurred at the time of menarche, when such conversation was unavoidable. A small number of participants did report turning to their mothers for support following menarche and described having had sufficient information. However, a large majority reported having felt disappointed or inadequately informed. For example, one woman told us, "my mother is an educated woman, she is a dentist, yet she summed the whole subject in 5 minutes and did not mention it again. She was shy to speak about such subject" (Iraqi). Many women

described topics covered by their mothers as being messages of warning, the need for concealment, and practical management, with an absence of the physical and emotional care women needed. For example, "I remember she didn't even give me a cuddle or comfort me. She just quietly put a very ugly and scary fabric inside my legs and told me to not tell anyone about it" (Afghani); "she did not tell me anything about changing feelings, she told me very little and did not talk about it much" (Iraqi). In other instances, the information that participants described receiving and relaying to their daughters was incorrect, or women were unsure of its meaning. For example, one participant's mother told her "not to sit anywhere dirty during our period because . . . everything is sort of open and you can get all kinds of infections" (Afghani). In another account, a participant described telling her daughter who began menstruating in Australia:

> I said ok if you want my advice when you got your period . . . you can't let the boy touch you . . . I told my daughter, she do it now . . . I don't know whether it is good or bad, I don't know. (South Sudanese)

The absence of education from mothers and at school meant that at the time of menarche many women reported they had poor knowledge about the function of menstruation in relation to reproduction. For some, it was not until well into their menstruating years that they became aware of the role menstruation had in childbearing: "I just know when we grew up aged 20 years, that's when I know this makes this" (Somali); "I really I didn't know until I became pregnant with my first son" (Iraqi). As a consequence of receiving little or no menstrual education themselves, many women disclosed being more open or wanting to be more open with their own daughters during menarche. For example, "I treat my daughters not like my mother treated me . . . I don't want them to be shocked, like I was" (Iraqi); "I want to avoid what happened to me when no one told me, so I told my daughter she already knows" (Sudanese). However, some of the mothers interviewed disclosed being "shy" to talk in depth with their daughters or "unsure" when the right time was to address menstruation:

> We were raised. . . we're shy from those matters and even I can't talk to my daughter frankly and tell her what happened . . . I tell her about the period, and I tell her about the baby, but not the long procedure . . . I think I felt embarrassed. (Iraqi)

In another account, a women described wanting to discuss menstruation with her 11-year-old daughter, but not knowing when or how: "until now I haven't said anything to her about it . . . I don't want her to experience the same as what I had . . . but I don't know when, and where and how" (Iraqi). As a result of the same concerns, another participant described attending a women's health course where she was provided with the appropriate information to support her daughter:

> I was scared and shy to talk about this topic . . . I went to a migrant resource center and there was a lady . . . she talked about the periods and how to tell their daughters. I learnt from that session and it encouraged me to tell my daughter. (Sudanese)

In another example, a participant disclosed wanting to talk to their daughters in the future but only when they are "old enough" by cultural standards: "I will explain to my daughters . . . at an age of you know, nine, ten. No younger than that because I think I'm still following the culture" (Afghani). These accounts highlight that although many mothers would like to educate and support their daughters through menarche, given their own poor experiences of menstrual education, they might lack the knowledge and confidence to do so at an appropriate time.

"When I got my period, my heart kind of broke": Experiences of first blood. In line with the finding that nearly half of all participants received very little or no preparatory menstrual education, most described having experienced negative emotions toward their first menses. Participants used strong emotive language such as "shocked," "scared," and "shame" when recalling these experiences: "I didn't know anything about bleeding . . . I was shocked" (Somali); "I felt ashamed, I felt scared, and I thought something abnormal happened to me" (Sudanese). Women without menstrual education were also more likely to construct their first menstrual blood as being an injury, illness, feces, or urine. For example, "I thought I might have had an accident and peed my pants" (Afghani); "I had no idea what menstruation meant . . . I was kind of horrified that something was wrong with me or I might have hurt myself" (Afghani). Other women positioned their first menses as a form of punishment: "I thought I had done a sin or something really bad" (Afghani); "I was thinking it might be something that I have done and I might be in trouble" (Afghani). These accounts demonstrate how menstrual blood can be constructed as evil and corrupting in the absence of information about its natural biological function. The internalization of such constructs not only positions women's reproductive corporeal bodies in a negative light but also might add to fear and feelings of shame.

However, not all experiences of menarche were negative. Women who were provided with adequate menstrual information prior to menarche described their first menstruation more positively. For example, "I want to have it, it was okay because my mum used to explain for me. I

used to see my aunties, yeah, it wasn't that bad" (Somali); "I knew about it before . . . I have a sister she is older than me and that's why, she told me, I didn't get surprised by that because I knew" (Iraqi). These accounts reiterate how menarche experiences are shaped through the provision of menstrual education and familial support girls receive prior to and during menarche.

Solitude and segregation: Isolation at menarche. For a number of Tamil women, the menarche celebrations described above occurred following a period of seclusion, reflecting a complex cultural construction of menstruation: "I was made to stay in the room for one month until they had the ceremony" (Tamil); "she moved me to a smaller room in the house and asked me to stay there and not to come out . . . I was locked up in the small room . . . for 11 days" (Tamil). Although some participants who had experienced menstrual seclusion positioned it as being "natural" and something that happens to every woman, others found seclusion challenging: "you can't go outside that was tough" (Tamil). Interviewees provided few explanations for menstrual seclusion; however, one participant described it in terms of the need for recuperation, drawing again on the concept of an internal wound: "there is some wound inside and the wound has to be healed, that's why they keep the girls in the room" (Tamil). Another participant commented, "because I was only nine years old, my parents thought I'm not ready to go to school because of the body changes . . . so they kept me nearly 4 months" (Tamil).

In addition to enforced isolation, many participants reported self-isolation, positioning menarche as something they were unable to communicate about with others. For example, women told us, "when I first got my period I went away and cried, nobody knew I was crying, I hide it, I cry, I still remember" (Somali); "there was a little dark room, and I would go there and I would lay out a mattress . . . and I would just sit there and cry" (Afghani). A number of participants also described not disclosing to mothers and family that they had begun menstruation, as they felt "ashamed" or "shy." As a consequence, some participants described menarche as being a lonely time: "it was a very sad situation because I was very, very lonely" (Latina), and positioned their menarche experience in a negative light, "I never wanted to remember this day again and I kept praying, oh god never ever let this happen to me again" (Afghani). In combination, these accounts suggest that associations between menstruation and shame or secrecy might be reinforced by menstrual seclusion, whether it is a cultural practice or self-enforced.

"When I got the period I always wear dark clothes": Concealment and contamination. Throughout women's accounts, menstrual blood was nearly always constructed negatively. Participants repeatedly positioned blood as "disgusting," "dirty," "awful," and "not clean." One participant said,

> It was disgusting . . . because it's blood . . . you can smell there is something different . . . I found in my bed some blood, so I tell my family, I can't sleep on this bed. They wash it, and I said . . . you have to change it, so they change the whole bed because of that . . . because the blood has come from the vagina, so I think it's dirty. (Iraqi)

This account captures the disgust a woman reportedly had about her own fecund body, resulting in her positioning menstrual blood and her vagina as abject. One of the consequences of menstruation being constructed as polluting and contaminating was women's desire to conceal their menstruating bodies from the wider world: "I started to wear dark colors when I get my period. I do not wear whites at all . . . it will look disgusting when it stains" (Iraqi); "my mother told me to wear more black when I get my period" (Afghani). Many women described feelings of self-consciousness and greatly feared leakages, resulting in frequent visits to the bathroom:

> I was cautious or conscious of getting my dress dirty so I would go more frequently to the wash-room. I was afraid of my dress getting stained. It is a big problem, how can you get out of school? It was like a shame. But it wasn't only me; all the girls felt this way. (Sudanese)

It is likely that the fear of leaking is further accentuated given the intolerance of visible menstrual blood and the threat of humiliation if this occurs: "my mum told me . . . make sure that it doesn't spoil your clothes, because people will laugh at you . . . they will scald you" (Somali). Not only did women have to wear dark clothes to counteract the possibility of leakage but also loose clothes were essential to hide any evidence of menstrual products: "they told me that when I have menstruation, try to avoid wearing tight clothes in order to avoid the pads to appear from your tight clothes" (Iraqi).

The onset of menses was also found to introduce restrictions into girls and women's domestic lives. For example, three Sudanese women described the inability to enter the kitchen and carry out normal household duties while menstruating, even following migration: "you can't cook, you can't wash dishes, you can't clean the house for one week until you are clean" (Sudanese). Although such restrictions might reinforce the notion of menstruation being dirty, one Sudanese woman viewed such restraint in a positive light given it meant she had a break from her usually demanding household activities: "seriously for me, it's good, because I can relax" (Sudanese). Such examples were unique to Sudanese women and demon-

strated how some women can position menstrual restrictions positively.

Nearly all women described sex during menstruation as strictly prohibited. Reasons for such restrictions on sexual activities included sex being "unhealthy," "harmful," and "dirty" when a woman is bleeding, and sexual abstinence being religiously sanctioned. For example, one woman said, "when it comes to religion, in Islam a man and a woman should not have sex when a woman is having their period, it is dirty, you are dirtying yourself" (Afghani). Women reported feeling shameful and embarrassed about their menstruating bodies, particularly with regard to the smell of menstrual blood:

> No penetration, this area is dirty and full of microbes during the period. Excuse me, but the smell no one can tolerate it . . . we know that our bleeding is dirt inside our body and it's being discharged, yuck. (Iraqi)

In addition, menstrual sex was avoided as women considered it inappropriate for men to witness their menstruation: "I never be near to my husband, this is a type of respect to him as a man. I don't like him to see something not good in me" (Iraqi). In another account, a Latina woman attributed avoidance of menstrual sex to her partners dislike for menstrual blood: "[men] feel disgusted by the smell of the blood . . . my husband, he hates the smell of blood . . . he's so disgusted and so grossed by our menstruation". These accounts reinforce the construction of menstruation as something that must be concealed from men, given its discursive position as something dirty and unpleasant. Only one participant countered such constructions, and positioned menstrual sex as acceptable, despite acknowledging common discourses of such practice being unhealthy: "both of us did not mind intercourse during the period despite the fact that it is said to be unhealthy and wrong to have intercourse" (Iraqi).

Many women also described prohibition from religious activities, such as visiting the mosque, temple, or church; praying; touching the Koran; participating in religious ceremonies; and observing Ramadan, when menstruating. For example, "these days we can't go to the temple" (Tamil); "praying is for when you're pure and clean and you're respecting yourself in front of God" (Afghani); "it's totally forbidden when a woman is having her period, she is not supposed to touch the Koran" (Somali). Some Muslim women reported that they were required to undertake a cleansing bath before resuming religious activities, because menstrual blood was polluting. Ritual bathing after the cessation of bleeding was assumed to restore "purity": "when you have your period, before you've cleansed yourself, you're not allowed to pray or read the Koran" (Afghani). Religious prohibitions and the requirement of ritualized bathing thus reinforce the construction of a woman's reproductive body as unclean and polluting, and herself as lacking purity.

Discussion

This article has examined the construction and experience of menarche and menstruation among migrant and refugee women who had recently migrated to Australia and Canada. Although participants were of differing cultural and religious backgrounds, they expressed similar negative constructions of the material event of menarche and menstruation, drawing on broader cultural discourse, positioning it as shameful, something to be concealed, and polluting.

Menarche and Sexuality

Menarche is a time of significant psychological and sociocultural adjustment, potentially leading girls to reconceptualize their identity as women within the patriarchal societies they live (Jackson & Falmagne, 2013). It is discursively positioned as a marker of adulthood and reproductive maturity across many sociocultural contexts (Ussher, 1989), as found in the present article. However, as reported in previous research conducted with culturally diverse women (Orringer & Gahagan, 2010; Uskul, 2004), many participants experienced this new adult positioning as overwhelming or unwanted, because of the sudden social and behavioral restrictions and the expectation that they would display hegemonic feminine behaviors. These accounts demonstrate that through a women's fecund body, she is integrated into the social and sexual order (Lee & Sasser-Coen, 1996; Ussher, 1989), which for some resulted in a sense of lost childhood and negative attitudes toward menstruation.

"Becoming a woman" was discursively linked to marriage and childbearing, with being a wife and mother a cultural imperative shared by all participants; for women in this study, menarche signified that girls were now marriageable. For some women, particularly those who originated in Afghanistan, getting married and having children were immediate material outcomes of menarche. As reported in previous research, this was to prevent women from engaging in unlawful practices, such as premarital sex and pregnancy outside of wedlock (Raj, Gomez, & Silverman, 2014; Schuler, Bates, Islam, & Islam, 2006), a potential threat to family honor, and to protect them from unwanted sexual advances of men. In prior research, menarche has similarly been documented as a time in which young women's emerging sexuality is discursively positioned as problematic (Lee, 1994; Teitelman, 2004). However, focusing on warning messages and the avoidance of men following menarche, with no concomitant explanation as to how menstruation is linked to pregnancy, has been found to be

confusing for young woman (Costos et al., 2002) and might lead to fears that any expression of sexuality would lead to pregnancy and thus a loss of reputation (Ussher, 1989). This could have negative implications where young women associate their developing bodies and sexuality with shame, danger, or victimization (Mason et al., 2013; Teitelman, 2004).

Within androcentric societies, pubertal women learn quickly that their developing bodies are objects of the male gaze and a signifier of sexuality (Lee & Sasser-Coen, 1996). As a consequence of such positioning, in line with earlier research with women from non-Western backgrounds (Golchin Nayereh, Hamzehgardeshi, Fakhri, & Hamzehgardeshi, 2012; Mason et al., 2013), participants in this study described being self-conscious of the sexualization of their bodies at menarche, particularly breast development, positioning it as being shameful. Accounts in this research are contrary to those of Western women, where the development of breasts has been reported to be seen as an asset (Lee, 2009), a finding that is likely a reflection of the increasing sexualization of girls and emphasis on breasts in the media among Western cultures (Graff, Murnen, & Krause, 2013). Given many participants in this research did not receive adequate pubertal education from their families or at school, girls might have lacked both the subjective and cognitive knowledge to make sense of their developing bodies and sexuality (Beausang & Razor, 2000; Martin, 1996), thus resulting in anxiety and body shame. This can have implications for the way these women communicate about sexuality with their own daughters (McMichael & Gifford, 2009).

Celebrations and Rituals

As reported in previous research, among women of varying cultural backgrounds (Chrisler & Zittel, 1998; Uskul, 2004), we found the practice of menarche celebrations uncommon, with the exception of Tamil and some South Sudanese women. Women who experienced celebrations positioned their purpose as one of "welcoming into womanhood." However, although wider society might value such celebrations, it does not mean the menarcheal girl will view them in the same light. Menarche is generally considered a personal event, and many girls feel anxious about people knowing they are menstruating, thus go to great lengths to conceal it (Jackson & Falmagne, 2013; Lee, 2009). The discomfort with menarche celebrations reported in our study might therefore be associated with the public sharing of an intimate bodily process and being "viewed differently" among their communities. Even though menarche celebrations might attempt to promote positive messages, such as "welcoming" into womanhood, women are simultaneously receiving stigmatizing messages about the taboo nature of menstruation, a bodily function to be contained and hidden (Johnston-Robledo & Chrisler, 2011).

The discursive positioning of menarche celebrations in this study was shaped through the intersections of culture and migration. Following migration, some women now viewed menarche celebrations as being inappropriate, as they are not practiced in the West, and therefore discontinued such practice with their daughters. Other women, notably in the Tamil community, showed evidence of adapted traditional celebrations, with a focus on having "fun" rather than announcing a women's marriageability to wider society, as traditionally intended. Such accounts highlight how women are negotiating multiple potentially conflicting discourses and modernization, affecting the cultural practices they choose to carry out with their daughters who enter menarche today.

Menstrual seclusion has previously been described among differing sociocultural environments (Crawford et al., 2014; Mendlinger & Cwikel, 2005). In this research, the material practice of seclusion was predominantly reported among Tamil women, and only occurred at menarche, primarily for the purposes of "recuperation." Similar to accounts of women in a study by Crawford et al. (2014), seclusion at menarche was described as challenging by some participants in our research. It is possible that in the absence of a coherent explanation of menstruation prior to menarche, menstrual seclusion might be confusing and lead girls to associate their menarche with isolation (Crawford et al., 2014).

As reported previously (Chang, Chen, Hayter, & Lin, 2009; Mendlinger & Cwikel, 2005; Sommer, Ackatia-Armah, et al., 2015), this study found culture specific rituals and dietary beliefs surrounding the consumption or avoidance of certain foods and drinks during menstruation. Similarities in rituals were expressed by women within each cultural group, highlighting how traditional knowledge surrounding women's health may be preserved and transmitted generationally (Mendlinger & Cwikel, 2005). These findings also emphasize the importance of considering cultural constructions of health and illness. Although menstrual rituals and practices described in this article might not align with Western views of medicine, changes in diet and hygiene during menstruation were considered key functions for the avoidance of increased menstrual pain and blood flow for a number of women who participated in this research.

Silence, Stigma, and Shame

Silencing menarche and menstruation acts as a reinforcer of the discursive positioning of a woman's bleeding as a source of stigma (Johnston-Robledo & Chrisler, 2011;

Ussher, 2006), and denies women the right to learn about the functioning of their reproductive bodies. Although menstrual talk is typically avoided, even in a Western context (Kissling, 1996), the implications of menstrual stigma are that menstruation is constructed as "unspeakable," as found in the present study across all cultural groups. As Chrisler (2011) argues, "stigma attached to women's bodies can divide women from each other and create conflict between 'good' and 'bad' women" (p. 8). Similar to previous findings (Al Omari, Abdel Razeq, & Fooladi, 2015), women in this research were positioned as "naughty" or "disrespectful" if they spoke about menstruation in public. Consequently, this created a collective silence among young women to avoid being labeled as "bad" and resulted in women feeling ashamed to ask about their experience of menarche. In addition, in some instances, discussion of menstruation was considered too shameful to listen to, thus women engaged in self-policing (Foucault, 1979) to regulate their own reproductive health knowledge. Findings of self-policing have previously been reported by migrant women in relation to receiving sexual health education (Wray et al., 2014). Self-policing of essential health knowledge, such as menstrual education, might result in women having limited understanding of their own reproductive bodies placing them at risk of poorer sexual and reproductive health.

In contrast to earlier research conducted in a Western cultural context, where mothers are described as "emotional anchors" during menarche (Koff & Rierdan, 1995; Lee, 2008), women interviewed in the present study across all cultural groups received little or no preparatory menstrual education or support from their mothers. Such finding supports that of previous studies with both Western and non-Western women (Al Omari et al., 2015; Cooper & Koch, 2007; Costos et al., 2002), highlighting that across sociocultural settings, menstruation continues to be discursively positioned as a shameful topic for mothers to discuss with their daughters, thus repeating intergenerational cycles of shame and secrecy (Bennett & Harden, 2014).

In parallel with previous research (Beausang & Razor, 2000; Uskul, 2004), the ways in which mothers reacted to girls at menarche was reported to have directly influenced a girl's experience. Where mothers did educate their daughters about menstruation, discussions were commonly described as "brief" or "unemotional," with a focus on menstrual rules, which can lead to girls feeling dissatisfied with their menarche experience and resentful toward their mothers (Costos et al., 2002; Uskul, 2004). Through participants retrospective accounts, we were able to see how migrant and refugee women, who experienced hegemonic discourses of shame toward menarche and menstruation, are now choosing to negotiate cultural secrecy and shame through menstrual communication and education with their daughters. As reported previously (Cooper & Koch, 2007; Kissling, 1996), many women who received poor quality or no menstrual support themselves intended to provide their daughters with menstrual education and counseling. At the same time, our finding that a substantial number of mothers wanted to educate their daughters, but were shy, uncertain, or had misunderstandings about how or when to approach menarche, suggests that migrant and refugee women may need support with addressing menarche with their young daughters. Conversely, some mothers passed on cultural beliefs that might reinforce menstrual shame and stigma, such as warning daughters to avoid being touched by boys during menses. This finding emphasizes the need for education sessions for mothers to ensure they have a sound understanding of menarche as a reproductive and emotional transition, as well as providing an opportunity to counter negative discourses of menstruation through positive representations of menarche and menstruation. Education sessions could also promote the discussion of menarche and provide constructive methods to enable mothers to approach daughters about this sensitive topic.

Although menarche is not always a smooth transition to womanhood, girls in the West seldom experience it with a complete absence of knowledge (Kissling, 1996), in contrast to the experience of women in the present study. In conjunction with poor maternal education, participants found menstrual teaching in school was frequently absent, inadequate, lacked practical support, or occurred when girls had already begun menstruating, a finding frequently reported in the literature with Western and non-Western women (Beausang & Razor, 2000; Cooper & Koch, 2007; Sommer, Ackatia-Armah, et al., 2015). In the absence of any framework to make sense of menarche, women associated their first menses with excrement, injury, and guilt, similar to those reported in previous literature in a Western context (Cooper & Koch, 2007; Lee, 2009). Negative constructions of menstrual blood lead women to feel humiliated and unclean, and might result in women developing ongoing associations between menstruation and contamination (Lee, 2009). An additional implication of being denied knowledge of their reproductive bodies meant a large portion of women were unaware of how menstruation was related to fertility, putting women potentially at risk of unplanned pregnancy (Koff & Rierdan, 1995). Consequently, it is important to ensure that menstruation is incorporated into sexual and reproductive health education available to all migrant and refugee girls and women. In addition, health care professionals should be aware that some newly arrived migrant and refugee women might not have adequate knowledge of their menstrual cycles in relation to fertility, and could require further explanation

and counseling during consultations when discussing topics such as contraception and pregnancy.

Contamination and Concealment

Although there are many cultural representations of blood, ranging from family and kinship, to violence and war, menstrual blood is almost always positioned negatively (Bramwell, 2001). Historically and cross-culturally, menstrual blood has been discursively constructed as being poisonous, magical, and polluting (Buckley, 1988; Laws, 1990). One explanation for this is because it exits the body from the vagina, a part of a women's body commonly represented as being unclean, shameful, and inherently sexual (Bramwell, 2001; Braun & Wilkinson, 2001). Experiences of shame and feelings of "dirtiness" toward menstrual blood are commonly reported in the literature (Donmall, 2013; Lee & Sasser-Coen, 1996) and are thus not unique to participants in this study. Understanding how women retrospectively experience and construct menarche and menstruation is important to recognize across all age groups, as negative experiences of shame could extend to influence how women view and experience ongoing aspects of their sexual and reproductive lives. For example, positioning menstruation as abject might mean women are reluctant to disclose menstrual cycle–related problems to their health care professionals, resulting in delayed diagnosis or treatment (Seear, 2009) and might impact on a women's ability to discuss abnormal vaginal symptoms when seeking medical advice (Braun & Wilkinson, 2001). To provide culturally sensitive care, it is essential that health care professionals are aware of cultural constructions of both the vagina and menstruation, particularly when considering the wider sexual and reproductive health of women (do Amaral et al., 2011), such as cervical smears.

Etiquettes of concealment, to prevent public knowledge of menstruation, were discussed at length within women's accounts, supporting previous research findings (Beausang & Razor, 2000; Burrows & Johnson, 2005; Uskul, 2004). Self-surveillance surrounding menstruation is likely to affect a woman's attitude toward her body and is energy consuming (Johnston-Robledo & Chrisler, 2011). In the context of this study, across cultures, participants' self-surveillance resulted in behavior changes during menstruation, such as frequent visits to the bathroom and missing school, a well-recognized consequence of being a menstruating woman in a developing country (Sommer, 2010). Menstruation also complicates the social construction of a woman's body as being attractive and objects of desire. Leaking bodies which "smell" do not fit the ideal feminine standards of beauty and thus the corporeality of the women's body must be repressed, contained, kept private, and outside the public gaze (Roberts & Waters, 2004; Ussher, 2006).

Women across cultures and religions are continually receiving paradoxical messages by which they are both demonized for their bleeding bodies, positioning them as unclean and polluting (Dunnavant & Roberts, 2013), but praised for their ability to procreate (Goldenberg & Roberts, 2011). When considering the intersections of gender and religion, the present study was no exception, with many women continuing to avoid activities during menstruation due to religious beliefs, even following migration. Although the prohibition of women from religious activities or places of worship during menses was seen across Hinduism, Christianity, and Islam, some practices were specific to participant's religious and cultural backgrounds. For instance, some Afghani women viewed menstruation as being so contaminating and unclean that only a religious bathing ritual following menses could neutralize such threat. Although similar findings have been found among Orthodox Jewish women who report practicing bathing rituals to restore purity after menses (Guterman, 2008), no other cultural groups in this study reported similar practices.

Although ritual bathing is uncommon in a Western context, the taboo nature of menstrual sex reported in women's accounts has been found in the West (Allen & Goldberg, 2009). Avoidance of menstrual sex is reported for reasons of "mess," negative self-perception, and partner's disgust (Fahs, 2011). Even though our participants shared some of these concerns, their primary reason for refraining from sex during menstruation was again centered on religion, particularly for women who practiced Islam. The exclusion of women from religious activities and sexual intimacy could be frustrating for women (Guterman, 2008) and might lead women to internalize feelings of shame and inferiority toward their own bodies (Crawford et al., 2014). However, not all exclusions currently practiced by women were experienced or positioned negatively, highlighting how menstrual restrictions occur paradoxically (Dunnavant & Roberts, 2013). In a Western context, the inability to enter the kitchen during menstruation could be positioned as being repressive; yet, for some Sudanese women, in this research, the cultural expectation to refrain from cooking during menses was found to be a welcomed break. In a similar light, women who are banished to menstrual huts during menstruation might position such cultural restriction as an opportune time to socialize with other women and a relief from their busy domestic lives (Mendlinger & Cwikel, 2005).

There are a number of strengths and limitations of this study. Strengths include participants being interviewed in

their first language meant women could explore their experiences in depth and were not limited by language. This also allowed for participation of women who were newly arrived to Australia and Canada and might not be fluent in English, and whose experiences are often ignored as a result. Interviewing women from diverse cultural groups made both within and between comparisons possible, an important element for the development of appropriate heterogeneous health promotion and education activities for migrant and refugee women. Limitations include the fact that researchers could not back-check translated transcripts for accuracy. Furthermore, meanings and discourses about menarche and menstruation may have been lost through the process of English translation given we could not analyze menstrual related terms in participant's first languages. Women were also retrospectively reflecting on their experiences; thus, stories shared in this research might not necessarily be illustrative of girl's experiences of menarche and menstruation in their countries of origin today. Lastly, given we spoke to a small subset of women from each cultural group, experiences and constructions of menstruation might not be representative of their community as a whole.

In conclusion, through the use of a material-discursive theoretical framework, we were able to examine women's constructions and experiences of the materiality of menarche and menstruation, in the context of cultural and religious discourse which provided meaning for such events. The current research demonstrates that there are many commonalities in migrant and refugee women's experiences and constructions of menarche and menstruation, as well as some differences across cultures, reinforcing the importance of considering intersections of gender, culture, religion, and migration in shaping the subject positions women take up in relation to the reproductive body. Our study findings highlight that as a result of menstrual shame and stigma, many women across cultural groups experience menarche with a complete absence of knowledge about their bodies, and within patriarchal societies, particularly those who follow strict religious doctrine, women might be more likely to consider menstruation as shameful and polluting, resulting in negative attitudes toward the corporeality of their bodies. This research has demonstrated that some migrant and refugee women arrive in host countries with little or no knowledge of menarche and menstruation, highlighting the importance of appropriate menstrual education as a part of sexual and reproductive health education, for young girls and for mothers to transmit to daughters. Our findings reiterate the importance of considering culturally specific experiences and constructions of menarche and menstruation given their possible implications on help seeking health behaviors and the wider sexual and reproductive health of migrant and refugee women.

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Note

1. The term "culturally and linguistically diverse" (CALD) is used in Australia to describe people who have a cultural heritage different from that of the majority of people from the dominant Anglo-Australian culture (Australian Government Department of Health, 2016), replacing the previously used term of people from a "non-English speaking background" (NESB). As this term is not used in Canada, we are defining our sample as "migrant and refugee women."

Supplemental Material

The online supplemental Table 1 is available at http://qhr.sagepub.com/supplemental

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Appendix J: Premarital Sexuality Published Journal Article

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Regulation and Resistance: Negotiation of Premarital Sexuality in the Context of Migrant and Refugee Women

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Constructions of normative sexuality shape the sexual scripts that women are permitted to adopt and the manner in which such sexuality can be expressed. We explored experiences and constructions of premarital sexuality among migrant and refugee women recently resettled in Sydney, Australia, and Vancouver, Canada. A total of 78 semistructured individual interviews and 15 focus groups composed of 82 participants were undertaken with women who had migrated from Afghanistan, Iraq, Somalia, South Sudan, Sudan, Sri Lanka, and South America. We analyzed the data using thematic decomposition. Across all cultural groups, women's premarital sexuality was regulated through cultural and religious discourse and material practice. Such regulation occurred across three main facets of women's lives, shaping the themes presented in this article: (1) regulating premarital sex—the virginity imperative; (2) regulation of relationships with men; and (3) regulation of the sexual body. These themes capture women's reproduction of dominant discourses of premarital sexuality, as well as women's resistance and negotiation of such discourses, both prior to and following migration. Identifying migrant and refugee women's experiences and constructions of premarital sexuality is essential for culturally safe sexual health practice, health promotion, and health education.

Across sociocultural settings and epochs, constructions of normative sexuality vary, influencing women's subjective experiences of sexual identity and sexual practices (Ussher, 1997; Weeks, 2014). Cultural ideologies and social practices are transmitted through language and representations, known as discourses, or discursive practices (Burr, 2015). An exemplar of cultural variance in discursive constructions of sexuality is the contrast between the acceptance and widespread practice of premarital sexual activity among the majority of people in secular countries, such as Australia and Canada, and its condemnation in many religious non-Western cultures globally. For example, in a national survey of Australians, the majority (87%) of men and women reported that they accepted sex prior to marriage as the norm (de Visser et al., 2014). The median age of first sexual intercourse in Australia is 18 for women and 17 for men (Rissel et al., 2014) and the average marriage age is 31 years old (Australian Bureau of Statistics [ABS], 2015), suggesting that a high proportion of individuals are engaging in premarital sex. These liberal attitudes toward premarital sex are associated with comprehensive sex education through the mainstream schooling system, which is strongly supported by parents (Berne et al., 2000; McKay, Byers, Voyer, Humphreys, & Markham, 2014), as well as widespread provision of preventive sexual health measures, such as the human papillomavirus (HPV) vaccine, to young people (Markowitz et al., 2012). Access to contraception for unmarried women is also the norm in both countries, reflected in the fact that many young and unmarried women are currently using some form of contraception (Black et al., 2009; Family Planning New South Wales, 2013).

It is important to acknowledge, however, that while Australia and Canada may be fairly tolerant toward premarital sex, this is not the same across all Western contexts. In the United States, for example, adolescent sexuality is regulated through the influence of conservative Christian institutions, which shape the continued cultural and political value of premarital virginity (Williams, 2011). This influence has resulted in the majority of state and federal policies supporting abstinence-only sexual health education programs within schools (Fine & McClelland, 2006; Weaver, Smith, & Kippax, 2005). Such lack of comprehensive sex education is thought to contribute to higher rates of teen pregnancy and sexually transmitted infections (STIs) and lower rates of contraception use compared to other developed countries with more pragmatic and sex-positive attitudes toward sexual health education (Weaver et al., 2005).

Among some contemporary Muslim societies in the Middle East, Asia, and Africa, the regulation of women's sexuality is more explicit. The significant value placed on a woman's virginity strongly shapes women's expression

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of sexuality, romance, marriage, gender relations, and gender equality (Hélie & Hoodfar, 2012; Khan, 2012). Such findings have similarly been found within Hindu cultures (Menger, Kaufman, Harman, Tsang, & Shrestha, 2015; Regmi, van Teijlingen, Simkhada, & Acharya, 2011) and a number of Christian cultures, such as those in South America (Espinosa-Hernández, Bissell-Havran, & Nunn, 2015; Hoga, Tibúrcio, Borges, & Reberte, 2010). Within these societies, a women's premarital chastity stands as an important marker of her own honor and that of her family (Bennett, 2005; Kaivanara, 2016). In some Muslim contexts, governmental policies and practices aim to control women's sexual autonomy and confine any expression of sexuality to the institution of marriage (Bennett, 2005; Khan, 2012). The existence of moral police authorities, who are employed to reinforce adherence to such regulations, combined with strict sex segregation and the severe surveillance of women and their sexualities, act to control women's expression of sexuality and sexual agency (Kaivanara, 2016; Yaghoobi, 2012). In these cultures, sexuality is considered a very private matter, closed to discussion, particularly for unmarried women who are culturally and religiously expected to be asexual until married (Ghanim, 2015; Shalhoub-Kevorkian, 1999).

What has not been sufficiently explored is how migrant and refugee women from culturally and linguistically diverse (CALD)[1] backgrounds negotiate competing discursive constructions of premarital sexuality when migrating from cultures where a discourse of sexual agency and acceptance of premarital sex is less prevalent to countries with more liberal attitudes and practices, such as Australia and Canada. This was the aim of the current study. To address this issue, the following research questions were asked:

RQ1: How is sexuality prior to marriage constructed and experienced among recent migrant and refugee women living in Australia and Canada?

RQ2: What are the commonalities and differences across a range of cultural groups?

RQ3: What are the implications of these constructions and experiences for the sexual and reproductive health of migrant and refugee women?

[1] The term "culturally and linguistically diverse" (CALD) is used in Australia to describe people who have a cultural heritage different from the dominant Anglo Australian culture (Australian Government Department of Health, 2006), replacing the previously used term of people from a "non-English-speaking background" (NESB). As this term is not used in Canada, where many of our participants reside, we are defining our sample as "migrant and refugee women."

It is important to understand how migrant and refugee women experience and construct premarital sexuality for a number of reasons. Within Australia and Canada, the sexual and reproductive health needs of migrant and refugee women is of growing concern due to their underutilization of sexual health services (Aminisani, Armstrong, & Canfell, 2012; Botfield, Newman, & Zwi, 2016; Manderson & Allotey, 2003). Past research has identified a number of barriers that shape migrant and refugee women's access to health care services (Botfield et al., 2016; Mengesha, Dune, & Perz, 2016). These barriers include practical challenges, such as the navigation of complex health systems (McMichael & Gifford, 2009), difficulties with language and communication (Riggs et al., 2012; Straus, McEwen, & Hussein, 2009), and the preference for female health care providers (Tsianakas & Liamputtong, 2002). Other barriers include perceived racism or discrimination when accessing services and receiving care (Allotey, Manderson, Baho, & Demian, 2004), such as cultural stereotyping based on ethnic background (Straus et al., 2009). Past literature has also highlighted that health care services may be avoided if the provision of care is considered culturally inappropriate or does not align with cultural constructions of acceptable care (Phillimore, 2015; Woodgate et al., 2017).

The underutilization of sexual and reproductive health services may also be associated with sociocultural beliefs surrounding premarital romantic relationships and sexual behavior. Past research has established that premarital chastity remains extremely important within some migrant and refugee communities (McMichael & Gifford, 2010; Meldrum, Liamputtong, & Wollersheim, 2014; Wray, Ussher, & Perz, 2014). This may inhibit equitable access to sexual and reproductive health services for unmarried women (Meldrum, Liamputtong, & Wollersheim, 2016), as such services are deemed inappropriate (Beck, Majumdar, Estcourt, & Petrak, 2005; Rogers & Earnest, 2014). A prohibition against accessing services has also been found to extend to preventive health practices, such as HPV vaccination, which are thought to be unnecessary for unmarried women who are presumed to not be sexually active (Salad, Verdonk, de Boer, & Abma, 2015). Previous research suggests that sexually active unmarried women from diverse cultural backgrounds may avoid accessing sexual and reproductive health services, as their personal reputation and family honor may be jeopardized if community members find out they are engaging in premarital sex (Manderson, Kelaher, Woelz-Stirling, Kaplan, & Greene, 2002; Rawson & Liamputtong, 2009).

It has also been found that the taboo nature of sexual and reproductive health discussion for unmarried women among some migrant groups may affect the sexual health education that women receive (Meldrum et al., 2016), thereby reducing their capacity to make informed decisions about their sexual and reproductive health (Shaw, 2009). Among many migrant and refugee families, the cultural taboo of talking about sex

with unmarried women may leave younger generations with limited sexual health knowledge, resulting in poor sexual health practices, such as the absence of contraception use (Dean, Mitchell, Stewart, & Debattista, 2017; Manderson et al., 2002; Rogers & Earnest, 2014; Ussher et al., 2012). Furthermore, in migrant communities where virginity is prioritized, parents may not support sex education at school for their daughters, as it is believed such learning may encourage premarital sex (Beck et al., 2005; Ussher et al., 2012); this leaves young women vulnerable to unplanned pregnancies and STIs. A lack of sex education may also lead to emotionally negative experiences of first sex, which have been associated with sexual difficulties later in life (Rapsey, 2014; Smith & Shaffer, 2013). Following migration, it has been found that exposure and integration into societies with differing sexual norms may cause intergenerational discord and family conflict, further limiting a woman's ability to discuss sex with parents and adding to acculturative stress (Dean et al., 2017; Manderson et al., 2002). Greater understanding is needed into how migrant and refugee women negotiate competing constructions of premarital sexuality and how this may influence their sexual health practices and sexual subjectivity—their experience of self as a sexual being, entitled to sexual pleasure and safe sex, free to make decisions in relation to sexual choices (Tolman, 2009).

Among diverse migrant cultures in the West where women's virginity is prioritized, it has been found that the meaning of virginity is often simplified and symbolically charged. Being a virgin commonly refers to not having had coital sex, with the material presence of a women's hymen signifying virginal status (Abboud, Jemmott, & Sommers, 2015; Cinthio, 2015). More globally, failure to prove virginity on the wedding night, through the presence of hymeneal blood, has been found to result in severe consequences for young women, such as immediate divorce, social stigmatization, and physical violence (Cook & Dickens, 2009; Eich, 2010). This has led to the medicalization of virginity, such as virginity checks and hymen reconstruction or "hymenoplasty," a procedure to artificially repair or restore the hymen to mimic expected bleeding at first coitus (Ahmadi, 2016; Amy, 2008; Kaivanara, 2016). It has been found that health care professionals in the West are increasingly being faced with questions from young migrant and refugee women surrounding issues such as hymenoplasty, which many feel ill-equipped to deal with, if they do not understand the sexual norms associated with premarital sex to which these women are adhering (Essén, Blomkvist, Helström, & Johnsdotter, 2010; Loeber, 2015).

Physical regulation of women's premarital sexual bodies also extends to the practice of female genital mutilation (FGM).[2] An estimated 200 million women and girls alive today have undergone FGM (United Nations Children's Fund [UNICEF], 2016), a tradition carried out in both Christian and Muslim communities (Mathews, 2011). It is practiced across 30 countries in Africa, the Middle East, and some isolated Southeast Asian contexts (UNICEF, 2016). FGM refers to "all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons" (World Health Organization [WHO], 2016). While the motives for FGM vary across cultural and geographical settings, the primary function is to mitigate a woman's sexual desire, ensuring virginity until marriage, and thus maintaining her family's reputation and honor (Fahmy, El-Mouelhy, & Ragab, 2010). FGM is widely considered a major breach of human rights, as it denies women's bodily integrity and has significant physical and psychological sequelae, including extensive pain and bleeding, complications with childbirth, recurrent urinary tract infections, and even death (WHO, 2016). Given that Australia and Canada are destinations for migrant and refugee women from countries where this practice occurs, understanding how women discursively construct FGM, in the context of constructions and practices associated with premarital sexuality, is important for health care professionals and educators.

Experiences and constructions of women's sexuality are not static; they are subject to change and transformation according to the social and historical context in which one is embedded (Ahmadi, 2003). For example, urbanization and the influence of the Internet has meant that in some traditionally patriarchal contexts, such as Iran, women are demanding sexual intimacy and romantic love prior to marriage, which is slowly leading to societal shifts in constructions of normative heterosexuality, potentially allowing women more freedom (Afary, 2009; Kaivanara, 2016; Mahdavi, 2009). Many Muslim women are also demonstrating resistance to policing of their sexuality in the public sphere by challenging dress codes and talking to nonrelated males in public—actions which are traditionally prohibited politically and culturally (Hoodfar & Ghoreishian, 2012). These examples highlight how women are not always passively situated within prevailing discourses but can reposition, resist, variably adopt, and negotiate dominant discourses to achieve a desired sexual subjectivity (Day, Johnson, Milnes, & Rickett, 2010, p. 238). This has been described as the adoption of counter-narratives or counter-discourses to facilitate the position of sexuality in more agentic ways (McKenzie-Mohr & Lafrance, 2014). Little is known about the ways in which migrant and refugee women, after migrating to Australia or Canada, may adopt counter-discourses in relation to premarital sex, which is the context of the present study.

While a small number of studies have considered migrant and refugee women's experiences and constructions of premarital sexuality, there are a number of gaps in existing research, which the present study aims to address. Qualitative research that has been undertaken on migrant women's sexual health commonly considers the perspectives of women who are from the same cultural or religious

[2] The terminology used for this procedure is complex and has undergone various changes. We have chosen to use the terminology "female genital mutilation" (FGM) as opposed to "female genital cutting" (FGC) or "female circumcision," as FGM is the current terminology used by the WHO and United Nations Population Fund (UNFPA), which describes the practice from a human rights viewpoint (United Nations Population Fund, 2015).

background (Manderson et al., 2002; Meldrum et al., 2016; Wray et al., 2014), limiting the ability to acknowledge commonalities and differences across multiple social structuring factors, such as religion, cultural background, or geographical location (Martinez & Phillips, 2008). Even where diverse cultural backgrounds have been considered, study sample sizes are small, making generalizations to the wider community difficult (Meldrum et al., 2016; Rogers & Earnest, 2014). Past research on migrant women's sexual health also often considers the perspectives of second-generation women (Rawson & Liamputtong, 2009) or the perspectives of unmarried women only (Manderson et al., 2002; Rawson & Liamputtong, 2009; Wray et al., 2014), leading to a call for research on adult women and those who are parents (Keygnaert, Vettenburg, Roelens, & Temmerman, 2014; McMichael & Gifford, 2009). These gaps in the research literature need to be addressed to implement effective sexual and reproductive health policies, services, and education, and to better understand the specific challenges facing migrant women from different sociocultural and religious backgrounds (Garrett, Dickson, Whelan, & Whyte, 2010).

Method

Research Design

A qualitative research design was utilized to examine constructions and experiences of premarital sex among recent migrant and refugee women living in Australia and Canada. The findings presented in this article are drawn from a larger program of research examining migrant and refugee women's sexual and reproductive health in Sydney, Australia, and Vancouver, Canada (Hawkey, Ussher, Perz, & Metusela, 2016; Ussher et al., 2017). A total of 78 individual interviews and 15 focus groups, with 82 participants, were conducted (total n = 160 women) from July 2014 to November 2015. Focus group participant numbers ranged from three women to 10 women within each group. Participants were women who were born in and migrated from other countries, including Afghanistan, Iraq, Somalia, and Sudan. Sri Lankan (Tamil) and South Sudanese women were included in the Australian sample, and women from South America (Latina) were present in the Canadian sample. Table 1 provides further demographic information for participants in each cultural group.

Participants and Procedure

Participants were women ranging from 18 to 70 years old, with a mean age of 35. All women, except for one Latina participant who identified as being in a same-sex relationship, identified as being heterosexual. Participants were women who had migrated in approximately the last 10 years, with the average time since migration being seven years. Women identified as practicing a range of religions, including Christianity, Islam, and Hinduism. The majority of participants migrated as humanitarian refugees, in which a visa is given to those who are fleeing their home country in fear of persecution or those who are suffering substantial discrimination and human rights abuses in their country of origin (Australian Government Department of Immigration and Border Protection, 2017).

Community stakeholders involved in the provision of sexual and reproductive health care and support of migrant and refugee women, such as community migrant resource centers and family-planning clinics, partnered with the research team to establish an advisory committee. Meetings with community stakeholders were held to determine the most appropriate methodologies of research, to develop interview schedules, and to refine project aims. Participants' countries of origin were selected because they were recognized as being underrepresented in previous research literature in this sphere, which in Australia has focused on Southeast Asian women (Garrett et al., 2010). In addition, community stakeholders identified selected cultural groups as being those who were not attending sexual and reproductive health services, despite contributing to a significant proportion of recent arrivals to both countries. Australia and Canada were chosen for this research study as they are comparable geographically, economically, and politically, and they host similar migrant populations. This project was also a part of an ongoing collaboration between researchers in Australia and Canada.

The majority of participants (72%, n = 115) were interviewed in their first language by trained community interviewers, women of the same cultural background or who spoke the same language as the interviewees. Members of the research team JU and JP, who are academics in the fields of women's health and sexuality, trained community interviewers in qualitative methods at a one-day workshop, which covered how to conduct conversational interviews and focus groups and how to transcribe data. In five focus groups (n = 16) and 29 one-to-one interviews, women who preferred to speak English, or who spoke English but wanted to be interviewed by a non–community member, were interviewed by a member of the research team. Such methodology has effectively been adopted in prior research with migrant women (Morrow, Smith, Lai, & Jaswal, 2008).

Individual interviews were utilized to facilitate the collection of in-depth information, which may not be disclosed in a group setting due to its sensitive nature, while focus groups were used to provide insight into cultural or community norms (Creswell, 2009). The integration of focus group and individual interview data allowed for enhanced trustworthiness of our findings through elaboration and clarification across the two methods (Lambert & Loiselle, 2008). As recommended by Krueger and Casey (2014), focus groups were homogenous, in that women were of the same cultural group, and married and single women were interviewed independently where possible.

Participants were recruited through the distribution of study advertisement flyers by community support workers, preexisting community cultural groups, the trained community interviewers, flyers displayed in women's health centers, and snowball recruitment (i.e., where women passed information about the study onto other

Table 1. *Sample Sociodemographic Characteristics*

	Afghani	Iraqi	Latina	Somali	South Sudanese	Sudanese	Tamil
	(*n* = 35)	(*n* = 27)	(*n* = 17)	(*n* = 38)	(*n* = 11)	(*n* = 20)	(*n* = 12)
Variable/Group	***M* (*SD*)**	***M* (*SD*)**	***M* (*SD*)**	***M* (*SD*)**	***M* (*SD*)**	***M* (*SD*)**	***M* (*SD*)**
Age	31.4 (9.1)	38.7 (12.5)	37.1 (5.6)	31.9 (10.4)	36.6 (6.2)	38.7 (7.5)	36.8 (7.3)
Years since migration	5.1 (4.1)	4.3 (2.1)	8.3 (4.9)	5.4 (3.1)	10.8 (2.1)	8.9 (3.4)	5.1 (2.5)
Number of children	3.3 (1.3)	2.7 (1.2)	1.5 (0.7)	3.7 (2.0)	4.5 (2.2)	2.9 (1.1)	2.1 (0.5)
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
Have children							
Yes/pregnant	20 (57.1)	20 (74.1)	11 (73.3)	23 (60.5)	11 (100.0)	19 (95.0)	11 (91.7)
No	15 (42.9)	7 (25.9)	4 (26.7)	15 (39.5)	—	1 (5.0)	1 (8.3)
Religion							
Islamic	35 (100.0)	23 (85.2)	—	38 (100.0)	—	16 (80.0)	—
Christian	—	3 (11.1)	10 (58.8)	—	11 (100.0)	4 (20.0)	5 (41.7)
Buddhist	—	—	1 (5.9)	—	—	—	—
Hindu	—	—	—	—	—	—	7 (58.3)
Nonpracticing	—	1 (3.7)	6 (35.3)	—	—	—	—
Education							
Primary	7 (20.0)	6 (22.2)	—	8 (21.1)	3 (27.3)	4 (20.0)	—
Secondary	15 (42.9)	3 (11.1)	2 (11.8)	3 (7.9)	2 (18.2)	5 (25.0)	7 (58.3)
Tertiary	6 (17.1)	18 (66.7)	10 (58.8)	3 (7.9)	2 (18.2)	10 (50.0)	5 (41.7)
Nil	2 (5.7)	—	—	1 (2.6)	2 (18.2)	1 (5.0)	—
Other	1 (2.9)	—	—	2 (5.3)	2 (18.2)	—	—
No response	4 (11.4)	—	5 (29.4)	21 (55.3)	—	—	—
Relationship status							
Married/de facto	17 (48.6)	14 (51.9)	13 (76.5)	13 (34.2)	6 (54.5)	13 (65.0)	12 (100.0)
Single	12 (34.3)	7 (25.9)	2 (11.8)	14 (36.8)	1 (9.1)	1 (5.0)	—
Divorced/separated	2 (5.7)	5 (18.5)	2 (11.8)	8 (21.1)	4 (36.4)	6 (30.0)	—
Widowed	4 (11.4)	1 (3.7)	—	3 (7.9)	—	—	—

women). All interviews and focus groups took place in participant-selected locations, including local libraries, community centers, or participants' homes. Participants were offered a $25 (AUD/CAN) supermarket voucher in appreciation of their time and travel costs to attend the interview. Interviews and focus groups were audio-recorded with participant permission. The interviews and focus groups were semistructured and lasted on average 90 minutes. The interview schedule contained broad open-ended questions about women's sexual and reproductive health, including experiences of menarche and menstruation, sexual health, and sexual health screening and support. The specific questions and prompts associated with premarital sexuality, the focus of this study, included the following:

- Tell me about sex before marriage in your culture.
- What does being a virgin mean?
- Are certain things okay in your culture, such as touching each other intimately, kissing, or oral sex, when you are not married?
- What happens to women who are not virgins at marriage?
- If a woman did have sex before marriage, is there anything she could do to regain her virginity?
- How do you feel about being in an Australian/Canadian culture where women often have sex before marriage?

Allowances to the interview schedule were made to accommodate each participant, for example, questions asked differed slightly according to whether a participant was married or unmarried. Informed consent was gained from all participants. This research was approved by the Western Sydney University Ethics Committee and the Simon Fraser University Ethics Committee, and by one of our stakeholder ethics committees.

Analysis

Interviews and focus groups that were not carried out in spoken English were translated and transcribed into English by the bilingual community interviewers. Translation was undertaken to retain as much original meaning as possible, while taking into consideration the subtleties of the English language. For example, community interviewers would at times translate statements such as "this is shame," which in English would be described as being "shameful." English spoken interviews were professionally transcribed verbatim and integrity checked to ensure accuracy. Filler words such

as "um" and "ah" were removed for the purposes of readability. All participant names were replaced with pseudonyms, and identifying information was removed from transcripts.

Our epistemological standpoint was critical realism, which recognizes the materiality of somatic, psychological, and social experience, but conceptualizes such materiality as being mediated by culture, language, and politics (Bhaskar, 2011). In this light, to acknowledge the materiality of women's premarital sexuality (e.g., the hymen, female genital mutilation), as well as the discursive construction of sexuality (e.g., being a virgin at marriage is essential), we adopted a material-discursive theoretical framework (Ussher, 2008). This approach moves away from the mind–body binary divide (Yardley, 1999) and considers the material and discursive aspects of sexuality to be equal and interrelated (Ussher, 2002).

Participants' transcripts were analyzed using thematic decomposition (Stenner, 1993). This form of discourse analysis identifies themes—that is, commonality in patterns or stories across the data—and then considers discourses and subjectivity of participants' accounts associated with such themes (Braun & Clarke, 2006). To begin analysis, a subset of participant manuscripts was independently read and reread by the authors and research officer on the project. During this process, potential first-order concepts and codes were noted; these included "meaning of virginity," "premarital sex is forbidden," and "premarital relationships boundaries." The entire data set was then coded by the first author and the research officer under these first-order codes, using the computer software NVivo, a program to aid in the organization of qualitative data. The second author continually checked for variability and consistency across codes. Codes were then collapsed into a fewer number of categories through discussion and vigilant decision making with all authors. Data within codes was read again by the first author and research officer and summarized to facilitate the identification of themes across codes. To allow for cultural and geographic comparisons, participants' accounts in coding summaries were color-coded to represent women from differing cultural backgrounds, and accounts from Canadian women were bolded. Any discrepancies, such as where coded data would fit best into themes and how to best collapse codes into themes, were brought up at project meetings and discussed until agreement was reached. The broader research team was made up of White women and women of color who either had migrated to or were born in Australia or Canada. Team members were academic researchers and those working with migrant women in the community.

Through the process of coding, summarizing, and highlighting, commonalities were identified across participants' accounts, as well as concepts or experiences unique to participants or women in specific cultural groups. Following coding, one core concept was identified across the data: women's sexuality prior to marriage was strongly regulated. Such regulation occurred across three major domains of women's lives forming the three discursive themes presented in this paper: regulating premarital sex—the virginity imperative; regulation of relationships with men; and regulation of the sexual body. While many women's premarital sexuality was controlled through dominant cultural and religious discourses and material practices, there were also accounts of resistance, both prior to and following migration. Adoption of and resistance to cultural and religious discourses was not binary, however. A number of women interviewed gave accounts of both accepting cultural and religious beliefs and practices associated with sexuality at the same time as they resisted such beliefs and practices. This suggests that women were engaged in active negotiation of their sexual subjectivity to gain a degree of sexual agency.

In the presentation of participants' quotes, the following transcription annotation was used: Ellipses (i.e., "…") are used to identify discussion sections where text was removed when it was not pertinent to the analytical context. Brackets (i.e., "[]") indicate text that has been included by authors to improve readability and preserve meaning of the verbal passage. Quotes are substantiated with a participant's pseudonym (or the use of "FG" in the case of a focus group), age, relational status, and ethnic background. For individual interviews, "Married" denotes participants who are currently married or have been previously married to men. For further breakdown of current relational context, see Table 1. "Mixed" describes focus groups where participants were of differing marital status. In our analysis, no differences were identified between accounts by women in Australia or Canada; thus, country of origin has been excluded.

Results

Regulating Premarital Sex: The Virginity Imperative

Premarital sex was discursively positioned as being "unacceptable," "forbidden," or "a mistake" by nearly all participants interviewed across the cultural contexts. For example, Hoodo (29, married, Somali) said, "It is not something that we take lightly … it's not permissible at all." A married Iraqi focus group participant told us, "It is a sin and it is a major mistake." Similarly, women across the cultural contexts described premarital sex as simply not a part of their culture: "It is wrong … it is not our culture!" (Nita, 27, married, Tamil); "That thing is forbidden… . Sex before marriage is not in our culture" (FG, married, Somali). Other participants, especially Christian and Muslim women, drew heavily on both religion and culture to reiterate the compulsory nature of being virginal until marriage: "We are Christian, we have our rule … our girls, they have to be virgins" (Nyandeng, 34, married, South Sudanese); "It's not in our religion, and also it's not in our culture. It is forbidden" (FG, married, Somali). Exceptions to this finding were predominantly from accounts with Latina women, who had migrated from countries such as Cuba, which were perceived to be more tolerant of premarital sex. As a Latina focus group member stated, "Having sexual relationships before marriage is okay… . People see it as normal and healthy." However, despite now

living in countries with more liberal ideologies toward premarital sex, the virginity imperative was described as being adhered to post-migration by the majority of women interviewed. Cross-culturally, participants told us: "I still believe in our culture, so I don't agree having sex before marriage is right" (Andrea, 26, married, Tamil); "The Sudanese culture does not agree with what happens here" (Nafisa, 36, married, Sudanese); and "I would love for my son to marry a virgin… . I realize that this is one of the cultural residuals that is left in me" (Nasima, 43, married, Iraqi). This was further evidenced in the fact that no young or unmarried participants disclosed having had sex, suggesting the virginity imperative may continue to regulate young new migrant women's premarital sexual practice even following migration.

Regulation through the virginity imperative was a gendered practice, with many women describing a sexual double standard in their communities, wherein premarital sex was permitted for men but forbidden for women. For example, women said: "My parents didn't mind them [brothers] to have relations, but for me I wasn't allowed" (FG, mixed, Iraqi); and "They have all these ridiculous sort of open-ended chances for men to redeem themselves … for a girl, they don't give you these concessions at all" (Homa, 40, married, Afghani). The double standard was partly attributed to there being no physical test to prove male virginity, in contrast to women, where the presence or absence of a hymen was considered material verification of a woman's prior sexual experience. For instance, Eira (26, married, Sudanese) said, "Boys, even if they play, there is no change … but for us, it's going to be a bit different." These accounts highlight the patriarchal ideologies that may govern unmarried women's sexuality, with the sexual double standard being a mechanism of control that denies women the right to choose if or when they would like to engage in premarital sex or intimacy.

Across all cultural contexts, women's transgression of the virginity imperative put them at risk of severe material consequences, such as family exclusion, a loss of reputation, stigmatization, and violence. Participants told us, "Nobody will respect her in society" (Suz, 42, married, South Sudanese) and "If a woman had sex before marriage, there is a very negative stigma that will follow her around… . She is 'cheap'; she is 'not worth it'" (Fahmo, 23, single, Somali). This stigmatization was said to result in women becoming "unmarriageable" or being "sent back" to their family home: "People start saying, 'She is a used woman, so I am not going to marry her into my family'" (Homa, 40, married, Afghani); "We knew a few girls that didn't bleed and they were sent back" (FG, married, Afghani); "They kill them; families kill their daughters if they cause such a bad name to the family honor" (FG, married, Afghani). These accounts suggest that the consequences of transgression may act as a deterrent for women's premarital sexual exploration, highlighting how cultural and religious discourse can regulate unmarried women's sexual agency and sexual subjectivity.

As a consequence of premarital sex being discursively constructed as culturally and religiously forbidden, some unmarried Afghan participants described a process of self-regulation to maintain sexual innocence, such as refraining from thinking about sex. For example, a member of an Afghani focus group disclosed, "Oh, my God, it's bad [to think about sex]… . We don't think like that. We follow our religion, so our thinking or ideas are all religious." A further account by Ara (34, single, Afghani) demonstrates the framework she adopts to govern her sexuality as an unmarried woman:

> We never think sex before marriage. That's automatically with Muslim girls… . It's not an important part of your life. As long as you think that you'll meet someone, that person is nice, that's it. I've never thought about that [sex] more than that.

These excerpts suggest that some unmarried women may engage in self-policing of their sexual thoughts and desires to adhere to the cultural ideals of a virgin woman, one who is chaste and naive about sex.

In line with findings reported in Ussher et al. (2017), across cultural groups the discussion of sex was also discursively positioned as "shameful" and "not allowed," particularly for unmarried women. This had material consequences in that women had limited opportunities to communicate about sex prior to marriage, as Raana (42, married, Iraqi) said: "My mum was so embarrassed to tell me anything." Some women disclosed they were unable to access information about sex, sexual health, or contraception, because they felt too shy to ask about it or it was seen as inappropriate for unmarried women. For example, one participant admitted: "I didn't ask anyone [about sex] because I am shy" (Hasina, 25, married, Somali). Others related: "I had bad acne, and the doctor suggested to take contraception. But obviously unless you are married in my culture, the girl shouldn't take it… . They question why you are taking the contraceptive pill" (Ara, 34, single, Afghani); "When I got married I didn't know anything about it [contraception]" (Azita, 37, married, Afghani). This led women to seek sexual health information from less reliable sources, such as the "cinema, from the movies" (FG, married, Tamil); "we learn from stories" (FG, mixed, Sudanese); and "most of my friends, they got married, so they told me" (Saadia, 30, married, Iraqi). The discursive positioning of sex as unspeakable for unmarried women also meant many participants had no knowledge of what to expect on their wedding night: "On the wedding night, in the hotel, I didn't know what will happen" (Madina, 45, married, Iraqi). An absence of knowledge about contraception also led to a number of participants having unplanned pregnancies shortly after marriage, as Andrea (26, married, Tamil) told us: "The second month [after marriage] I got pregnant… . Everything [was a] shock. I was really upset. I didn't cope with that… . No one didn't give any advice, nothing." These findings reflect how a lack of comprehensive sex

education can affect women's experiences of first sex, and the importance of sexual and reproductive health information prior to sex, to enable greater agency over women's reproductive choices.

Constructions of Virginity: The Hymen and Beyond. In women's accounts, constructions of virginity were complex and described differently within and across cultural groups. Many women from Muslim backgrounds discursively constructed virginity in an abstract manner as a symbol of purity, cleanliness, and honor. For example, being a virgin was described as being "pure and clean" (Suhaira, 21, single, Afghani); "not corrupted in mind" (Samira, 21, single, Afghani); "still innocent" (Raana, 43, married, Iraqi); and that "beauty and dignity depend on it" (Saafi, 43, married, Somali). Other participants cross-culturally told us that the importance of virginity was centered on personal, family, and community dignity, which was positioned as their primary motivation to remain virginal prior to marriage: "You keep it for yourself, for your husband, for community, for family" (Nyandeng, 34, married, South Sudanese); "I don't do sex because, number one, for my religion and, number two, for myself, my dignity, and for my family" (Manoo, 19, single, Somali). These accounts highlight how unmarried women's sexuality is potentially shaped by both the individual desire to remain virginal as well as the expectations of family and the wider community. While an absence of premarital sexual exploration may be considered retrograde in some Western contexts, this was not the case for some women interviewed. A number of participants cross-culturally described remaining virginal until marriage as a choice, positioning it as a positive decision. For example, Akeck stated she was "proud knowing that I haven't been sleeping with a lot of other men … no one will say something about your past, no one['s] got your privacy" (31, married, South Sudanese) and Eira (26, married, Sudanese) said its "good" to be a virgin because "you can't have sex with everyone."

For other women interviewed, constructions of virginity frequently centered on the materiality of the hymen; the presence of a hymen discursively signified a woman's chastity and virginity. Most notably among Muslim women, the hymen was constructed as a "membrane" that could be "broken" or "ruptured" through penetration during first sexual intercourse. Bleeding because of a ruptured hymen signified that a woman was no longer a virgin: "Virginity is determined by when the hymen is broken… . They say it's blood that indicates it" (Samira, 21, single, Afghani). The discursive positioning of the hymen as delicate and a material symbol of virginity led some Muslim participants to regulate their premarital physical activities. Carrying heavy objects, bike riding, falling, skipping, and the use of tampons were all described as "risky" behaviors that could damage the hymen. A few participants believed that "when you ride a bicycle you may lose your virginity" (FG, single, Somali) and "no more playing skip rope … especially until you get married" (Geti, 30, married, Afghani); "it would be a bit risky [to use tampons]… . What if … I wouldn't be a virgin anymore?" (Setara, 23, single, Afghani).

A further consequence of the construction of virginity as related to the materiality of the hymen and hymeneal blood was the expectation that women would bleed on their wedding night. This finding was absent in Tamil women's narratives, and mentioned only briefly across other cultural and religious contexts, such as Christian, Latina, or South Sudanese women. It was, however, commonly mentioned among women from Muslim backgrounds. A married Sudanese focus group member said, "We needed to prove that we are a virgin. They don't know that if blood doesn't come, a girl still could be [a] virgin." Akeck (31, married, South Sudanese) told us, "Normally it's a white bed sheet that is spread on the bed … they expect blood on that thing." While the majority of accounts positioned this expectation in retrospect, in one account, Suhaira (20, single, Afghani) reported that women in her community were still expected to show blood following their wedding night even after migration: "Yes, it happens in Australia. Even if you come to a new country doesn't mean we have to forget our tradition and culture and our beliefs." The pressure to bleed on her wedding night caused Suhaira anxiety. She went on to say:

> I wish [that] all our Afghan people, women especially, our grandmas, were educated. They'll know that, look, not many girls bleed… . I'm very worried. I know I should bleed, but … when the girls talk about this issue, I get kind of nerve-wracking in my body… . I know I'm a very pure girl … this sort of thing is a big part of my life.

This account highlights the emotional consequences for women who are embedded within cultures that still highly regard hymeneal blood, and in this case may be suggestive that this expectation for some women may continue even following migration to Australia or Canada. In addition, these findings suggest that new migrant women of all ages may benefit from education surrounding the physical structure of the hymen and variability of bleeding following first sex.

Resisting the Virginity Imperative. While the virginity imperative served to regulate women's premarital sexuality, there were also accounts of resistance to this cultural and religious discourse. One woman exercised resistance by stating she would like to engage in sex before marriage: "I think it's a good experience…. I'd rather have experience before marriage to know what it is" (FG, mixed, Iraqi). A minority of women reported that they had acted on their sexual desire and had premarital sex: "My first relationship was when I was 22…I just wanted to experience sex" (FG, mixed, Latina); "I did it [premarital sex] because I was sure he would be the man that I was going to get married to and be with him forever" (FG, mixed, Latina). However,

women's attempts to resist the virginity imperative were not always experienced positively. Participants who had sex outside of wedlock were predominantly from Latina backgrounds and disclosed feeling "bad" and "guilty," with women stating they were "thinking that I'm a sinner" (FG, mixed, Latina) and now have "this connotation of sex as something bad and dirty" (FG, mixed, Latina). Across cultural contexts, other participants stated that some unmarried women in their communities did engage in sex since migration, but that it needed to remain a secret. As Safia (28, single, Afghani) said, "Some people have sex before marriage, but no one will know, no one will find out." Nasima (43, married, Iraqi) also said, "It stays a secret … that does not mean that they are not practicing it." These accounts illustrate women's agency and resistance in choosing to engage in premarital sex, at the same time as adhering to cultural expectations by maintaining their virginal image through secrecy. Other participants described resistance to the virginity imperative by drawing on a sexual rights discourse: "She has the right [to sex]; no one can choose for her" (Shima, 39, married, Iraqi); or through stating that sex before marriage was acceptable if the two people "have the intentions of getting married" (Setara, 23, single, Afghani) or "if she is in love" (Nasima, 43, married, Iraqi).

Accounts of resistance or negotiation were most common among women who were younger and unmarried, even if they had migrated more recently, suggesting there may be an attitudinal shift in younger generations of women or those who may have attended school within an Australian or Canadian context. Unmarried women frequently challenged the sexual double standard, positioning the asymmetric expectations on women as being "not fair" and by stating, "If someone is going to want a virgin, then the guy should be a virgin as well" (Samira, 21, single, Afghani). In a further account from a focus group, an unmarried Iraqi woman stated:

> Unfortunately, this is in the culture. It's all on the woman; why not on the men? Why are they allowed to do things? Why is the woman not allowed to do that? They have the same desire for sex. Why she cannot express her desire and she will be punished for that if she does?

This account suggests the participant is situated within a resistant identity position by both acknowledging the sexual double standard as an "unfortunate" aspect of her culture and by drawing on a sexual drive discourse, a discourse that acknowledges one's need to have sex, and in this case that this may exist even prior to marriage for women as well as men. Furthermore, while the majority of unmarried participants did not disclose engaging in premarital sex themselves, resistance was demonstrated through women's accounts of not judging women who did. For example:

> I don't have any position against that. I think it's just a way of life that people choose for themselves… . You can't really judge people's relationships based on your own experiences or opinions. (Setara, 23, single, Afghani)

> Everyone has their own choice if they want to have sex before marriage or if they don't want to have sex I really think that is up to them. (Fahmo, 23, single, Somali)

Unmarried women also showed resistance to the cultural silencing of sex by discussing it with potential partners or friends, as in these examples: "I was close to being engaged with someone, and I talked about it and how we were going to approach this, every detail I wanted to know" (FG, mixed, Iraqi); "Sometimes I talk about it. I mean, my friends talk about it as well … but it's a very intimate [thing]" (Samira, 21, single, Afghani).

Resistance was also evident in accounts where participants positioned proof of virginity, through the showing of hymeneal blood, as being outdated and a practice rejected in an Australian or Canadian context: "Here, no one knows. It's between you and your partner" (FG, married, Afghani); "It's not right to, I guess, [to] judge someone's character or their life based on whether they are going to bleed on the night of the marriage" (Samira, 21, single, Afghani). Other participants gave accounts of resistance to this practice in their home countries prior to migration: "My mother just told me to take white clothes to put it under me… . I didn't use it" (Madina, 45, married, Iraqi), suggesting women's negotiation occurred both prior to and following migration.

Negotiating the Virginity Imperative With Daughters: "I Tell My Daughter Her Body is for Her Husband." Discrepancies in cultural outlooks toward premarital sex were a major cause of concern for older women who had daughters. Women cross-culturally described the experience of having their daughters raised in a Western society as being "very scary" and "very difficult," and that they were "afraid" or "worried." Mothers were concerned about the amount of "freedom" young women have in their new countries and the influence that peers may have, with many women describing it as their role to educate their daughters about these differences. As Hooria (35, married, Sudanese) told us, "I do have worries, especially the older daughter, because of culture differences and freedom for the girls … other girls from other backgrounds also worry me." Women described using public displays of affection or intimacy on television to explain cultural variances to their children and to reinforce their own belief systems surrounding premarital sexuality. As Kamelah (36, married, Sudanese) said:

> If they watch something [kissing] on the TV, it's a chance for me to explain to them that is not acceptable… . One time they saw a couple kissing each other on the street… . [I] told them this is normal in Australia, but in our culture and Islam it is wrong.

Sex education provided by mothers to their daughters often contained warning messages surrounding relationships with men, reinforcement of the importance of chastity and the consequences of degeneracy, as highlighted in the following examples:

> I always talked to her about the culture in Australia and the things that is not acceptable in our culture. (Saba, 48, married, Sudanese)

> I tell them [daughters] this country is free … people have sex before they get married … but our religion doesn't allow this … I don't approve [of] it. (Amran, 47, married, Somali)

> You have to tell her that this is wrong in Islam… . They're going to see you like trash. Like you are nothing, and no man commit to you again because he doesn't trust you… . No one likes you at home, even your family, even anyone. (FG, mixed, Sudanese)

Other mothers negotiated the differences in culture by monitoring their daughter's relationships with friends and online activities. A member of a mixed Sudanese focus group said, "We're trying to keep our kids from the bad girls"; and Hooria (35, married, Sudanese) told us, "I always check on what she is doing on her laptop." These accounts suggest that mothers may police their daughters' activities in an attempt to preserve culturally appropriate sexual ideals for young unmarried women and how such ideals shape the educational messages mothers may pass on to their daughters.

While having virginal daughters at marriage was very important to some women, other participants resisted the virginity imperative for their daughters by stating, "We should trust our children here" (FG, married, Afghani). A minority of participants disclosed that they did not mind if their daughters engaged in premarital sex: "Although I am Catholic … I'm not a fanatic, and I don't think that she needs to be a virgin until marriage" (Mariana, 38, married, Latina). A number of women stated that they recognized they could not control their daughters growing up in a different cultural environment, nor did they want to: "It depends on them … you can't like control them" (Saadia, 30, married, Iraqi); "I will tell her it is your choice … you can't control a human being" (Erina, 39, married, Somali).

Regulation of Premarital Relationships With Men: "Your Purity is Much Better Than Any Love in the World"

The imperative to be a virgin extended beyond the control of the hymen to the regulation of any premarital contact with men. A number of unmarried participants cross-culturally described how family members, particularly fathers, brothers, and uncles, positioned any contact with men, including extended family, as being forbidden: "My family, they don't accept any relations with a male … even if he is just a friend, not my love… . My parents don't accept it, and even my brothers don't accept it" (FG, single, Iraqi); "I am not even allowed with my cousin in a room alone… . My father would say to someone to stay with us" (FG, single, Afghani). Consequently, the Western notion of dating was an unfamiliar and unacceptable concept. Married women told us: "I didn't come across this sort of dating thing in my culture. That's why it's hard to accept by me" (Janni, 32, married, Tamil); "No, definitely, no boyfriend usually in our culture, no" (FG, mixed, Somali). In other accounts, particularly from unmarried Muslim participants, women reported that even following migration, premarital dating was positioned as culturally unacceptable and there was "no option for a boyfriend" (Ara, 34, single, Afghani) and "girlfriend and boyfriend, I can't do that" (FG, single, Iraqi).

Across cultural groups, women described strict etiquette with regard to physical intimacy limits prior to marriage. For example: "Holding hands, cuddling, all these are not acceptable, so we never did it" (Zarina, 32, married, Tamil); "It's forbidden … you guys can talk, but you cannot touch" (Faaiso, 32, married, Somali). Some women attributed the prohibitions to culture: "[It's] not in my culture … we don't do that" (Hawa, 30, single, Sudanese); "Somali culture says … if the women allow the man to touch her she's not a good woman" (Arliyo, 26, single, Somali). Other participants, particularly Muslim women, focused on religion: "You know, holding hands and stuff like that, it's not okay in Islam. What's the point in being a Muslim if you're going to do these things?" (FG, married, Afghani); "In our religion it is not encouraged, touching, kissing, or any sort of physical relationship" (Fahmo, 23, single, Somali). This was because of the fear that any premarital intimacy may lead to further sexual acts, thereby threatening the virginity imperative: "It's common sense. When you love someone and you guys see each other every day, something will happen" (Faaiso, 32, married, Somali); "Holding hands, it's the first thing … then I would kiss you. It leads to sexual intercourse" (Wafa, 40, married, Sudanese). For these reasons, participants across cultures described having limited or regulated contact with their future husband prior to marriage: "For four months just talking by phone… . We are a little bit strict" (Farah, 36, married, Iraqi); "Privately you cannot see him… . My mother is very strict and even my uncle" (Andrea, 26, married, Tamil).

Negotiation of the differing cultural beliefs following migration was sometimes positioned as challenging by unmarried women. For some women, being touched, hugged, or even seen in public with a man was described as being inappropriate as it may give the erroneous impression of being in a premarital relationship, leading to judgment by family and the wider community: "Some people here [Canada] try to tap your back… . If someone saw me in this condition, they may think I have a relation with this boy" (FG, single, Iraqi). This led unmarried women to self-regulate their sexuality following migration, such as "avoiding boys" in order to maintain culturally appropriate ideals of premarital feminine sexuality. A single Afghani focus group member told us:

> In school, if there are boys and if we need to share the same room for study it is all good, but anything more than that … even talking, I don't really feel comfortable… . If a boy is sitting next to me I would try to sit somewhere else … I am very careful…. It is better to stay away from them altogether.

Following migration, some participants described being embedded between two conflicting cultural spaces as difficult: "You see your friends in the school, they are free to do anything and you can't do this" (FG, mixed, Iraqi); "They're like a free bird [Australian women] … having so much fun in their life and you're like … locked up in the cage… . It's kind of difficult" (Suhaira, 20, single, Afghani). Setara (23, single, Afghani) also questioned the impact of sex segregation on how she may experience intimacy in the future: "Coming from a Muslim background and covering up all the time, it kind of worries me how would I open up suddenly to a person … I think I would be shy." Setara went on to show resistance to the practice of sex segregation and prohibition of premarital intimacy: "I'm totally against it … understanding between the couple … builds up, definitely by getting to know each other beforehand, not being forced into kind of like [a] lifetime relationship." Further resistance was evident in the account by Ara (34, single, Afghani), where she questioned the purpose of a relationship without contact prior to marriage:

> There's no point to be in a relationship… . Because of my culture you can't hang around with that person, you can't go anywhere unless someone is with you outside … you've got to be all the time on the phone or text message, and [in] my understanding, that's not a relationship.

Resistance was also evident in accounts of mothers allowing their daughters to spend time with their future partners to avoid the stressful marriages they had experienced: "I encourage young people getting to know each other, so what happened to me doesn't also happen to them" (Homa, 44, married, Afghani). Other mothers described the segregation of sexes as unnecessary following migration: "If they go and they have coffee and they are going out with friends of the opposite gender, I think it's not a big deal and it's unavoidable" (FG, married, Afghani), which may be suggestive of acculturation toward norms in the West.

Regulation of the Sexual Body: "If Girls Are Not Circumcised They Become Hyperactive"

Participants from Sudanese and Somali communities described the cultural imperative to be virginal at marriage as being so vital that women were required to undergo the practice of FGM or "circumcision," as they described the procedure. The material practice of removing the clitoris and infibulation of a woman's labia was positioned as an act that physically prevented sexual intercourse prior to marriage. Women reported, "There is no space for the man to penetrate" (Hido, 68, married, Somali) because they had been stitched "to the size of rice" (FG, mixed, Somali). Many participants discursively positioned FGM as a procedure that served to regulate an unmarried woman's sexual desire. Participants told us, "The meaning behind [it] is just to control them, the sex, whether they have sex or not" (FG, mixed, Somali) and to "stop the desire of the girl to have sex before marriage" (FG, mixed, Sudanese). In this way, the honor of the family would be maintained:

> The families are scared; they're worried about their honor or maintaining their honor. So that's why they cut girls down below… . Families are afraid that girls might do anything that would bring the family's name to shame. (Nafiso, 36, married, Sudanese)

In their countries of origin, female circumcision was positioned as essential to avoid women being publicly ridiculed and labeled promiscuous: "My mother was sure that I have to be circumcised. She said, 'People will say bad things about my daughter … that she is not circumcised, that she will be looking for men'" (FG, married, Somali). Faaiso (32, married, Somali) told us, "People used to call me names, and when I came home, I'm crying … I wanted this thing off [clitoris]." Undergoing FGM was also described as being prerequisite for getting married in women's home countries, as men associated the procedure with a guaranteed virgin bride: "If a girl doesn't do this, she doesn't get married … no men will be interested in her" (Hawa, 30, married, Sudanese); "If she gets married and the place is not stitched up, the man will think that she is not a virgin" (Amran, 47, married, Somali). These examples illustrate the extent of the material practices that serve to control a woman's premarital sexuality and the role that men may have in reinforcing this practice.

A small number of participants continued to support the idea that the removal or nicking of the clitoris was important in the control of a woman's premarital sexual desire:

> The clitoris is the one that makes you want to have more sex. I think if it was left … I'll be just all over men and having sex like crazy… . It's been removed, so I'm not hyperactive … but if that thing was not removed … I would just have babies before the age of fifteen because I would just engage in sex. That's my belief. (FG, married, Somali)

Another participant in the same group told us that she had circumcised her older daughters for this very reason, but that she couldn't circumcise her younger daughters as it was against the law in Canada, which made her worry because "it's going to make them look for men." Some women supported cutting of the clitoris but not infibulation, stating that the removal of the clitoris was supportable "because you move quickly" (FG, mixed, Sudanese) and "We call it *sunna*; they only take a little part" (Ammal, 42, married, Somali). These accounts demonstrate that some migrant and refugee women continue to support the cultural meanings

associated with FGM and virginity, highlighting the importance of their consideration in sexual health education with women from communities in which FGM is practiced.

The large majority of participants, however, openly resisted the practice of FGM, saying, "I'm totally against it" (FG, single, Somali); "It's wrong and barbaric" (Hoodo, 29, married, Somali); "That's bad; I hate it" (Arliyo, 26, single, Somali); and felt it should not be continued. Others said: "I wouldn't do that to my kids, it's not good" (Faaiso, 32, married, Somali); and "I respect the law in Australia. I am not going to do it" (Hooria, 35, married, Sudanese). Muslim women positioned FGM as a "bad cultural practice" that "my religion is against" (Saafi, 43, married, Somali) or something that "doesn't have a basis in Islamic religion" (Hoodo, 29, married, Somali). These accounts of resistance to FGM drew on religious discourse to challenge cultural practices, with some women going further and describing a woman's right to sexual pleasure as a God-given right: "It's killing off a part of women's lives. I believe this part is very important when you have sex. God created this part for a reason" (Kamelah, 36, married, Sudanese). Other women said that FGM now only happened in rural areas in their home countries and that they were happy it was not practiced following migration.

Reconstructing Reputations. Physical regulation over women's premarital sexual bodies extended to the practice of hymenoplasty. A number of women from Iraqi backgrounds stated that hymen reconstructions were frequently practiced in their community, while in other cultural groups, such as South Sudanese and Tamil, women had not heard of this practice being undertaken in their contexts. While no participant interviewed for this study disclosed having undergone hymenoplasty, women had polarizing opinions about this practice. Women told us: "It depends on the culture she is living in. In our culture, this has happened a lot" (Sharifa, 43, married, Iraqi); "Many women repair their hymen before marriage due to the pressure and demand of the society, culture, and the men themselves" (Nasima, 43, married, Iraqi). In these accounts, the function of the intact hymen in signifying virginity was reified, at the same time as women manipulated this practice through surgical intervention. For other participants, virginity was discursively positioned as something that could not simply be replaced or repaired through a surgical procedure. As one woman said: "You are born with virginity. People think they can make it, but it is not so. It is something God made … it's only one chance. I am sorry, but it's not repairable" (Safi, 43, married, Somali). For other women, a hymen reconstruction was positioned as "cheating for the future husband" (FG, married, Iraqi), "wrong," and "deceiving" and therefore was not supported; "What she has done is wrong and she has to be responsible for her own doings and bear the consequences" (Sharifa, 43, married, Iraqi); "She is deceiving the person that she is going to marry. I don't agree with this" (Wafa, 40, married, Sudanese).

Social stigma was positioned as a major regulatory factor shaping a woman's decision to undergo hymenoplasty: "If I wasn't a virgin, yes, I would [get a hymen repair] … because of the stigma… . If you get married and you're not a virgin, your in-laws will not respect you, nor will your husband respect you" (FG, single, Iraqi). In a further account, Najiba (64, married, Iraqi) told us:

> I feel sorry for the girls who do it, they [are] forced to do it, the community and the culture force them to lie… . The society treats her unfairly when it comes to remain[ing] virginal, so they have to do hymen repair to prove they are still virgin.

Other participants supported the procedure on the grounds of being "raped," an "accident," or a "mistake." For example, participants told us: "If the girl had hymen rupture by raping or accident, this type of hymen repair operation is good" (FG, married, Iraqi); "One may deceive her … or she may enter into a love story, so why we don't help her … to have [a] repair or to be fixed again, and improve herself" (Madina, 45, married, Iraqi). These accounts suggest that women who are concerned about the presence of their hymen, or who have had premarital sex, may approach health care professionals in their new countries of residence to seek advice or to request a hymenoplasty.

Discussion

Across each of the cultural groups that took part in this study, traditional cultural and religious discourses positioned premarital sex as forbidden for women, as reported in previous research with women from migrant backgrounds (Meldrum et al., 2014; Ussher et al., 2012; Wray et al., 2014). While it appeared the imperative to remain virginal effectively regulated many of the participants' premarital sexual knowledge and experience, other women gave accounts that suggested they were challenging or resisting these dominant discourses to negotiate their own meanings of sexuality prior to marriage. These findings demonstrate how women negotiate cultural or religious discourses in order to obtain a degree of sexual agency or a desired sexual subjectivity (Day et al., 2010). An exemplar of such negotiation occurred where women took up a "both/and" position (Brown, 2007), *both* reproducing dominant discourses surrounding premarital sexuality by refraining from premarital sex *and* enacting a degree of agency by resisting cultural and religious discourses, through talking about sex, thinking about sex, and accepting premarital sex as appropriate for "other" women.

It is important to note, however, that discursive options available to migrant women were not endless, reflected in the fact that the virginity imperative was still strongly supported across all cultural groups interviewed, regardless of length of stay in Australia or Canada. Even following migration, feared consequences of transgression acted to limit the discursive space available to women to negotiate

agentic premarital sexuality or relationships with men. Loss of reputation, stigmatization, and being considered unmarriageable are societal mechanisms frequently enacted to regulate unmarried women's sexualities, reduce their sexual autonomy, and restrict exploration of their own sexual desires (Bennett, 2005). While it is important to recognize that some of the women interviewed valued remaining virginal until marriage, the harsh consequences of transgression reinforce the notion of women's uncontrolled sexuality as being dangerous and potentially threatening to patriarchy (Khan, 2012). Latina women who transgressed from the cultural norm of premarital chastity predominantly expressed ongoing guilt and experienced negative connotations toward their sexuality. This suggests that when women do diverge from cultural expectations, they are faced with conflict between their desire for sexual agency and cultural traditions and/or religious morals (Meldrum et al., 2014). In addition, as found in previous research (Abboud et al., 2015; Meldrum et al., 2014), across cultures women's expression of premarital sex was regulated through a sexual double-standard discourse. In comparison to men, there was no discursive or material space for women's exploration of premarital sexuality. In the context of migration, the "symbolic role attributed to women as carriers of ethnic identity" (Akpinar, 2003, p. 428) arguably results in greater pressure being exerted on women to uphold and reproduce traditional cultural values. Thus, women and their bodies may primarily be held responsible for the preservation of sexual morality, with it being a woman's responsibility to control and discipline her desire, while men's behavior is not so scrutinized (Kaivanara, 2016).

In this study, across participant groups, cultural and religious discourses shaped ideals of feminine sexuality that required unmarried women to remain chaste, sexually innocent, and in control of their sexual desire. These findings resulted in unmarried women across the cultural groups engaging in a process of self-policing (Foucault, 1979), such as refraining from thinking or talking about sex and avoiding men, particularly in public spaces. These accounts are analogous to research with young Western women from Australasia, Canada, and the United States, where dominant discourses of feminine sexuality have customarily been tied to a "good girl" discourse, which idealizes the image of women who are passive, asexual, and not knowledgeable about sex (Harris, Aapola, & Gonick, 2000; Jackson & Lyons, 2013; Tolman, 2002). In this vein, young women are required to navigate their sexual expression according to a slut/prude/virgin continuum, expressing enough sexuality to be normative but not so much as to be labeled a "slut"(Holland, Ramazanoglu, Sharpe, & Thomson, 2004; Tolman, 2009; Tolman, Anderson, & Belmonte, 2015). However, these discourses have consequences for women's sexual knowledge, sexual agency, and sexual subjectivity. Women who adopt gendered sexual scripts may have decreased sexual-risk knowledge, are less likely to advocate for themselves sexually, such as negotiating the use of contraception (Bennett, 2005; Curtin, Ward, Merriwether, & Caruthers, 2011), and may have a limited understanding of their own sexual desires and right to pleasure (Tolman, 2009). A lack of dialogue surrounding sex prior to marriage also results in women being vulnerable to negative embodied experiences of first sex (Ahmadi, 2003; Menger et al., 2015; Ussher et al., 2012), as reported by women interviewed in this study. The discursive positioning of sex as culturally and religiously forbidden may prohibit access to sexual health information and services for unmarried women, as being seen by other members of the community at sexual health clinics could result in public ridicule and family conflict (Beck et al., 2005; Rawson & Liamputtong, 2010; Rogers & Earnest, 2015). Consequently, migrant and refugee women may be at risk of poor sexual health outcomes, such as untreated STIs and unplanned pregnancies, if they do have premarital sex (Bennett, 2005; Meldrum et al., 2016).

Our study revealed that, cross-culturally, the majority of mothers we interviewed continued to internalize the virginity imperative for their daughters following migration. In line with previous research with migrant women (Manderson et al., 2002; Salad et al., 2015), mothers used strategies of social control and reiteration of religious norms to promote chastity among their daughters. Across cultural groups, many of the sexual health discussions between mothers and daughters revolved around the material consequences of transgression, through religious and cultural "moralizing" discourses, limiting young women's ability to make sense of their sexuality, with no acknowledgment of sexually safe practices, sexual rights, or a discourse of desire (Tolman, 2009). Disparities in generational beliefs surrounding sexuality, parental control, and pressure to preserve cultural identity may contribute to intergenerational tension (Abboud et al., 2015; Dean et al., 2017; Manderson et al., 2002) and prevent young women from addressing sexual health concerns with their mothers (Rogers & Earnest, 2015). This has implications for young women's sexual health, as the ability to address sexual concerns with parents is a strong predictor of good sexual and reproductive health outcomes (Aggleton & Campbell, 2000). Our findings suggest that new migrant parents may need help to facilitate open sexual health communication with their daughters, as well as support in understanding how migration can affect their daughters' negotiation of premarital sexuality (Dean et al., 2017).

As found in previous research (Cinthio, 2015), cross-culturally, a number of Muslim women who participated in this study discursively constructed the hymen to be a material symbol of virginity. Participants' reference to the hymen as an anatomical structure that "breaks" and "bleeds" reifies constructions of the hymen as a corporeal membrane. This discursive construction is problematic, however, as the hymen is not a reliable indicator of prior sexual experience (Adams, Botash, & Kellogg, 2004; Edgardh & Ormstad, 2002), nor is it a physical structure covering the opening of a woman's vagina. Women may damage the hymen in other nonsexual activities (Essén

et al., 2010) or be sexually inexperienced but still not bleed during first sexual intercourse (van Moorst, van Lunsen, van Dijken, & Salvatore, 2012). It is suggested that factors such as forced sexual relations, lack of sexual arousal, or a vaginal infection are more likely to contribute to the possibility of vaginal bleeding at first sex (Essén et al., 2010). The sociocultural fixation on the hymen as proof of virginity puts pressure on women to bleed following first coitus, leaving women vulnerable to anxiety, violence, depression, and family ostracism (Bekker et al., 1996; Cinthio, 2015; Cook & Dickens, 2009), as reported by women in this study. The continued material significance placed on hymeneal blood may force migrant women to consider hymenoplasty to avoid consequences of transgression (Loeber, 2015; van Moorst et al., 2012). However, the medicalization of the hymen is concerning, given the lack of medical guidelines surrounding the procedure in a Western context (Essén et al., 2010), as well as its questionable efficacy (van Moorst et al., 2012). There is a need to integrate virginity-based education into sexual health information for new migrant and refugee women and men, their families, and community leaders. This includes material aimed to challenge the construction of the hymen as a tangible structure that can verify virginity, as has been done in a European context (Knöfel Magnusson, 2009).

While there have been many explanations for the practice of FGM, such as "tradition" and affirmation of femininity or womanhood (Vissandjée, Kantiébo, Levine, & N'Dejuru, 2003), the majority of Sudanese and Somali women interviewed in this study drew on a discourse of premarital sexual chastity and control to describe why FGM was carried out in their communities, as noted in previous literature (Johnsdotter, Moussa, Carlbom, Aregai, & Essén, 2009; Vissandjée et al., 2003). Similar to prior research with migrant women from countries where FGM is practiced (Johnsdotter et al., 2009; Morison, Dirir, Elmi, Warsame, & Dirir, 2004), this study demonstrated a cultural shift in attitudes toward FGM, with it no longer being positioned as a favorable practice. Women drew on religious discourse to challenge FGM, which confirms previous reports that Islam can be deployed to either criticize or legitimize particular subject positions in sexual health discourse (Sargent, 2006). Following migration, women are more likely to be in a position to resist FGM, as it is no longer considered to provide the advantages it did in their countries of origin, and legal discourse can be drawn on to justify refusing the practice. Exposure to alternative ways of conceptualizing feminine sexuality and a reduction in societal pressure to circumcise daughters may have supported attitude change (Johnsdotter & Essén, 2016; Johnsdotter et al., 2009). However, given the small number of participants who supported FGM, some new migrant women from FGM-practicing countries may benefit from ongoing counseling that is considerate of the sociocultural discourses surrounding women's premarital virginity (Johansen, 2017), as well as education to facilitate understanding of the consequences of FGM for women's health (Elneil, 2016; Wagner, 2015).

The findings of this study have a number of practical implications for service providers and sexual health educators working with migrant and refugee women and their communities. Due to the virginity imperative, sexual and reproductive health services for unmarried migrant women need to be provided discreetly and ensure confidentiality. Single women's prerogative to access sexual and reproductive health information and care, within a human rights perspective (WHO, 2015), needs to be emphasized among migrant communities. Sexual health promotion and education for migrant and refugee women needs to be culturally appropriate and spiritually significant, by acknowledging the complex realities associated with premarital sex within culturally diverse communities (Kebede, Hilden, & Middelthon, 2014; Mosavi, Babazadeh, Najmabadi, & Shariati, 2014). Specific religious principles could be drawn on to promote a sex-positive approach to sexual health education, strengthening women's sense of entitlement to sexual and reproductive health rights (Bennett, 2005). Health care professionals also need to be aware of the sociocultural constructions of virginity to be responsive to migrant and refugee women's questions and requests in relation to hymenoplasty and fear of the absence of blood at first sex.

Strengths of the study include participants being interviewed in their first language, allowing women to explore their experiences in depth; it also meant that newly arrived migrant women could participate in the study. Interviewing women from varying cultural backgrounds also allowed for within- and between-group comparisons. Limitations include the inability of researchers to back-check translated transcripts for accuracy and the fact that transcripts were not member checked. This process would be a helpful addition to future research studies with migrant and refugee women and would facilitate validation of findings and accuracy of interpretation. In addition, many of the participants' accounts were retrospective, which means their experiences may not be reflective of women in their home countries today or of all young migrant women currently living in Australia and Canada. Given the small number of women interviewed from each cultural group, experiences and constructions may not be representative of the communities as a whole. Similarly, given this research is specific to the context of Australia and Canada, our findings may not be generalizable to other Western countries that host migrant and refugee women, particularly where virginity norms may differ from those presented in this study. Further, given the utilization of focus groups as part of the methodology, participants may have felt pressured to provide socially and culturally desirable accounts, rather than their personal experiences and constructions, due to concerns for reputation. For example, if participants had engaged in premarital sex, it is unlikely this would have been disclosed in a group setting, given the stigma attached to such practice in the communities interviewed.

In conclusion, using a material-discursive theoretical framework this study demonstrated that migrant and refugee women's premarital sexuality is closely regulated through cultural and religious discourse and material practice. The imperative to be virginal at marriage shaped women's sexual behavior and premarital relationships, and in some instances denied women their bodily integrity. While previous research has primarily examined migrant women's sexual health within a specific cultural group, the findings of this study have highlighted the importance of considering how multiple intersecting identities, such as cultural identity, gender, religion, and marital status shape women's constructions and experiences of premarital sexuality in the context of migration. Identifying the nuanced ways in which women both reproduce and resist dominant discourses of premarital sexuality is important in understanding their impact on women's sexual subjectivity, is essential to destabilize unitary assumptions about migrant and refugee women, and plays a critical role in the development of culturally safe sexuality education and health care.

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Appendix K: Fertility and Fertility Control Published Journal Article

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"If You Don't Have a Baby, You Can't Be in Our Culture": Migrant and Refugee Women's Experiences and Constructions of Fertility and Fertility Control

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ABSTRACT

The present study was designed to explore experiences and constructions of fertility and fertility control among new migrant and refugee women in Sydney, Australia and Vancouver, Canada. Seventy-eight individual interviews and 15 focus groups ($n = 82$) were conducted with women who had migrated from Afghanistan, Iraq, Somalia, South Sudan, Sudan, Sri Lanka, and South America. Participants positioned having children as a cultural and religious mandate and as central to a woman's identity. Many women had limited knowledge about contraception, positioned contraception as forbidden or dangerous, and described negative experiences with its use. These findings are interpreted in relation to the provision of culturally safe medical practice and sexual and reproductive health education.

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The ability of a woman to choose whether and when to have children is an essential human right endorsed by international health governing bodies (UNFPA, 2013; WHO, 2014a). Women's access to reliable information and to a preferred method of contraception, free from coercion, discrimination, or violence, is fundamental to gender equality and makes possible women's full participation in society (Ibañez, Phillips, Fine, & Shoranick, 2010). Contraception facilitates women's ability to space or limit the number of children they have, reduces associated morbidity and mortality, and enables women to complete their education, thereby improving the economic security of women and their families (WHO, 2017).

In industrialized Western countries, such as Australia, Canada, and the UK, a range of hormonal contraceptive methods are available at a low cost through government subsidy programs. Despite this, inequalities in contraceptive use exist among women from disadvantaged ethnic or racial groups, including women from migrant and refugee[1] communities (Sangi-Haghpeykar, Ali, Posner, & Poindexter, 2006; Aptekman, Rashid, Wright, & Dunn, 2014). Research conducted in Canada, Australia, and Nordic countries has shown that, in comparison to native-born women, migrant and refugee women are less likely to use contraception (Family Planning NSW, 2013; Omland, Ruths, & Diaz, 2014); are more likely to use less effective methods of contraception, such as condoms,

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withdrawal, and rhythm methods (Family Planning NSW, 2013; Richters et al., 2016); and have higher rates of abortion following an unintended pregnancy (Helström, Zätterström, & Odlind, 2006; Vangen, Eskild, & Forsen, 2008).

Migrant and refugee women also have fewer consultations with general practitioners to discuss contraception management than native-born women do, and contraception is less often prescribed to them (Mazza et al., 2012; Raben & van den Muijsenbergh, 2018). Further, in an Australian survey, Sri Lankan migrants were less likely than Australian-born participants to have heard of more effective means of contraception, such as contraceptive implants and IUDs (intrauterine device), and they were more likely to report that they had difficulty in accessing helpful contraception advice (Ellawela et al., 2017). Understanding the factors that impede migrant and refugee women's access to and use of contraception is essential to their reproductive rights, but also important because the ability to plan pregnancy is key to a woman's quality of life, as unintended pregnancies have substantial social, health, and financial costs for women and their families (Cheng, Schwarz, Douglas, & Horon, 2009; WHO, 2009).

Qualitative studies have shown that migrant and refugee women often arrive in their host countries with limited knowledge, or even misinformation, about the range of contraceptive methods available to them (Watts, Liamputtong, & Carolan, 2014). Religious objections to family planning (Degni, Koivusilta, & Ojanlatva, 2006), myths and misconceptions about contraception use (Rogers & Earnest, 2014; Watts et al., 2014), and sociocultural attitudes that prohibit premarital sex continue to shape women's access to fertility control (Wray, Ussher, & Perz, 2014). The influence of patriarchal discourse and practice is evident in migrant and refugee communities, where the use of contraception is often not supported by husbands (Degni, Mazengo, Vaskilampi, & Essén, 2008; Sargent, 2006; Ussher et al., 2012), which suggests that, despite having transitioned to countries where a reproductive rights discourse is more widely accepted, gender inequalities may persist following resettlement (Khawaja & Milner, 2012).

Socially acceptable family sizes and timing of childbearing differ across cultures, religions, and history (Hampshire, Blell, & Simpson, 2012; Srikanthan & Reid, 2008). Some migrant and refugee communities, particularly those from Africa and the Middle East, are expected to have large families following resettlement (Allotey, Manderson, Baho, & Demian, 2004), a cultural norm that may impact the acceptability of contraception use. In contrast, over the past decades in developed countries there has been significant transformation in fertility patterns and family size (Bongaarts, 2002), facilitated by a shared cultural acceptance of modern forms of contraception. For example, the majority of sexually active heterosexual women of reproductive age in Australia use some form of contraception (Freilich et al., 2017; Richters et al., 2016). This has resulted in delayed childbearing, declining fertility rates, and an increasing number of women who choose not to have children at all (Carmichael & Whittaker, 2007; Rowland, 2007), which stands in contrast to discourses and practices associated with women's fertility and fertility control within some migrant and refugee communities (Ussher et al., 2012; Watts, McMichael, & Liamputtong, 2015).

Although previous research has documented rates of contraception use with women from migrant and refugee communities (Family Planning NSW, 2013; Omland et al., 2014), we lack an in-depth understanding of how such women experience and construct fertility and fertility control. Exploring women's subjective experiences in this sphere is

important to understand factors that shape migrant and refugee women's fertility practices, information that is crucial to inform culturally safe sexual and reproductive health care, sex education, and health promotion (Allotey et al., 2004). Past researchers have focused on knowledge and experiences of contraception or fertility among migrant women who have experienced unintended teen pregnancy (McMichael, 2013; Watts et al., 2014; Watts et al., 2015). Qualitative research on contraceptive beliefs and practices has focused on specific populations, such as women from African countries (Degni et al., 2006; Rogers & Earnest, 2014; Sargent, 2006) or young unmarried women (Meldrum, Liamputtong, & Wollersheim, 2016; Wray et al., 2014). Migrant and refugee women are not a homogenous group but come from a wide variety of sociocultural contexts that shape beliefs and practices concerning sexual and reproductive health (Ussher et al., 2012). This suggests that an understanding of the nuanced ways in which intersecting identities, such as gender, religion, and culture, shape adult migrant and refugee women's experience of fertility and reproductive agency is paramount. That was the aim of the current study.

To explore this issue, we formulated the following research questions: How do migrant and refugee women experience and construct fertility and fertility control? How may understanding of these experiences and constructions be used to shape and deliver appropriate sexual and reproductive health information and promotion, education, and clinical practice?

Method

Participants and recruitment

Seventy-eight individual interviews and 15 focus groups ($n = 82$) were conducted between July 2014 and November 2015 in Sydney, Australia and Vancouver, Canada. Our study sample was made up of migrant and refugee women who were between the ages of 18 and 70 years old, with a mean age of 35 years. To allow for analysis within and across diverse cultural communities of migrant and refugee women, we recruited participants who had migrated from Afghanistan, Iraq, Somalia, and Sudan in both locations. Women from Sri Lanka (Tamil) and South Sudan were included in the Australian sample, and women from South America (Latinas) were included in the Canadian sample. The women practiced a range of religions including Islam, Christianity, and Hinduism. With the exception of one Latina who reported that she was in a same-sex relationship, all participants identified as heterosexual. Most participants had arrived in Australia and Canada on humanitarian visas; the average time since migration was 7 years (see Table 1 for more detailed demographics of the sample).

We recruited migrant and refugee women 18 years and older who had settled in Australia or Canada within the previous 10 years. Specific cultural backgrounds were chosen in consultation with our community partners, organizations who provide reproductive health services and resettlement support to migrant and refugee populations. The cultural groups selected were identified as poorly served within existing sexual and reproductive health services, despite the fact that they make up a significant proportion of newly arrived migrant and refugee women; they were also identified as underrepresented in prior sexual and reproductive health research. Australia and Canada were

Table 1. Sample sociodemographic characteristics.

Variable/Group	Afghan (*n* = 35)	Iraqi (*n* = 27)	Latina (*n* = 17)	Somali (*n* = 38)	South Sudanese (*n* = 11)	Sudanese (*n* = 20)	Tamil (*n* = 12)
	M (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)
Age	31.4 (9.1)	38.7 (12.5)	37.1 (5.6)	31.9 (10.4)	36.6 (6.2)	38.7 (7.5)	36.8 (7.3)
Years since migration	5.1 (4.1)	4.3 (2.1)	8.3 (4.9)	5.4 (3.1)	10.8 (2.1)	8.9 (3.4)	5.1 (2.5)
Number of children	3.3 (1.3)	2.7 (1.2)	1.5 (0.7)	3.7 (2.0)	4.5 (2.2)	2.9 (1.1)	2.1 (0.5)
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
Have children							
Yes/pregnant	20 (57.1)	20 (74.1)	11 (73.3)	23 (60.5)	11 (100.0)	19 (95.0)	11 (91.7)
No	15 (42.9)	7 (25.9)	4 (26.7)	15 (39.5)	–	1 (5.0)	1 (8.3)
Religion							
Islamic	35 (100.0)	23 (85.2)	–	38 (100.0)	–	16 (80.0)	–
Christian	–	3 (11.1)	10 (58.8)	–	11 (100.0)	4 (20.0)	5 (41.7)
Buddhist	–	–	1 (5.9)	–	–	–	–
Hindu	–	–	–	–	–	–	7 (58.3)
Non-practicing	–	1 (3.7)	6 (35.3)	–	–	–	–
Education							
Primary	7 (20.0)	6 (22.2)	–	8 (21.1)	3 (27.3)	4 (20.0)	–
Secondary	15 (42.9)	3 (11.1)	2 (11.8)	3 (7.9)	2 (18.2)	5 (25.0)	7 (58.3)
Tertiary	6 (17.1)	18 (66.7)	10 (58.8)	3 (7.9)	2 (18.2)	10 (50.0)	5 (41.7)
Nil	2 (5.7)	–	–	1 (2.6)	2 (18.2)	1 (5.0)	–
Other	1 (2.9)	–	–	2 (5.3)	2 (18.2)	–	–
No response	4 (11.4)	–	5 (29.4)	21 (55.3)	–	–	–
Relationship status							
Married/de facto	17 (48.6)	14 (51.9)	13 (76.5)	13 (34.2)	6 (54.5)	13 (65.0)	12 (100.0)
Single	12 (34.3)	7 (25.9)	2 (11.8)	14 (36.8)	1 (9.1)	1 (5.0)	–
Divorced/separated	2 (5.7)	5 (18.5)	2 (11.8)	8 (21.1)	4 (36.4)	6 (30.0)	–
Widowed	4 (11.4)	1 (3.7)	–	3 (7.9)	–	–	

selected as the study locations due to their geographic, political, economic, and sociocultural similarity; they also have comparable migrant and refugee populations.

Participants were recruited for the study through the distribution of flyers, by staff members employed by migrant resource centers, by the community interviewers themselves, and through snowball methodology. In addition, women were invited to participate through pre-existing cultural community groups and through flyers displayed in sexual and reproductive health clinics that service migrant women. We continued recruitment within each cultural group until there was evidence of data saturation.

Procedure

This research was approved by Western Sydney University Human Research Ethics Committee, Simon Fraser University Human Research Ethics, and by the ethics committee of one of our community stakeholder organizations. To gain cultural insights and to refine the study aims and methods, we consulted key informants and stakeholder organizations. Following this, two members of the research team, in a 1-day workshop, trained community interviewers in qualitative research methods. Training included how to conduct interviews and focus groups and how to transcribe data. Community interviewers were migrant or former refugee women, who were engaged specifically for the study through our stakeholder partnerships. This methodology has been successfully adopted in prior sexual and reproductive health research with non–English speaking

women (Morrow, Smith, Lai, & Jaswal, 2008). The majority of participants ($n = 115$) were interviewed in their first languages by trained community interviewers, who were women of the same ethnic background ($n = 9$) or who spoke the same languages as the participants ($n = 3$). Participants who preferred to speak English or preferred not to be interviewed by a community interviewer undertook interviews with a non-migrant member of the research team; this occurred with 29 interviews and five focus groups ($n = 16$).

Prior to participation, the women received information about the purpose of the research and what the study involved. Participants provided informed consent before the interview or focus group. With the exception of one participant who declined, all participants consented to having their interviews audio-recorded. The interviews and focus groups were semi-structured and lasted, on average, 90 minutes.

The broader study covered questions about menarche and menstruation, sexuality, and health service provision (Ussher et al., 2017). The questions related to contraception were: "Tell me about the use of contraception in your culture"; "Have you used something to help you not have babies, and how do you find these method(s)?"; and "Tell me about the importance of having babies in your culture." The use of focus groups was intended to facilitate the collection of data that highlighted cultural or community norms and practices concerning fertility and fertility control, whereas interviews were used to gain more nuanced in-depth and personal accounts of women's constructions and experiences (Creswell, 2013). However, following data analysis, there were no obvious patterns of disclosure identified across these two methods. As recommended (Krueger & Casey, 2014), focus groups were homogenous; the women were of the same cultural group, but separate groups were conducted for single and married women where possible. Interviews and focus groups took place at locations nominated by participants, such as their homes, community centers, and libraries.

Analysis

We adopted a material-discursive-intrapsychic theoretical approach (Ussher, 2000) situated within a critical realist epistemology (Bhaskar, 2011). Critical realism recognizes the materiality of the body or experience but conceptualizes such materiality as mediated by culture and language (Bhaskar, 2011; Ussher, 2000). A material-discursive-intrapsychic analysis allows researchers to acknowledge the "real" aspects of the body or experience but conceptualizes these events as discursively constructed or shaped within a specific sociocultural and historical context (Williams, 2003). Within a critical-realist epistemology, none of these material, discursive, or intrapsychic levels of analysis is privileged above the other but are seen as irrevocably interconnected (Ussher, 2010).

We also drew on the concept of intersectionality (Crenshaw, 1991) to consider how categories of difference (e.g., gender, culture, religion) intersect to shape individual lives, social practices, and cultural discourses (Davis, 2008). An elemental principle of intersectionality is the view that social categories are not independent or unidimensional but multiple, interdependent, and mutually constitutive (Crenshaw, 1991). Thus, in order to understand or address health disparities, intersectionality moves away from an additive approach of single variables (e.g., gender or race) to consider experience in the light of multiple influential factors that are continuously interacting (Bowleg, 2008).

Data were analyzed using a process of thematic decomposition, a form of discourse analysis that identifies participants' subjectivity and positionality across themes within data (Stenner, 1993). Data analysis was inductive, whereby the development of the themes was driven by the data, not by pre-existing theory, concepts, or research. Interviews and focus groups that were not carried out in spoken English were translated and transcribed by the bilingual community interviewers. English spoken interviews were professionally transcribed verbatim and integrity checked to ensure accuracy. Participants' names were replaced with pseudonyms. A subset of transcripts of interviews and focus groups was read and reread by members of the research team. During this process, first-order concepts, such as "learning about contraception" and "experiences of contraception use," were noted. Through discussion and modification, these first-order concepts formed the basis of the coding framework. Two members of the research team then concurrently discussed, crosschecked, and coded the entire data set using NVivo, a software program that facilitates the organization of coded data. A third member of the research team monitored this process for accuracy.

Codes were then grouped into fewer distinct categories and summarized in detail; notes were made of participants' cultural background and geographical location to highlight commonalities and unique experiences across the data set. The research team met several times to discuss central themes identified through the coding process. Three core ideas were recognized: the mandate that all women have children, men's role in women's fertility choices, and the impact of discursive meanings on the acceptability of contraceptive use. These core concepts formed the three discursive themes described and discussed below: "The motherhood imperative," "Patriarchy, power, and parity: Motherhood and male control," and "Negotiating fertility control: Balancing the unknown, forbidden, and dangerous." Quotes are marked with the participant's pseudonym or "FG" in the case of a focus group, age, and ethnic background. As no substantive differences were identified between accounts by women in Australia and Canada, country of origin is not noted.

The researchers for this study were of a non-migrant or refugee background, as defined by the project. We were aware of our positioning and engaged in a process of reflexivity during the design, data collection, and analysis stages of the research. Reflexivity requires a process of critical self-reflection into the ways in which a researcher's social background, assumptions, positioning, and behavior may shape the research process (Finlay & Gough, 2003). As a part of our reflexive model, and central to an intersectional approach (Hankivsky et al., 2010), we consulted with stakeholders and community members who work with migrant and refugee women at each point of the project. We also had lengthy discussions as a research team to examine and reflect on the ways in which our own subjectivities and identities might have shaped our analysis.

Results and Discussion

The motherhood imperative

The discursive theme "The motherhood imperative," which encapsulates the cultural and familial requirement for women to have children, was discussed by the majority of

participants interviewed. Womanhood was strongly linked to ideals of motherhood, and thus played a central role in the women's identity. Not only were the women expected to be mothers, but they faced additional pressure to reproduce immediately after marriage and to provide a boy child. This is reflected in the subthemes: "Motherhood as central to identity," "Immediate motherhood as a social requirement," and "Preference for a boy child."

Motherhood as central to identity

Across cultural groups, motherhood was positioned by all participants as synonymous with womanhood. As Akoi (40, South Sudanese) told us, "You are a woman, you are considered to have kids," and an Iraqi focus-group member stated, "Everybody wants children, it's nature." Participants drew on religious and cultural discourses to emphasize the importance of motherhood for women: "If you don't have a baby, you can't be in our culture" (FG, Tamil); "We always respect our religion … you can't say 'I don't want marriage' and 'I don't want children'" (Arliyo, 26, Somali). The prerequisite of motherhood to achieve womanhood has previously been reported among migrant women, with childbearing positioned as synonymous with being a "proper," happy, and fulfilled woman (Yebei, 2000, p. 136; van Rooij, van Balen, & Hermanns, 2009). Motherhood is also privileged in Western societies, as evident in discourses that denigrate women who choose to be voluntarily childless (Gillespie, 2000) or in women's reported feelings of inadequacy when faced with infertility (Dryden, Ussher, & Perz, 2014). However, in the West, many women have alternative identity positions or social roles available to them (Batool & de Visser, 2016), and voluntarily child-free women increasingly report positive feminine identities that are separate from that of motherhood (Gillespie, 2003).

The discursive construction of motherhood as central to a woman's identity, and as a cultural or religious duty, had material implications for migrant and refugee women. Our findings suggest that compulsory motherhood may mean that there is little room for women to explore other identities, life achievements, or life pathways. As Janni (32, Tamil) told us: "In our culture, we don't have that sort of choice, lots of women they have the baby, we don't have a choice." As a consequence, women may feel devalued and distressed when they cannot fulfill the motherhood imperative (Remennick, 2000; Riessman, 2000). This was reflected in accounts where women were described by participants as "very broken" (Saadia, 30, Iraqi); "Our culture is like poor her, if you don't have a baby" (Raana, 43, Iraqi).

Among Tamil participants, women without children were described as at risk of stigmatization and exclusion. Sumi (37, Tamil), a participant who described having had trouble conceiving said, "Life was going okay until about 2 years after marriage. Since we didn't have any babies, my relations and friend's parents started calling me names." Tamil focus-group participants stated that women who could not have children were labeled "the unluckies." Janni (32, Tamil) told us:

> When you have a wedding, or … you have your first period, they have a ceremony … women who don't have children they don't really take these women to this function … they think maybe the couple won't have babies because of this woman.

Severe social repercussions of infertility, including ostracism, exclusion, and abuse have similarly been reported among women from other non-Western contexts (Fledderjohann, 2012; Riessman, 2000). However, a cross-cultural study (Batool & de Visser, 2016) showed that, although Western women do experience infertility-related stigma, there was no public scrutiny, rather an internalized "felt stigma" (Scambler, 1984). This is in contrast to the overt social discrimination or "enacted stigma" experienced by infertile women in non-Western contexts.

Immediate motherhood as a social requirement: "When you get married you have to get pregnant straightaway"

With the exception of Latinas, participants across all cultural groups described having been expected to have children immediately after they got married. As Eira (26, Sudanese) said, "When you get married in our culture, they're going to count the first month … [by] the third [month], you are going to get in big trouble." The ability to get pregnant straight after marriage was positioned as "like a test for the woman, if she can give birth or not" (Nasira, 52, Iraqi) and was seen to be important in getting the "reproduction system going" (FG, Afghan). Western women may be located by others within a deficit identity position if they are not partnered with children by a certain age (Addie & Brownlow, 2014); however, they are unlikely to experience such overt expectations and pressures to have children immediately after marriage.

The cultural expectation to reproduce immediately after marriage caused a number of participants to become worried about their fertility. Mahta (39, Afghan) told us: "I didn't get pregnant for the first 5 years, everyone was talking about this … [later] I got pregnant until we reached five [children]. I wanted his family to see we could have children." In instances where conception did not happen immediately, the woman's body was always considered at fault; as Hido (68, Somali) said, "If a man and a woman are married and they cannot have babies, most of the time they will normally check the woman, even the traditional medicine will only treat the woman." In the present study, cross-culturally, much of the reproductive pressure was said to come from mothers-in-law and extended family, as has been found in other studies with migrant women (Hampshire et al., 2012). An Afghan focus group member said:

> My mother-in-law and all the in-law family were getting louder and more boisterous about what's going on, 'why isn't she having a child' … 'it's been 6 months how come she is not pregnant' … I thought they were going to think I am barren or something so … I tried to make it as quick as possible.

The expectation to reproduce immediately after marriage had a number of material consequences for women's sexual and reproductive agency, including the autonomy to choose whether and when to use contraception and to determine the timing of childbearing. For example, a Sudanese focus-group participant said: "I didn't want to get pregnant for 2 years after marriage but … my aunt stopped me, she told me 'you don't know if you can get pregnant or not, so no contraceptive pills for now.'" Even where women were able to negotiate the timing of childbearing with their husbands following migration, they then faced questioning by wider family and community members, as the thought of delaying childbearing was unthinkable to others. For instance, Janni (32,

married, Tamil) described an aunt questioning her choice to use contraception by stating that is was "not really right" and that she would "end up having an IVF baby." In the West, women's contraception decisions generally follow a "my body, my choice" discourse (Wigginton, Moran, Harris, Loxton, & Lucke, 2016, p. 734), but our participants' stories reflect a collective governance over women's reproductive bodies, which had implications for their reproductive agency.

Preference for a boy child: "It's a problem when you only have girls"

One of the major differences found between the participants and native-born Australians and Canadians is the expectation for women to provide a boy child. As a consequence of this requirement, many women reported that they felt pressured to continue to get pregnant until they had a boy: "If you don't have a boy, they will try until they get the boy" (FG, Tamil); "People encourage you, you have to have a boy, you have to have a boy" (Nasira, 52, Iraqi). Across cultural groups, having a boy child was described as important because boys are responsible for "carrying the surname," "the inheritance," and supporting parents in later life. Male offspring are also responsible for ensuring the appropriate burial of parents in the case of Hindu Tamil women. Some women described the pressure to have a boy child as having decreased since migration, but others said such pressure continued: "Here and back home as well, it's the same… - they prefer a boy to carry the name" (FG, Iraqi). The pressure to have a boy child confirms previous research with women from migrant backgrounds (Morrow et al., 2008; Puri, Adams, Ivey, & Nachtigall, 2011). This is partly a reflection of gender inequalities and patriarchal cultural beliefs that men provide greater economic security for parents in old age (Puri et al., 2011). It is also likely to be linked to patrilineal social systems that marginalize and devalue women (Das Gupta et al., 2003).

The expectation to have a boy impacted the acceptability of contraception use following the birth of a child: "If you got a boy, you will be on the safe side, if you got a girl then no, she has to try [again], they will keep pushing" (FG, Iraqi). Such expectations were reported to have made some participants anxious, particularly due to their husband's disappointment about having girls. Azita (37, Afghan) told us: "I was worried because my husband wanted a boy and we only had girls." For some women, this resulted in multiple pregnancies in close succession to achieve the reproductive wishes of their partners and extended family. As Kamila (34, Sudanese) said, "I have two girls first, everyone say you have to get pregnant quick to bring a boy." The sociocultural expectation to give birth to a boy is problematic, as it may increase the likelihood that migrant women experience post-partum depression, reproductive anxiety, and/or verbal or physical abuse from husbands and family if they do not give birth to a son (Morrow et al., 2008; Puri et al., 2011).

Patriarchy, power, and parity: Motherhood and male control

Across all cultural groups, a number of women described their husbands as having the authority to decide when, and how many, children to have. Minoo (32, Afghan) told us: "[If] their husband says he would like to have more children… the woman does not have much say and needs to obey her husband." In addition to the expectation to have

children, women in the Sudanese and Somali communities positioned husbands as pressuring wives to conceive a large number of children: "The man will say, we should have kids every year, he will just say that it's the religion which suggests so" (FG, Somali). Faaiso (32, Somali) said: "It's really crazy, it's the pressure from the husband, it's a culture, men like to have more kids."

When women did not fulfill their husbands' demands for children, divorce was a potential consequence. Participants said things such as: "If you don't want any more [babies], they are going to find another wife" (Kamila, 34, Sudanese). This was further epitomized in Nosheen's (37, Afghan) account:

> I was with him [husband] for 10 years, after that we separated because I didn't get pregnant … he was happy, but only because I couldn't give him a child, he got married again. It is our culture to have children.

This practice continued after migration, as Ranna (43, Iraqi) said, "Even here [Australia] … they have the same mentality, she should have a baby because maybe the husband will marry another lady." The fear of being left by their husband had material and psychological consequences for women's health. As Hasina (25, Somali) told us, "Sometimes they get sick [women], the doctor says don't get pregnant again, and she is thinking 'the man will leave,' that's why she risks herself." The expectation to have many children was also difficult for women to manage, particularly following migration where women lost traditional familial support networks that help them to raise children. As Akoi (40, South Sudanese) said, "Raising a kid is extremely difficult, we are not in Sudan where we get support, here it's just you and your baby."

A further consequence of men's preference for large families was that, in some instances, husbands prohibited their wives from using contraception. As Joyce (45, South Sudanese) said, "Some of the men are not accepting it [contraception] … they want to have a big family." Other women reported that contraception use may be allowed; however, they would need to gain consent from their husbands: "We would talk to our husbands, we will not do anything before talking to them" (FG, Somali). Similar accounts have been reported by other migrant and refugee women (Rogers & Earnest, 2014) and acknowledged by health care professionals who work within these communities (Kolak, Jensen, & Johansson, 2017; Mengesha, Perz, Dune, & Ussher, 2017). Consequently, addressing patriarchal control over women's reproductive bodies needs to be made a priority in future programs that address contraception use in migrant and refugee communities.

Resistance to patriarchy: Negotiating fertility control with partners

In a number of accounts, women described having resisted attempts to control their fertility. Some women reported taking hormonal contraceptives in secret: "I used to do it [use contraception], but still men don't like it you know … I used to hide them from him" (Faaiso, 32, Somali); "I used the tablet for 2 or 3 months … he didn't know" (Nyandeng, 34, South Sudanese). Other women resisted their husband's control over their fertility by stating that contraception use was up to the woman, as she was the one carrying the pregnancy, or by asserting their own wishes: "it's up to me … they're not the one carrying for 9 months" (Faaiso, 32, Somali); "I just tell my husband to back off"

(FG, Somali). Participants described migration as having provided women with the ability to challenge patriarchal control, which resulted in greater reproductive freedom than they had had in their home countries: "In Afghanistan the males are dominant … in Australia, the woman has to be happy to get pregnant, the husband cannot force her" (Safia, 28, Afghan).

Not all husbands were described as controlling their wife's fertility, which suggests that not all migrant and refugee women are denied reproductive agency. A number of women positioned contraception use as a joint decision and felt supported in their decisions: "He would happily support me on whatever I wanted to use" (Akeck, 31, South Sudanese); "I made a decision … so I talk to my husband and he was like really keen" (Janni, 32, Tamil). Other women described normalization of family planning within the marital relationship as having been facilitated by health care professionals after migration; as Eira (26, Sudanese) said:

> When you give birth to the baby at the hospital, the nurse comes and talks to you, even your husband … to tell you after 6 weeks, you have to go and get it [contraception], its normal, not like Sudan, if you do it your husband can hit you.

Such accounts suggest that including women's husbands when health care professionals are providing contraceptive counseling to women may support the acceptability of its use. This recommendation stands in contrast to practices of health care professionals in the West, who believe that the presence of men may inhibit women's reproductive choices (Mengesha et al., 2017; Newbold & Willinsky, 2009).

Across Somali, Sudanese, and South Sudanese participants' accounts, women positioned large families as a choice that reflects culture, migration, and their own personal desires. For example, Elmera (34, Sudanese) said that, having come from a "big family background" herself, she would prefer a large family. The importance of large families was enhanced in the context of migration for some women, particularly when they had migrated alone or had few family members in their new host countries: "I came by myself … I don't have any family here. What can I do better [than] to make my own family" (Lokoya, 42, South Sudanese). Large families were also constructed as providing more status within the community: "Big families, nobody can bother you" (Suz, 42, South Sudanese). Large families were also seen as necessary, in case children should die of illness or not fulfill their duty to look after parents in old age. These accounts reveal that large family sizes were celebrated and wanted by some women, who adopted positions of agency in relation to their reproductive choices. This suggests caution in positioning migrant and refugee women as passive victims of patriarchal cultural norms or expectations if they fail to conform to Western norms of small family size (Hampshire et al., 2012).

Negotiating fertility control: Balancing the unknown, forbidden, and dangerous

Participants who had considered fertility control described themselves as navigating a myriad of discourses and regulatory practices associated with contraception use. The three subthemes that fall beneath this central theme are: "Fertility control: An unknown territory," "Contraception as forbidden," and "Dangerous liaisons: Adverse contraceptive experiences, fears, and misconceptions."

Fertility control: An unknown territory

Across and within cultural groups, women reported various levels of knowledge and uncertainty about contraception methods, which had implications for their decision making in relation to fertility control. In some instances, women reported that they "don't know anything" and have "zero awareness" (FG, Tamil) or "have no idea" (Suz, 42, South Sudanese) about contraception. Other women had some knowledge and could describe a small number of contraception options: "All I know is the IUD or taking pills" (Mahta, 39, Afghan). Modern forms of fertility control most commonly mentioned by women were the pill, IUD (without differentiation between hormonal and non-hormonal devices), injectable contraception, implants, and condoms. However, the women did not discuss, or demonstrate awareness of, the range of contraceptive pills available, vaginal rings, tubal ligation, or the use of emergency contraception.

Women's unawareness of contraception, or specific contraceptive methods, may be a reflection of limited knowledge of fertility control. In line with previous research with migrant and refugee women (Quelopana & Alcalde, 2014; Watts et al., 2014), this suggests that some women may arrive in host countries with limited or inaccurate knowledge of contraception and the reproductive functions of the body. However, women's self-positioning as having "no idea" may also be a reflection of a cultural reluctance to discuss such a topic in an interview context. For example, some participants described a lack of contraceptive knowledge as being a consequence of a "culture" in which sexuality and reproductive talk is discouraged: "We can't talk like that, we are very shy" (FG, Tamil); "In general it is really hard to speak about it" (Azita, 37, Afghan).

One of the consequences of this silence is that a few women reported reluctance to speak to one another about contraception or to seek medical advice about its use. Akeck (31, South Sudanese) said: "No one would talk to another person regarding that [contraception] … I never seek any … like health advice in that regard. I just make my own analysis." A reluctance to discuss contraception has similarly been reported in prior research with migrant and refugee women (Rogers & Earnest, 2014); it may, in part, explain why migrant women are less likely than other women to discuss contraception management with their general practitioner (Mazza et al., 2012). It may also mean that women could find it difficult to discuss contraception with their husbands, which is problematic as spousal communication is associated with greater contraception use (Kamal & Islam, 2012).

Across the cultural groups interviewed, many women described having received extremely limited education about contraception prior to migration; thus they arrived in their new countries of residence with little or no sexual and reproductive health knowledge: "Education is very low, that part of education is nil" (FG, Tamil); "In Afghanistan, it is very hard to find information about stuff like this" (Azita, 37, Afghan). The majority of women interviewed said they had learned about contraception following migration: "It wasn't until I came here [Canada] that I got information and knowledge about the big variety of different contraceptive methods" (FG, Latina); "I got to know about it [contraception] here" (Nita, 27, Tamil). Other reasons for poor contraceptive knowledge included not having had the time to look into it and ambivalence about contraception information, particularly if women had no intention of using it: "It's a very busy life … I have no time to think about that [contraception] now"

(Andrea, 26, Tamil); "No, I don't know anything about it … honestly I don't want to take it" (Amaal, 42, Somali). These accounts highlight the importance of recognizing the structural factors that may impede women's ability to prioritize their sexual and reproductive health. Migrant and refugee women face multiple challenges during the resettlement period, such as finding employment and securing housing, which may result in their sexual and reproductive health needs being given a low priority (Benson, Maldari, Williams, & Hanifi, 2010).

In a few accounts, women did report good knowledge about contraception, gained through seminars while in refugee camps, the Internet, family doctors, and community health programs. Participants also described seeking information from mothers, aunts, sisters, and married friends, whom they positioned as well-trusted and frequently accessed resources: "I also knew about it [contraception] from my aunts … we have a strong connection, they are like our sisters" (FG, Sudanese); "[I learned] from my sister, she is older than me and is married" (FG, Iraqi). However, across cultural groups, even where women could describe contraceptive methods and options, this did not guarantee that they used them. Bashira (44, Iraqi) said, "I know some information about it, but actually I didn't use it"; and Banoo (28, Afghan) said, "Yes, I have heard of them, but I haven't used any." This disjuncture between contraception knowledge and behavior has similarly been reflected in previous literature with migrant and refugee women (Watts et al., 2015). Women need accurate contraceptive information for informed decision-making, and it is equally important that women's wider sociocultural contexts are recognized, as knowledge alone does not always lead to changes in fertility-related behavior (Marston, Renedo, & Nyaaba, 2018; Watts et al., 2015).

Many women, across all cultural groups, constructed contraception as untrustworthy. This was reflected in accounts where women described getting pregnant despite having used contraception: "In spite of taking pills … I got pregnant" (FG, Latina); "We used condoms, but then, that's how I got pregnant with my second child, so I didn't trust it anymore" (Homa, 40, Afghan). Contraceptive failure is a commonly endorsed reason why many non-migrant women experience unintended pregnancies (Rowe et al., 2016). However, women or their partners may also be unaware of the ways in which specific forms of contraception prevent pregnancy, or they may not use contraception regularly. For example, Sharifa (43, Iraqi) told us, "The two sides of the IUD close the two passages to tubes that take you to the eggs … sperm can't get through and they have to return back" and Faaiso (32, Somali) said, "I got pregnant while using the tablet, maybe I forgot sometimes."

A large number of women across all cultural groups gave accounts that suggested that they did not have adequate knowledge about their reproductive bodies, particularly in relation to menstrual cycles, breastfeeding, and pregnancy. A Tamil focus group member said, "When I got the first child, after 6 months I'm pregnant with the second one … we never expected that"; and Erina (39, Somali) said, "I was breastfeeding only, I was thinking if someone is breastfeeding they can't get pregnant … I got pregnant so quick." Similar findings of low knowledge in relation to fertile days of the menstrual cycle (Rowe et al., 2016) and the use of breastfeeding as a form of contraception (Richters et al., 2016) have also been reported among women in population-based surveys within Australia.

Limited knowledge about fertility was also evident when women no longer took precautions to prevent pregnancy in midlife, as they believed they were no longer fertile in their early 40s. Ariana (40, married, Latina) said: "I'm currently not using any method [of contraception]… fortunately now I am 40, so it is difficult for me to get pregnant… I can finally enjoy sex without being worried that I am going to get pregnant." Inadequate knowledge about the reproductive body and contraception methods may leave women vulnerable to unintended pregnancy (Watts et al., 2014). Consequently, migrant and refugee women may benefit from access to comprehensive sexual and reproductive health information that details contraception options, specifics about the way in which they function, and broader knowledge of the reproductive body.

Contraception as forbidden: "My religion doesn't allow us to stop having children"

Although religious beliefs are important in some Western women's fertility choices, migrants are even more likely to report being influenced by the teachings of their affiliated religions (Ellawela et al., 2017). In a number of participants' accounts, contraception was discursively positioned as culturally or religiously forbidden. Such beliefs were described as having strongly shaped women's reluctance to use hormonal contraceptive methods: "Whatever number of kids God will give me, I will keep on having… my religion doesn't allow us to stop having children" (Hani, 32, Somali); "My religion doesn't allow it… it's like killing" (Maano, 19, Somali). The cultural and religious prohibition of hormonal methods of contraception resulted in many women using "natural" methods of contraception, such as withdrawal or the rhythm method. This was particularly evident in interviews with Muslim women and in some Christian women's accounts. Elmera (34, Sudanese) told us: "In my religion, I can't go to the doctor to make the medicine [contraception], I use natural rhythm." Fears about hormonal contraception use were a further reason why some women used natural methods. Anju (44, Tamil) said she "never used anything… we avoided the conceiving time"; and Kamelah (36, Sudanese) told us, "I think the 'days system' is safer for me and it works." A high use of withdrawal for contraception has similarly been reported in population-based studies in Australia and Canada (Black et al., 2009; Rowe et al., 2016). This may reflect broader concerns that women and couples have about side effects of hormonal contraception, as well as the view that withdrawal offers a safe, convenient, and free alternative (Jones, Fennell, Higgins, & Blanchard, 2009).

However, practices such as withdrawal and the rhythm method are problematic because they are less effective methods of pregnancy prevention (Trussell, 2004), which was confirmed by Zarina (32, Tamil), "[I didn't] use any pills or condoms I made a mistake on the day's calculation and fell pregnant with my second child," and a Tamil focus group participant, "two time[s], it was an accident, then I got a termination." Natural methods also had intrapsychic implications for women; participants described feeling anxious about unwanted pregnancy, as it was always "on your mind" (Tamil, FG).

Religious edicts also prohibited contraception for unmarried women, because they are often forbidden to be sexually active prior to marriage: "I don't use it you know, we are not married" (FG, Somali); "I've never been in that sort of [sexual] relationship… I haven't had the need to think about it… I don't find any interest to ask people either" (Samira, 21, Afghan). However, a lack of contraception knowledge prior to marriage

may leave married women vulnerable to unintended pregnancy, as evident in Nasira's (52, Iraqi) account: "I didn't know how to use it … the contraception pills, so I didn't use them." It could also mean that when young women choose to have premarital sex, they may avoid contraception use or health care services, in fear that their parents or community would discover they are sexually active (Rogers & Earnest, 2014; Shoveller, Chabot, Soon, & Levine, 2007).

In a few accounts however, women drew on religion to justify family planning and fertility control. Amran (47, Somali) told us, "Even the religion itself talks about spacing the children"; and Arliyo (26, Somali) said, "I don't know why they think you can't use it [contraception] … the religion allows that." These contrasting findings highlight how diverse religious interpretations account for different reproductive practices (Degni et al., 2006; Srikanthan & Reid, 2008) and how religion may be employed to both criticize and legitimize sexual and reproductive health practices (Sargent, 2006).

Dangerous liaisons: Adverse contraceptive experiences, fears, and misconceptions

Negative experiences with hormonal contraception and fear of its side effects are consistently cited across global contexts and sociocultural settings in both Western and developing countries (Chebet et al., 2015; Dixon, Herbert, Loxton, & Lucke, 2014). In line with previous research, women in our study, across all cultural groups, described concerns about side effects and constructed contraception as dangerous. For example, women reported that, in their communities, "There's a lot of concerns" (FG, Sudanese) and "There were a lot of horror stories" because contraception "creates a whole range of damages to other parts of the body" (FG, Afghan). Feared concerns and embodied experiences included weight gain, hair loss, growths in the uterus, fibroids, cancer, changes in libido, headaches, infertility, fluctuations in mood, and changes to the menstrual cycle. As Sumi (37, Tamil) said, "We didn't want to use contraceptives because through my friends I knew it can mess up conceiving." A Latina focus group participant told us: "The pills had a very negative effect on my body and my overall emotional life."

A "disturbance to the menstrual cycle" (Setara, 23, Afghan) as a consequence of contraception was culturally constructed as "very unhealthy" or "harmful" because menstruation is thought to play a cleansing role in the body. For example, Habibah (43, Iraqi) said: "In our culture, we say that if there is no bleeding, the blood will harm the body." Anosha (30, Afghan) had questions about the long-term ramifications of no monthly bleeding: "I wonder … will it create complications? So, all those periods just stay in and gather up, right? I don't know, but these are the kind of problems." The value of regular monthly menstruation has also been reported in other non-Western contexts in relation to its "cleaning" function and as a signifier of fertility (Marston et al., 2018). Although some women in Western contexts view regular menstruation as important, many other women see the absence of menses as a positive non-contraceptive benefit of methods such as subdermal implants (Flore et al., 2016; Kelly et al., 2017). This highlights how different cultural constructions of menstruation influence the acceptability of certain contraceptive methods.

Similar to previous research (Kelly et al., 2017; Weisberg, Bateson, McGeechan, & Mohapatra, 2014), many of our participants described experiences of heavy bleeding after having used the IUD, "the implant," or "the injection." Madina (45, Iraqi) said: "I

had bleeding for 4 months … so I went to the physician and told him 'I can't stand it, I want to pray, I want to fast … I don't want it. Please remove it.'" Cultural constructions that position a woman's menstrual blood as dirty and polluting prohibit some women from diverse cultural and religious backgrounds from engaging in specific activities during menses, including praying and sexual intercourse (Dunnavant & Roberts, 2013; Hawkey, Ussher, Perz, & Metusela, 2017). It is therefore likely that these restrictions render some forms of contraception, which may cause unpredictable or prolonged bleeding, unacceptable (Hawkey et al., 2017). Consequently, possible changes in bleeding patterns following initiation of contraception, such as long-acting reversible methods, must be sufficiently acknowledged with women during pre-contraception counseling (Weisberg et al., 2014).

These negative embodied and psychological experiences led women to use a range of contraceptive methods in an attempt to find an appropriate fit or to stop using contraception altogether. As one participant said, "I tried the IUD, it was not suitable for me because of the continuous bleeding … then I used contraception pills, it caused nervousness and headaches … I have no other options" (FG, Iraqi); another said, "Once I used the IUD and it made me bleed and I stopped it. I didn't do anything else" (FG, Sudanese). Feelings of dissatisfaction with available contraceptive methods that led to discontinuation have similarly been reported by Western women (Dixon et al., 2014; Mills & Barclay, 2006). This highlights not only women's experimentation with contraceptive methods to avoid pregnancy and find an appropriate fit, but also the need for clinicians to adopt a model of shared responsibility, such as encouraging the use of male condoms (Wigginton, Harris, Loxton, Herbert, & Lucke, 2015).

In contrast to the positioning of contraception as dangerous, a few women described being "very happy," feeling "safe," and feeling "worry free" with their choice of contraception and reported no negative effects on their health and well-being. For example, one woman said that she liked having no periods following the insertion of her IUD: "I didn't get any period … I think it's a good thing because I had over-bleeding" (FG, Tamil). Similarly, Nafisa (36, Sudanese) told us: "I'm very happy … I would not try something else, it's [IUD] very convenient for me right now." These examples show that some women were able to overcome negative past experiences and community myths or misconceptions to find an appropriate contraceptive fit.

Implications and Suggestions for Future Research

The results indicate that migrant and refugee women's fertility and fertility control were shaped by the interplay of cultural and religious discourse and the materiality of women's relational context and influenced by women's negotiation of both. Although cultural or religious discourse acted to regulate some women's fertility and fertility control, other women actively resisted restrictive discourses and practices to enact their own reproductive agency. This finding illustrates how women have the potential to "rewrite" or resist traditional constructs and practices associated with their reproductive bodies by mobilizing counter-stories that position their fertility choices in more agentic ways (McKenzie-Mohr & Lafrance, 2014). These nuanced differences highlight the heterogeneity that exists both within and across cultural and religious groups of migrant women, and they show that religion and culture are often exaggerated categories of difference

that are drawn on to describe the cultural "other" as devoid of agency or autonomy (Bilge, 2010). It is important that health care professionals recognize migrant and refugee women's different constructions and experiences by providing individualized sexual and reproductive care that avoids stereotypes often attached to specific cultural or religious groups (Srikanthan & Reid, 2008).

At the same time, however, health care professionals working with migrant and refugee women need to be aware of the range of sociocultural factors that shape women's ability or willingness to use contraception (Newbold & Willinsky, 2009). To address these factors, it is important that health care professionals ask women whether there are any cultural or religious beliefs that they should be aware of when discussing contraceptive methods. To facilitate such conversation in practice, future researchers could work with migrant and refugee women and health care professionals to develop a contraception decision-making tool to be used during contraceptive counseling. This could provide clear information of the contraception options available and how they work, their efficacy, and their potential side effects.

It is also important that, where possible, health care professionals employ a whole-of-family approach to education and decision making about contraception and family planning (Rogers & Earnest, 2014; Watts et al., 2015). It is equally important that women are aware of their own sexual and reproductive rights following migration to Australia, Canada, or elsewhere. For women who wish to enact control over their fertility and who do not have support from their husband or family, it is important that health care professionals encourage women to make their own contraceptive decisions by drawing on a human rights–based approach (WHO, 2014b). Furthermore, given the reported effect of husbands on some women's reproductive agency, future researchers need to include in their studies migrant and refugee men's perspectives on fertility and fertility control. This could include possible changes in gender roles in the context of migration, how men themselves construct hormonal methods of contraception, strategies that best foster husbands' support of contraception, and the most appropriate ways to increase men's access to sexual and reproductive health education.

High-quality communication between patient and health care providers about contraception has been associated with patients' continued use of highly effective contraceptive methods (RamaRao, Lacuesta, Costello, Pangolibay, & Jones, 2003). However, migrant and refugee women often report a lack of cultural competency and ineffective communication with health care professionals (Degni et al., 2006; Rogers & Earnest, 2014). This suggests the need for cultural competency training for health care professionals and health educators who work with migrant and refugee communities (Mengesha, Perz, Dune, & Ussher, 2018; Rogers & Earnest, 2014). Such training could cover ways to initiate and discuss sexual and reproductive health effectively, as well as provide insight into health issues specific to migrant and refugee women (Mengesha et al., 2018). To support women in finding the most appropriate contraceptive fit, health care professionals must go beyond simply prescribing contraception and must enter into a process of shared decision-making and information sharing, and they must appropriately respond to concerns and manage side effects (Carvajal, Gioia, Mudafort, Brown, & Barnet, 2017; Chebet et al., 2015).

It is critical to address misconceptions about and negative experiences with hormonal contraception methods in order to support migrant and refugee women to achieve

reproductive goals and counter secondhand knowledge that may be present within their communities (Chebet et al., 2015). Following arrival and during resettlement, migrant and refugee women need access to transparent information about culturally constructed contraceptive misconceptions, the ways in which contraceptive methods work, and comprehensive education about the reproductive body (Rogers & Earnest, 2014). Women may also need reassurances that, although some women do experience mild side effects, such as headaches or weight gain, severe complications are rare (Kiley & Hammond, 2007). Given women's reluctance to communicate about contraception, providing sexual and reproductive health information in the women's native languages that accommodates different literacy levels may also facilitate increased reproductive health knowledge and awareness of available health care services (Rogers & Earnest, 2014). To ensure cultural sensitivity, education sessions focused on sexual and reproductive health topics could be developed and disseminated by same-sex community educators or community leaders and could take place at migrant resource centers or as outreach activities attached to community events (Kolak et al., 2017).

Strengths and Limitations

The strengths of the current study include the use of a qualitative research methodology, which captured women's voices, subjective experiences, and constructions of fertility control. Including women from multiple different cultural backgrounds facilitated examination of differences and commonalities across cultural groups. Interviewing women in their first language allowed women to explore their experiences without the limits of their spoken English and meant that newly arrived migrant women could participate in the study. Providing English-speaking participants with the option of being interviewed in English with a non-migrant interviewer meant that we could provide women with choices in relation to how they were interviewed, as some might have felt more comfortable talking with another member of their community, whereas others might have felt more comfortable with an outsider. Limitations include the fact that some participants' accounts were retrospective (i.e., they may not be representative of women's experiences in their home countries today). Furthermore, we could not back-check translated transcripts for accuracy or complete member checking of our findings. Member checking, particularly where researchers do not share the same cultural background as participants, could be a useful strategy in future research with migrant and refugee women to help ensure that the realities of women's lived experiences are represented appropriately.

Conclusion

It is important that migrant and refugee women have access to appropriate contraceptive information and methods, but education about methods of fertility control alone is unlikely to result in changes to fertility behaviors. Greater recognition of the complex cultural, religious, and gendered discourses and practices that restrict women's reproductive agency must be reflected in sexual and reproductive health care provision, education, and health promotion programs.

Note

1. The term *culturally and linguistically diverse* (CALD) is used in Australia to describe people who have a cultural heritage different from the dominant Anglo Australian culture (Australian Government Department of Health, 2016); it replaced the previously used term of people from a "non-English-speaking background" (NESB). As this term is not used in Canada, where many of our participants reside, we define our sample as "migrant and refugee women."

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