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Factors Influencing Contraception Awareness and Use: The Experiences of Young African Australian mothers

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The aim of this study was to examine contraception awareness and use among African Australian women in Melbourne, Australia, who have experienced teenage pregnancy, and to explore the social contexts that shape these women's attitudes towards contraception. Among young immigrant and refugee women living in sites of settlement, knowledge and use of contraception are a public health concern. The study used a qualitative research approach and was informed by anthropology, public health and human rights frameworks. Between June 2009 and November 2010, in-depth interviews were conducted in Melbourne, Australia, with 16 African Australian teenagers and women who had experienced teenage pregnancy. In addition, two focus group discussions were held with service providers and African women and five key informant interviews were conducted. Data were transcribed verbatim, coded, and key themes identified and analysed using thematic analysis. The findings revealed that attitudes towards and use of contraception are influenced by parental sexual health literacy and attitudes, gender roles and culturally informed attitudes around motherhood. Service providers should consider the value of whole-of-family and community approaches in order to improve knowledge and decision-making around contraception among young African Australian women.

Keywords: Sexual health, migrants and refugees, gender equity, unprotected sex, HIV/AIDS, adolescent pregnancy

Introduction

In this article, we explore the social contexts that shape young African Australian mothers' attitudes towards contraception, including their parental influences, gender roles and cultural values around pregnancy and motherhood. We consider the perceptions of service providers, young African Australian mothers and older African women. The sociocultural significance of sex, sexuality, contraception and parenthood are a determinant of sexual and reproductive health outcomes. This article contributes to the limited body of research that focuses on the sociocultural dimensions of sexual health literacy among resettled young people with refugee backgrounds. It examines contraception awareness and use among young African Australian mothers with refugee backgrounds living in Melbourne, Australia, and provides suggestions for service provision and policy.

The sexual and reproductive health of resettled young people with refugee backgrounds is a significant public health concern. Young people are at a critical developmental stage of their sexual and reproductive lives; young people with refugee backgrounds face particular challenges associated with forced displacement and resettlement that have the potential to contribute to adverse sexual and reproductive health outcomes. Yet there is limited research that focuses on the sexual health needs and experiences of young people with refugee backgrounds following resettlement in developed countries. Research focusing on refugee sexual and health has predominantly focused on complex emergency services in camps and first countries of asylum. Yet, in resettlement contexts, young people with refugee backgrounds have specific sexual health concerns, including inadequate contraceptive knowledge and use (McMichael and Gifford 2010; Ngum Chi Watts *et al.* 2013). For young resettled refugees, contraceptive knowledge and use are shaped through the intersections of forced migration and settlement experiences, identity, economic status, intergenerational engagement, family and social networks, ethnicity and culture, gender and access to services. The dynamics of these intersections have important implications for the sexual health and wellbeing of young people with refugee backgrounds. In this article, we examine contraception awareness and use among young African Australian women with refugee backgrounds living in Melbourne, Australia.

Globally, social contexts inform and shape contraceptive knowledge, attitudes, belief and practice (Cleland and Ali 2006; Cleland *et al.* 2006; Adanu *et al.* 2009; Bogue 2010; Ngum Chi Watts 2012). Low contraception uptake and use have been attributed to constraints relating to availability, affordability and accessibility together with cultural/social orientation and gender inequalities (Asamoah-Odei *et al.* 2004; Halperin and Epstein 2004; Foster *et al.* 2012; Ngum Chi Watts 2012). Conversely, improved contraception uptake and use have been documented in some countries, which has been attributed to effective education, community engagement and service delivery: in Ethiopia, contraception use has more than doubled in a decade (Olson and

Piller 2013) contributing to lower birth rates; in Uganda, an increase in condom use has recently significantly reduced the incidence and spread of HIV (Cleland and Ali 2006). Nonetheless, there are ongoing debates regarding the central factors that support and inhibit contraceptive use (Boonstra 2014).

While contraceptive knowledge remains a central focus of sexual health promotion and harm-reduction strategies, it is not the sole determinant of contraceptive behaviours. Indeed, knowledge of contraception does not necessarily translate into usage—a trend observed among low-income African Americans (Ricks *et al.* 2013) and sub-Saharan Africans (Arowojolu *et al.* 2002; Cleland and Ali 2006; Braeken and Cardinal 2008). Differences in contraceptive use have also been linked to culture, ethnicity and gender differences (Cleland and Ali 2006; Snow 2007; Dlamini *et al.* 2009; Wamoyi *et al.* 2011; Hankivsky 2012). Sociocultural contexts shape and influence health-related thinking, behaviour and outcomes. It is now widely recognized that effective health interventions should focus not only on education and increasing knowledge, but must build upon local practices, target ‘receptive’ community members, mobilize communities, increase local skills, and recognize time, economic, gender, cognitive, cultural and social constraints on agency (Boonstra 2014).

Gender substantially affects health and decision-making abilities, including contraceptive uptake and use. In many traditional African cultures, male superiority over females is assumed, which creates gender inequalities, with direct and often adverse implications for contraception knowledge, attitudes and uptake among women (Halperin and Epstein 2004; Shearer *et al.* 2005; O’Sullivan *et al.* 2006; Dlamini *et al.* 2009; Wamoyi *et al.* 2011; Khawaja and Milner 2012). Khawaja and Milner (2012) have highlighted the gender inequalities that exist among African Australians prior to migration and how these persist post settlement. Following migration to Western countries (Khawaja and Milner 2012; Mellor *et al.* 2012), the traditional gender roles of countries of origin continue to affect decision-making and health outcomes.

In the last two decades, refugees from Africa who have resettled in Australia through the Humanitarian Program have fled violence and instabilities in their homelands (Hugo 2009). As a result, many have experienced disrupted education, including sexual health education, limited access to health care, and fragmentation of family and social networks (McMichael and Gifford 2010). Upon migration to new countries of settlement, girls and young women with African backgrounds face many demands and challenges, and their sexual and reproductive health needs are often overlooked (McMichael and Gifford 2010). Many African parents retain traditional gender norms and values and they expect girls to dress conservatively, minimize interactions with the opposite sex, and confine themselves to schoolwork and home duties. ‘Good girls’ are submissive and obedient, which is evidence of a good character and morals and reflects well on the female and her family (Ngum Chi 2006; Mellor *et al.* 2012). Being a good girl increases

an African girl's chances of securing a good marriage, husband and bride price (Kaye *et al.* 2005; Bishai *et al.* 2009). Paradoxically, parental and community expectations of submissiveness and obedience among young women can increase the risk of oppression within marriage (Abu-Duhou 2007; Ngum Chi Watts 2012; Khawaja and Milner 2012) and limit their negotiating power, including in relation to contraceptive use (Kaye *et al.* 2005; Ngum Chi 2006; Bishai *et al.* 2009).

As a newly emerging migrant group (inclusive of skilled migrants and refugees) (Hugo 2009), many Africans in Australia remain conservative with strong traditional and religious belief. Many African refugees continue to live in low socioeconomic situations with comparatively large families averaging six children or more (Khawaja and Milner 2012). For women from conservative backgrounds, pregnancy is a norm (Abu-Duhou 2007; Ngum Chi Watts 2012), with larger families awarded higher respect in the community (Abu-Duhou 2007; Phakathi 2012). Conversely, in Australia, among women with European ancestry, small family sizes remain the norm because of social attitudes, high educational levels, widespread contraceptive access and use, and positive attitudes towards family planning (Marie Stopes International 2006), while pregnancy, birth and abortion rates have reached historic lows in America (Boonstra 2014).

Studies have highlighted concerns about the sexual health knowledge and literacy among newly arrived African Australians (Sheikh-Mohammed *et al.* 2006; Lemoh *et al.* 2008; Drummond *et al.* 2011; Ngum Chi Watts *et al.* 2013), with teenage pregnancy perceived to be problematic within this population (McMichael 2008). Additionally, inadequate knowledge and low uptake of contraception among African Australians have been variously attributed to limited education, poor attitudes and beliefs about contraception, and gender imbalances (Arowojolu *et al.* 2002; Asamoah-Odei *et al.* 2004; Tensou *et al.* 2008).

Methods

This article derives from doctoral research conducted by the first author that focused on contraception, teenage pregnancy, culture and motherhood among young African Australians with refugee backgrounds in Greater Melbourne, Australia. Qualitative methods are widely used in the health sciences and are regarded as an effective and appropriate method when exploring the complexities of life experiences, or a phenomenon that is highly sensitive (Marshall and Rossman 2011; Creswell 2013; Liamputtong 2013). Qualitative methods are frequently used to explore 'sensitive' topics such as sexuality and sexual health (Tillman 2006; Furler *et al.* 2010; Gyesaw and Ankomah 2013) including among participants with culturally diverse backgrounds. A qualitative approach was used for this research in order to generate a rich picture of the contexts, experiences and processes that influence contraception uptake

and use among young African Australian mothers. Ethics approval was granted by the Victoria University Human Research Ethics Committee.

Cultural Competency Framework

The study used a cultural competency framework that requires the researcher to have awareness of their own culturally determined values, beliefs and actions (Lee and Farrell 2006). Helman (2007: 2) states that culture can be understood as a lens through which people perceive and understand their world. It provides a framework for shaping values, beliefs and practices, and gives meaning to our collective lives (Helman 2007). Culture develops within specific social, political and historical contexts yet, in today's complex world, it is more appropriate to speak of multiple cultures which people engage with and adapt to. To achieve cultural competency, a researcher has to be culturally aware and to accept, value and honour diversity. In this research, participants' cultures were acknowledged and the researchers' own knowledge, beliefs and values were 'bracketed' as much as possible. This was applied during the study design, recruitment, data collection and the data analysis phases.

Sample Selection, Inclusion Criteria, Recruitment and Data Collection

The study recruited 16 young African Australian mothers who had experienced teenage pregnancy. All participants were born in Africa and had a refugee background, having migrated to Australia under the Humanitarian Program, or having been sponsored by someone who had migrated under this program (see Table 1).

Key informants, all service providers, also participated in interviews and a focus group discussion and these occurred in service settings used by people with African backgrounds. Key informants were of mixed ethnicity and gender, and included registered nurses and community support/bi-cultural workers; they were of African ($n=3$) and Anglo-Australian ($n=2$) descent and included one male and four females (see Table 2).

The two focus group discussions included one with African women with a refugee background ($n=6$) and another with a different set of service providers ($n=5$). This second focus group was purposively sampled and included a nurse, community leader, bi-cultural worker, school principal, medical doctor and church minister.

Recruitment of eligible participants occurred via 'purposive snowballing' through formal and informal networks. After being contacted, the potential participants were provided with a plain-English-language statement providing details about the research. If the potential participant was willing to proceed, an interview site and date were arranged. This allowed participants the opportunity to cancel the interview if they did not want to proceed. They also had the choice to withdraw the information already provided after the interview; this did not occur.

Table 1

Demography of 16 African Australian Teenage Mothers with Teenage Pregnancy Experience						
Employment status	Gender	Current age	Country of birth (length of stay)	Transit country (countries)	Approximate length of stay in Australia	Main languages spoken at home
Unemployed	F	20	Ethiopia	Egypt	5 years	Arabic, Dinka
Unemployed	F	21	Sudan	Uganda	4 years	Dinka, English
Unemployed	F	19	Liberia (2 months)	Guinea (10 years), Kenya (5 years)	4 years	Gio, English
Employed (casual)	F	24	Sudan	Egypt	8 years	Dinka, Arabic
Unemployed	F	27	Liberia	Not stated	9 years	French (other)
Unemployed	F	19	Sudan (North)	Egypt (7 years)	Not stated	Arabic, Dinka
Unemployed	F	18	Sudan (2 months)	Kenya (2 years)	16 years	English (a little Dinka)
Unemployed	F	30	Sudan	Egypt	Not stated	Arabic, Dinka
Unemployed	F	22	Sudan	Egypt	6 years	Nuer, Arabic
Unemployed	F	20	Burundi	Tanzania (8 years)	5 years	Kirundi, Kiswahili
Unemployed	F	17	Sierra Leone	Not stated	2 years ago	Timinie, Creole
Unemployed	F	17	Sudan (7 years)	Uganda (6 years)	3 years	English (a little Dinka)
Unemployed	F	Early twenties	Sudan	Egypt	7 years	Arabic, Moro
Unemployed	F	28	Sudan	Egypt	Not provided.	Arabic, Dinka
					Had lengthy stays in refugee camp prior to arrival in Australia	
Unemployed	F	17	Liberia (5.5 years)	Guinea, Liberia, Sierra Leone	4 years	Gio, Madingo, Mana, Berle, French, English
Unemployed	F	18	Sudan	Not stated	2 years	Dinka

Table 2

Demography of Key Informants and Focus Group Participants/Service Providers								
Pseudonyms of interviewees	Professional background	Type of participant	Gender	Age	Country of birth	Other countries of residence	Languages spoken at home	Religious affiliation
<i>Service providers for in-depth interviews</i>								
Elisa	Registered nurse	Service provider	Female	27	Sudan	Kenya	Nuer	Christian
Jacob	Registered nurse	Service provider	Male	38	Ghana	–	–	Christian
Fiona	Community support worker	Service provider	Female	22	Sudan	Kenya	Dinka	Christian
Nikky	Community education worker	Service provider	Female	52	Australia	–	English	–
Chantal	Registered nurse	Service provider	Female	25	Australia	Kenya, New Zealand	English/ Somali	Muslim
<i>Focus Group 1: service providers</i>								
Marima	Registered nurse	Service provider	Female	50	Australia	–	English	Christian
Jonathan	Church and community support person	Service provider	Male	40	Sudan	Kenya	Dinka, Arabic	Christian
Cameron	Bi-cultural worker	Service provider	Male	42	Ethiopia	Kenya	Tegrinya	Christian
Elizabeth	School principal	Service provider	Female	>50	Australia	–	English	Christian
Ruben	Medical doctor	Service provider	Male	52	Australia	–	English	Christian
Charlie	Church minister	Service provider	Male	77	Australia	–	English	Christian
<i>Focus Group 2: African mothers</i>								
Awel	Employed (casual, cleaning services)	African mother	Female	28	Sudan	Egypt	Dinka, Arabic	Christian
Akot	Employed (personal care assistant)	African mother	Female	31	Sudan	Egypt	Arabic, Dinka	Christian
Amima	Employed (factory worker)	African mother	Female	42	Sudan	Egypt	Dinka, Arabic	Christian
Christina	Unemployed (former school teacher in country)	African mother	Female	37	Sudan	Egypt	Arabic, Dinka	Muslim
Laura	Unemployed (former school teacher in country)	African mother	Female	41	Sudan	Egypt	Arabic, Dinka	Muslim
Patricia	Unemployed	African mother	Female	28	Sudan	Egypt	Arabic, Dinka	Christian

In-Depth Interviews and Focus Group Discussions

In-depth interviews allow participants to ‘tell their stories’ in a rich and personally meaningful way (Liamputtong 2013). The in-depth qualitative interviews, namely with young African Australian mothers and ‘key informants’, occurred at a place chosen by the participants, with the researcher ensuring the site was available, accessible, secure and private. Sites included participants’ homes, an education facility where some young mothers attended literacy classes and the workplaces of service providers. The interviews lasted from 30 to 90 minutes. The focus group with service providers was conducted within religious premises and was co-organized by a participant. The focus group discussion with the older African women took place at one of the participant’s homes, which was a familiar setting where the women could feel relaxed.

Data Collection and Analysis

Interviews and focus group discussions were audio recorded, with participants’ permission, and transcribed verbatim. Reflective notes were also taken during or shortly after the interviews and focus group discussion, and these were included in the data analysis. Following data collection, the transcripts and notes were read several times to identify key themes and develop a coding framework. Data were analysed using thematic analysis (Creswell 2013). Key words and phrases were extracted; these were merged to become code words. Following this process, the codes were grouped and analysed for divergence and convergence. This process of divergence continued until no new codes and categories emerged. Data judged not to be useful were excluded. Data were analysed manually in conjunction with the use of NVivo software. Using both manual and electronic analysis facilitated the analysis process, but enhanced thoroughness and completeness of the process. The codes were then grouped into themes for analysis (Patton 2002).

Findings

In the following sections, we first summarize the key demographic characteristics of the young mothers. We then examine four themes that provide the sociocultural context for understanding the barriers and facilitators to contraceptive use among young African Australian women: (i) knowledge of contraception and sexual transmissible infection; (ii) communication with parents about sex and contraception; (iii) gender roles and the cultural shaping of attitudes towards contraception within intimate relationships; and (iv) valuing motherhood. While there is some overlap, each section takes a different thematic area as its primary focus. This is consistent with the intersecting nature of social contexts that shape sexual health, knowledge, attitudes and behaviours (Crenshaw 1989; Collins 1990).

Characteristics of Participants: Young African Australian Mothers

Sixteen young African Australian mothers participated in the study. At the time of interview, they ranged in age from 17 to 30 years. Their countries of birth included Sudan ($n=10$), Liberia ($n=3$), Ethiopia ($n=1$), Burundi ($n=1$) and Sierra Leone ($n=1$). All came to Australia via the humanitarian programme as a refugee or as a dependent of their parents, guardians and in one case prospective husband. They had passed through one or more transit countries prior to settlement in Australia, including Egypt, Uganda, Kenya, Guinea, Tanzania, Liberia and Sierra Leone. Participants spoke a diverse range of languages including English, Arabic, Dinka, Gio, French, Nuer and Kiswahili. Fifteen of the young mothers identified as Christian and one as Muslim. Fifteen were unemployed and one had secured casual employment. All had experienced teenage pregnancy. Their age at first pregnancy ranged from 15 to 19 years (see [Table 1](#)).

Knowledge about Contraception and Sexually Transmissible Infection

Most young mothers spoke of having low knowledge and inadequate use of contraception and barrier methods prior to their (first) pregnancy. During interviews, participants were asked: 'Could you tell me what you knew about contraception before you became pregnant?' Their responses included:

Hmm, I didn't know anything, I knew nothing (Josephine, Liberia, aged 27).

I did not have an idea, that's why. If I had idea then we just use something (Veronica, Sierra Leone, aged 17).

Two of the young mothers said they did not know that sexual intercourse could lead to pregnancy and, accordingly, they had no understanding of the need for contraception to prevent unintended pregnancy:

No... I had no idea; I did not even know that having sex was the way that gets you pregnant. I didn't even know that I could get pregnant (Jessica, Ethiopia, aged 20).

Other young mothers said they heard about contraception after arrival in Australia from friends and the media. However, they did not understand how contraceptives worked or how to use them:

Yes, not really. I guess I'd just heard about them [contraceptives]... from friends but never used them... I knew one name, the condom and the other one I didn't know about (Francisca, Sudan, aged 17).

I only learnt about it in Australia. I used to hear about it on the TV, but I did not understand how it goes and what type of things you can have to protect yourself getting pregnant (Kayla, Sudan, aged 19).

For those who learnt about contraceptives after arrival in Australia, they were often unsure whether using contraceptives would affect their ability to

have children later on in life. This lack of understanding acted as a deterrent to using contraceptives for some:

I didn't know about that [contraception]... I heard when I just came here to Australia but I never had it there and I thought when I was in [country], I thought it was something that would make you know to not give birth at all. I didn't know it's something you use and then you can have babies later (Alimatou, Sudan, aged 21).

Young mothers had limited knowledge about transmission and symptoms of sexually transmissible infections (STIs). Knowledge of the most prevalent STIs was very limited (e.g. Chlamydia). According to service providers, young people with African backgrounds assume that STI symptoms will be both apparent and immediately treatable:

Chlamydia and all that stuff... young people's attitude is that, 'Just take a pill and I'm done with it... I'm not going to die from it. I'm not going to do anything with it' (Elisa, Key Informant, Registered Nurse).

Participants had some awareness of HIV/AIDS, particularly as most had lived in African countries where the HIV/AIDS epidemic had affected friends, family and the wider community. Some recalled HIV/AIDS as being a focal point of sexual health education in Africa, including in refugee camps. Yet, while HIV/AIDS was regarded as terminal, participants did not regard it as a health concern in Australia. As one service provider said:

They don't use condoms... that goes back to my notion that people are not scared of STDs [sexually transmitted diseases] anymore because they don't think it's an epidemic here, especially with AIDS. HIV/AIDS, that's the one thing that everyone is scared of but because it's not rampant in Australia there's not much need to worry about condoms and all that stuff (Elisa, Key Informant, Registered Nurse).

Health service providers emphasized that contraception is not widely used by young sexually active African Australians and, among those who do, the focus is on prevention of pregnancy rather than STIs:

When I talk about those different STIs, I get a lot of shocked faces. It looks like that's the first time they've heard about it. When they mainly use condoms I think the perception is it's only protecting you from getting pregnant, because they don't want to be pregnant. That's the first thing they think about and STIs would be the secondary thing (Chantal, Key Informant, Registered Nurse).

Communication with Parents about Sex and Contraception

In this study, an important determinant of young African mothers' knowledge of sexual health and contraception was parental knowledge and attitudes. The young mothers said that their parents had little knowledge of

contraception. They suggested this makes it difficult for parents to provide education or guide their decisions about contraceptive use:

Because they are not sure if this is good or not. If they go like to their family doctor the parents may say they took wrong decision to take contraception (Faustina, Sudan, aged 28).

Young African Australian mothers indicated that their parents retained strong cultural beliefs and largely regarded contraception unfavourably, and this impeded their ability to provide informed opinions and guidance:

I believe that because of the culture, some of them [parents] don't know... some of them don't have no knowledge of contraception and some of them... don't talk to their children because of the culture (Chelsea, Liberia, aged 19).

Further, young African Australian mothers said that their parents were not comfortable talking with them about sexual health and contraception. As Elisa, a nurse of African background with refugee experiences, iterated:

Our parents not being the ones to talk to us about sexuality and all that stuff, which means that most of these young people haven't had the sex education that they actually need (Elisa, Key Informant, Registered Nurse).

Indeed, young African Australian mothers said that their parents tended to believe that knowledge and use of contraception would lead to initiation of sexual relationships and promiscuity among their teenage daughters. Parental attitudes towards contraception, however, were not reported as being uniformly negative: some young women spoke of their mother's positive attitudes towards contraceptive use. For example, prior to becoming pregnant for the first time, Carmen (a young woman with Sudanese background) decided not to use contraception for fear of her parents finding out she was sexually active. She later had a contraceptive device inserted and, when her boyfriend demanded she have the device removed, her mother encouraged her to re-insert it to prevent a subsequent pregnancy:

My mum said it was a good thing, so I'm going to get it [implanon] put back in for a little while (Carmen, Sudan, aged 18).

This indicates that parental attitudes towards contraception use are not fixed—an important consideration for policy development in this area.

Health care professionals who work extensively with people from African backgrounds also stated that African parents had little knowledge of contraception and were unwilling to talk with their children about sex and contraception:

There is no knowledge about contraception... the knowledge is often not there anyway (Jonathan, Key Informant, African Bi-Cultural Worker).

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There seems to be a cultural barrier to getting the messages across; there are issues of clash of culture...parental unwillingness to educate their children about sexuality. It's not a subject that is usually discussed anyway within the family unit (Ruben, Key Informant, General Practitioner)

They indicated that negative attitudes towards contraception among African parents emerge from a lack of understanding of the value of preventative health behaviours:

There is a cultural lack of interest in preventative health...there seem to be cultural barriers to getting messages across (Ruben, General Practitioner).

This view was echoed by Chantal, a nurse of African ancestry, who herself has a refugee background. She indicated that sexual health and preventative health have low priority in everyday lives of people with refugee backgrounds, given the trauma of forced displacement and the challenges of settlement in a new country:

African heritage has a big influence on the decisions they make regarding sexual health...because we don't seek medical assistance, we don't get checked because it's not important. If we had trauma and we came from a war and came to Australia, that's the last thing we'd want to think about—about our sexual health (Chantal, Key Informant, Registered Nurse).

Other service providers noted that traditional cultural values led to a denial that young African Australian girls had boyfriends, let alone that they had sex out of wedlock. Such denial meant that parents did not see the need to educate their daughters about contraception:

There is the premise that there is no sex without marriage, either cultural or religious (Jonathan, Key Informant, African Bi-Cultural Worker).

Attitudes towards Contraception within Intimate Relationships

Young African Australian mothers hold gender-specific values that affect their knowledge and use of contraception. Young African Australian mothers fear that the male in a sexual relationship will regard a woman's use of contraception, such as the oral contraceptive pill and implants, as evidence that she has other sexual partners, is sexually experienced or intends to cheat on them:

They just think having an implant in, I'm going to sleep around with other men and not getting pregnant.... In Africa there's no contraceptives (Carmen, Sudan, aged 18).

Participants suggested that some boyfriends interpret requests to use barrier contraception as an indication that their girlfriend does not trust they are monogamous. This was reiterated by Chantal, a registered nurse:

I think one of the biggest issues is, and a lot of people don't emphasise the topic, is when women ask the male—especially African men—to use the

condom, the man thinks that he's being questioned of cheating (Chantal, Key Informant, Registered Nurse).

And yet some young women also viewed use of condoms by their male sexual partners as a sign of distrust, indicating that condoms are to be used with casual partners and women you do not love or are not in a 'relationship' with.

A few participants continued unprotected sexual relationships even when this exposed them to risk of infection and unplanned pregnancy, and they said that males would threaten to leave a relationship if the woman insisted he use a barrier method. Living in a community where socialization is orientated towards having a partner, and marriage and childbearing are seen as paramount for females, these young African Australians said they had succumbed to such pressures even when they understood the risks and the consequences. The following excerpt details Jessica's experience of an attempt to say no to unprotected sex with her boyfriend:

Because my boyfriend told me he wanted to have sex and then he told me we can have a baby, but I told him no, because I'm not ready yet to have another baby. Then after that he tried to cause trouble and he was telling me that maybe I had another boyfriend because I didn't want to have a baby with him and we'd been together for three years. Then I said that no, I didn't have another boyfriend but I just wasn't ready yet because I want to study. He caused a lot of trouble and he wouldn't listen to me. He was happy [when I fell pregnant] and he said, 'That's what I want and I wanted you to get pregnant because I'm ready to be a father.' I told him that I wasn't ready yet because it's very hard to do it by yourself and he said, 'I promise I will help you' (Jessica, Ethiopia, aged 20).

Further, while contraception is perceived to be liberating and empowering by most women (as it provides opportunity to manage fertility and to plan their families), some male partners reportedly regard contraceptive use as undermining their authority, value and control over their wives and sexual partners:

He feels like if he can control that then he controls the family. A lot of [country] communities don't even believe in contraception so when they come to the Mercy Hospital for Women they maybe have their ninth child and then I would be talking about contraception and the male would be like, 'No, no, don't listen to her' (Chantal, Key Informant, Registered Nurse).

I can say yes, 'you have to use a condom', and the boy can say, especially if it's someone that you've been in a relationship with for so long, 'there's no need for me using condom' (Alimatou, Sudan, aged 21).

Valuing Motherhood

The sections above have discussed the limited literacy and largely unfavourable attitudes towards contraceptive use among African Australians,

including among the parents and sexual partners of young women. However, it is also critical to highlight the high value placed on motherhood, and the influence this has on young African Australian women's choices around sexual activity and contraception.

Mothers have high status within African communities, where childlessness by choice is almost non-existent (Oladokun *et al.* 2009) including among those who have resettled in Australia. In this study, many young women spoke of the value of motherhood. Mothers command greater status and respect than women without children. Participants indicated that their teenage pregnancies, while apparently 'unplanned', were also valued as an opportunity to attain motherhood, form a family, and gain greater maturity and meaningful responsibilities. In this study, young African Australian mothers were generally happy to have a baby of their own, even during difficult times. They were positive and thought their lives had changed for the better after motherhood. In a few cases, teen pregnancy provided escape from an arranged marriage or an expensive wedding which they could not afford. Motherhood gave them someone they could truly love and, for some, motherhood brought a sense of self-worth:

I was excited to have a baby... In a lot of ways. In my culture, if a girl gets pregnant it's really easy for the parents to just say to the daughter 'Okay, now you're going to have a baby and if you're going to look after the girl and the baby then you can have her' plus we didn't have that much money to do wedding things (Alimatou, Sudan, aged 21).

Now I'm like a woman. I'm sort of a girl and a woman. I'm an older girl, not young girls that are getting new stuff. I'm not one of them... Because I had a baby and comparing to the girls who haven't had a baby (Francisca, Sudan, aged 17).

Pregnancy is a huge thing for Africans... the person who is most respected is the person who is the unmarried woman with a child rather than the married woman without a child. That's our view on children and that's our view on continuity of this society (Elisa, Key Informant, Registered Nurse).

Motherhood raised young African Australian women's status among her peers, family and community. The risks of unprotected sex and the challenges of teen pregnancy were considered short-term challenges. Subsequent unplanned pregnancy and early motherhood were preferred over childlessness in the long term.

Discussion and Conclusion

Resettled young African Australian mothers with refugee backgrounds face multiple barriers including social, educational and economic disadvantage. Their migration pathways are characterized by instabilities prior to settlement, including violence, persecution, disruption of family and social networks, and forcible displacement. Following resettlement, they experience

complex demands and opportunities, and teen motherhood contributes additional layers of complexity. And yet young people from refugee backgrounds are also resilient, and actively build lives and identities in sites of resettlement. The intersecting complexities in the lives of young African Australian mothers and the dynamic role of culture in shaping their knowledge, attitudes towards and use of contraception are critical factors to be considered for policy development.

This article has discussed the ways in which young African Australian mothers' attitudes towards contraception are shaped by: knowledge about contraception and sexual transmissible infection; communication with parents about sex and contraception; the attitudes towards contraception among males and boyfriends; and the high value placed on motherhood. The study had a number of limitations: the small sample size and the diversity of participants (e.g. country of origin, transit routes, time since arrival) mean the findings are not generalizable to all young people with refugee backgrounds, or even all African Australians with refugee backgrounds; males were not included, except as key informants, and accordingly their particular perspectives and attitudes are not explored; the sensitive nature of the topic could have hindered the reliability and validity of findings. However, this article does provide a number of insights that can inform service provision and policy development for young people with refugee backgrounds.

The article indicates that there is low sexual health literacy, including knowledge of contraception, among young African Australian mothers and African Australian parents. Further, knowledge (where present) does not necessarily translate into contraception use—a finding consistent with other health research including with African people (Cleland and Ali 2006; Dennis and Grossman 2012). Nonetheless, there is an established link between knowledge and responsible sexual protective behaviours, and there is a need to develop effective sex education and support programmes for young African Australians. Parents' culturally informed beliefs further impede young African Australians' acceptance and use of contraception, as many parents regard contraception as supporting premarital sex or promiscuity on the part of their daughters (Bachar *et al.* 2002; Raine *et al.* 2010). As a result, young African Australians have limited opportunity within family settings to learn about or be supported to use contraception. For those parents who support use of contraception among young people, this was typically in response to a daughter's unplanned pregnancy and with a view to preventing further pregnancies. Parents' belief that premarital sex is unacceptable and that their children should not engage in sex was a barrier to contraception uptake and use. Indeed, within resettled African communities, preventative health behaviours are not common (Lemoh *et al.* 2008; Drummond *et al.* 2011). Service providers working with these groups of refugee migrants should encourage and support families to use a proactive rather than a reactive approach to their children's sexual health and contraception use.

Boonstra (2014) found that there has been a decline in teen pregnancies in the United States but notes that there is no clarity between the trends in the use of contraceptives and the actual sex experience. Instead, Boonstra (2014) highlights the positive structural factors that may be influencing the change in behaviour among teens' pregnancy, abortion and birth rates. Changes in economic demographics whereby teens who may have grown up in low socioeconomic poor families and have low education attainment which puts them at risk of unplanned teen pregnancy are now achieving higher and better economic statuses because of their families' own economic improvements. These, Boonstra (2014) suggests, may have impacted positively on teens, thus the reason for a reduction in teen pregnancy rates. In our study, most of the young mothers were born and grew up poor and in low socioeconomic circumstances with low education attainment. The two combined put them at higher risk of teen pregnancy. This is important for policy, as better and higher education attainment has a direct influence and impact on employment and income, which improves socioeconomic status which then has a positive impact on teenagers and their families, thereby reducing their risk of teen pregnancies.

The gender dynamics within relationships are a deterrent to contraception use (Tensou *et al.* 2008). Young women sense that some men regard contraception as a disempowering agent and/or an indication of promiscuity on the part of the woman. Hence, women within relationships are vulnerable, particularly when they do not want to lose the partner (Tensou *et al.* 2008). Similarly, a few young women regarded use of condoms by male partners as evidence of distrust and lack of respect. These findings are aligned with those of Drummond *et al.* (2011), who report that resettled African women said they would feel 'insulted' if their partner wanted to use condoms. This highlights the cultural barriers to contraceptive uptake and use, particularly condoms. Low male participation in contraception use coupled with the higher status awarded to males within relationships affects women's decision to use contraception regardless of their level of knowledge (Arowojolu *et al.* 2002; Tensou *et al.* 2008; World Health Organisation and United States Agency for International Development 2008; Drummond *et al.* 2011).

Finally, there is high regard and status awarded to mothers and motherhood within the African community, where motherhood is almost imperative. Young women regard themselves as future mothers. Motherhood and the pro-natalist ideology is not an isolated issue for African teens or mothers. Remennick (2000) contends that Israel has a 'pro-natalist ideology with life and community activities orientated towards motherhood and family' (Remennick 2000: 821–822). Remennick states that childbearing and motherhood are perceived to be both a 'religious and a moral' duty for women (2000: 821). Similarly, this study demonstrates that motherhood has high value within African communities in Australia and, for some women, a teen pregnancy may provide the basis for increased social recognition, status and a purpose in life. These social and cultural values have

implications for young African Australians' decision-making around contraception use, pregnancy and parenthood, and should be better understood by service providers and policy makers.

This article highlights some of the ways in which culture, community and family shape young African Australian women's attitudes to and use of contraception. Health care services that engage with African Australians, many of whom have refugee backgrounds, should address the broad cultural factors that influence health care decision-making including gender imbalances within relationships and cultural values relating to motherhood. Hence, sexual health education should encompass a family and whole-of-community approach (see Ngum Chi Watts 2012). The complexities and challenges that exist in the lives of young African Australians with refugee backgrounds in a new site of settlement, and the sensitive nature of sexual health, remain barriers to contraception acceptance. Further in-depth research on sex education, sexual health behaviours, informed consensual sex, and knowledge transfer and acquisition for young African Australians is warranted. This article indicates there are widespread concerns around sexual health literacy, contraception use and opportunity for sexual education. Policy making and programmes should move beyond the focus on individual risk and not only address contraception and sexual health literacy, but also empower young people to negotiate safer sex, address intergenerational value-based conflict, and engage with the social and cultural significance and impact of teen pregnancy and early motherhood. This holistic approach can provide a foundation from which to develop effective sex education, prevention and support programmes for young African Australians.

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