



Caught between two cultures

A young African women's
sexual and reproductive
health project

Consultation Report 2014

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Definitions

This report draws on the following internationally recognised definitions of sexual and reproductive health:

Sexual health is a state of physical, mental and social wellbeing in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (International Conference on Population and Development, 1994).

Reproductive health is a state of complete physical, mental, and social wellbeing, and not merely the absence of reproductive disease or infertility. This deals with reproductive processes, functions and systems at all stages of life (International Conference on Population and Development, 1994).

Defining female genital mutilation/cutting and its prevalence

Female genital mutilation/cutting (FGM/C) is defined by the World Health Organisation (WHO) and the United Nations (UN) as ‘the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons’. The practice is deeply rooted in tradition and is conducted in 28 African countries and in some parts of Asia and the Middle East. It is estimated that between 130 and 140 million girls and women have been subjected to the practice worldwide and 3 million girls are at risk of FGM/C every year (WHO, 2013). FGM/C is a gender-based health and human rights violation.

According to WHO (2008), there are four types of FGM/C:

- Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)
- Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)
- Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and positioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)
- Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation

Defining community and religious leaders

For the purposes of this report, we define a community leader to be a member of the community either chosen by community members or seen by the community as a person who is highly trusted and cares for the community’s wellbeing. They act as a community

liaison, mediator of marriage, personal or community disputes, care giver, spokesperson and advisor.

A religious leader within the African community is a person who has a higher knowledge of Islamic religious teaching and its principles. Because Muslim people engage with Islamic principles as a way of life, religious leaders are consulted by the community to provide advice and guidance on a raft of topics. They function as marriage celebrants, teachers, advocates, conflict mediators, trainers, and spiritual healers, and provide advice on financial and business matters.

Note regarding language

Due to cultural sensitivity and the reality that sex is taboo in many African communities, the majority of parents and community leaders that were interviewed avoided using the word sex. In their responses, preferred terms included 'this thing', 'that thing,' 'it' and 'something like that'. Therefore, in this report the word sex and the term 'sexual and reproductive health' are inserted in brackets within quotes to highlight the respondent's intention.

Caught between two cultures: Project background

Women's Health West's *Caught between two cultures (CBTC): A young African women's sexual and reproductive health project* aims to enhance young African women's confidence, independence and capacity to make informed decisions about their health and wellbeing now and into the future. The overarching goal of the project is to prevent the practice of female genital mutilation, or cutting (FGM/C), as is the preferred term among communities and young African women affected by the practice in Melbourne's western region.

The project has three key objectives that are designed to achieve this goal. These are:

- To empower young African women to make informed decisions regarding their own sexual and reproductive health
- To develop young African women's confidence, independence, leadership skills and pride in their African and Australian identity
- To promote attitudes and behaviours among young women that support and promote the elimination of FGM/C so that they later choose not to practice FGM/C on their daughters.

CBTC is one of a number of projects that sit within Women's Health West's Family and Reproductive Rights Education Program (FARREP). FARREP works toward a vision of a just and gender equitable society in which women and girls are provided with equal opportunities to thrive and succeed. CBTC is tailored to the unique needs of women and girls affected by FGM/C and works to create positive social change by building on the strengths of individual women and their communities. It is designed to increase partnerships for health promotion action that reduce gender-based disparities in the health status of African women. The Victorian Women's Benevolent Trust supported this two-year project as part of their 2013 general grants program. The final report will be released at the end of 2015.

The CBTC project is informed by international research and best-practice health promotion programs that have demonstrated successful outcomes in the prevention of FGM/C. Drawing on this evidence base and Women's Health West's (WHW) decade of experience working to prevent FGM/C, it is expected that there will be an array of positive short, medium and long term outcomes associated with the project.

Short term outcomes will include:

- Consultation (detailed in this report) that ensures the voices and perspectives of young African women, parents and female community leaders are heard and inform the development of a culturally sensitive and appropriate project
- Identification of sexual and reproductive health concerns and health literacy gaps experienced by young African women in Melbourne's west.

Medium to long term outcomes will include:

- Development of a culturally appropriate sexual and reproductive health program designed for the specific health and wellbeing needs of young African women who have migrated from countries affected by FGM/C
- Collaboration with schools and community organisations to improve the access of young African women to a range of different health services
- Collaborative work with young African women to develop and enhance their confidence, independence, leadership skills and pride in their African and Australian identity, which is likely to increase civic and economic participation
- Capacity building, knowledge and skills development of young African women to make safe and positive sexual and reproductive health decisions for themselves and their children
- An increase in participants' attitudes and behaviours that support and promote the elimination of FGM/C
- Improvement in women's health and wellbeing status, while the economic burden of ill health and the associated costs of health service expenditure subsequently decrease.

Community consultation process

In late 2013 and early 2014, a series of community consultations were held in Melbourne's western suburbs. The consultations were designed to explore community perspectives regarding the sexual and reproductive health of young African women.

Fifteen community members were interviewed, which included five young women between 18 and 25 years of age, three female community leaders, five mothers, one female academic with expertise in young African women's sexual reproductive health, and one male religious leader.

Community and religious leaders were considered important informants for the project due to their unique position within African communities. Community leaders can be elderly women or men; however, only female community leaders were interviewed given the sensitivity of young women's sexual and reproductive health.

Consultation participants were selected from different African communities known to have a high practice rate of FGM/C. This included two Ethiopians, four women from Eritrea, five from Somalia and four from Sudan. All consultation participants were born overseas and had migrated to Australia in their youth or as an adult. Participants were given advice about informed consent and about how their data would be stored and de-identified. All participants signed consent forms.

The consultations took the form of semi-structured, one-on-one interviews, except for two consultations where women preferred to be interviewed together. The interview questions differed slightly depending on the group being consulted (see appendices). Questions were specifically tailored for different groups and for the specific knowledge, expertise and information we believed to be most relevant to each participant group.

FARREP has three established women's groups for whom we provide ongoing community education sessions. The majority of the interviews were conducted with these groups to overcome potential distrust problems and to ensure that community members were comfortable disclosing information about sexual and reproductive health, which is a culturally sensitive topic.

All interviews were taped and transcribed verbatim, analysed by Women's Health West's FARREP worker and then grouped according to key themes. The following sections of this report cover the key themes raised by community members when asked to consider the sexual and reproductive health concerns of young African women, and what culturally appropriate projects and services are needed to redress inequities in their health status.

Cultural and gender norms relating to sexuality and intimate relationships

Cultural norms

Race, ethnicity, culture and experience have profound effects on how individuals perceive and interact with each other, their peers, community and society. Culture encompasses more than a person's or community's racial and ethnic background. It includes their religious traditions and beliefs, language, and traditions associated with their heritage and country of origin, among other factors.

The five young women interviewed spoke about the complexity associated with navigating differences between their African and Australian cultural identity, language barriers and different social structures and systems.

I came here at a young age ... I guess at the beginning language was a barrier, so it was bit challenging to fit in. When I came I was ten years old so I was put in a classroom at year five. It was really hard for me to fit into class ... We had a special teacher to help me but still it wasn't enough ... There are a lot of differences, but what I did is I tried to pick the best in the Australian culture and still have my culture.
(Young woman)

It is very different growing up here in a western country, because the cultures are very different here. We are a minority, so it is very difficult to blend in.
(Young woman)

In Australia there is only one common language, which is English. Things are more open and everything is structured and established.
(Young woman)

It is difficult because it is a different culture, different language, and it is always two worlds you have to live in; your own one and then your country.
(Young woman)

Three of the five young women interviewed spoke of how this complexity of negotiating cultural norms and social structures was easier if they had migrated at a young age.

It depends on if you come to Australia at a young age. It's easier, you could learn the language. But if you come here at an older age, it is hard to get used to the Australian culture and understand their values, as you are focused on your own set of values. It's hard to bring those two cultures together.
(Young woman)

I think when you are younger is easier, you could learn the language, but when you come at old age it is really hard. So language was in the beginning hard for me, but I picked up really quickly, which is really good, and I love living here.
(Young woman)

Two of three community leaders interviewed and all parents spoke about the importance of cultural identity, their expectation of their children to keep their identity, and adapting to the new environment as a topic of concern.

They love everything that is allowed in Australia, but in my family there is a lot of restrictions and they feel that is not fair, but at the end they know that it is for the benefit of their safety and respect of their culture. I don't know they would like to have whatever Australia allows them to have, but they have to respect me and Australia.
(Community leader)

Gender norms

All five young women interviewed spoke about the different gender norms in Africa compared to Australia, where gender equality is perceived to be greater.

Role sharing and responsibilities are equally shared between men and women here in Australia compared to Ethiopia, where women stay at home and men go and earn.
(Young woman)

Two young women spoke about the pressure and different expectations on young women and girls from their parents and community, compared to that of their male siblings who enjoy greater freedom.

You are expected to perform well at school, you are also expected to come home, clean and cook and look after your siblings, because as a girl you are expected to look after the kids while boys can go outside and play.
(Young woman)

In our culture being a young woman you face a lot of pressures in terms of domestic roles and looking after the family, as well as doing well in your studies.
(Young woman)

Gender and cultural norms relating to sexuality

Sexuality and sexual health is not openly discussed in many African cultures, with participants reporting that it is commonly viewed as a taboo topic. Two community leaders stated that if discussions about sexuality do occur with young women, this usually occurs just before young women get married.

I didn't grow up talking about it so that it is a barrier and something expected to be shy about.
(Community leader)

This is a very sensitive issue and it's the mother's role to educate her daughter when the need comes, especially when a girl reaches puberty age or the marriage time arrives. Sometimes elderly women give the advice on the night of the wedding or just before that.

(Community leader)

The religious leader also stated that sexuality was taboo among many African communities. However, he also reiterated that this was a cultural norm, as opposed to a norm sanctioned by religion.

It's very sensitive topic. It is not Islamic, of course, to keep it under the carpet; it is a cultural thing, it is very confined topic and it is not within the reach of everyone.

(Religious leader)

Young women agreed with the older women's perspective, although four of the five young women interviewed also spoke about the need to overcome this cultural norm, particularly for young women who have sexual relationships outside of marriage.

It is important that we as Africans should be open about it. You don't want to wait until something happens to your child and say, 'I need now to learn about [sexual and reproductive health]', because it is too late.

(Young woman)

The gendered power dynamics that exist between young women and their partners was also noted as having a direct impact on young African women's sexuality and sexual and reproductive health.

A lot of the girls, even those who know about contraception, don't have the power to use it... because their partner opposes them using it. For some women contraception is an empowerment, but their husbands or partners see it as disempowerment and there are power imbalances; partners have a power of control. Because it's like they don't have the control over women anymore, and she can decide to have children or not to have children. So there is all of this conflict as a result of the young women's knowledge about contraception, which is still really very low.

(Academic)

Gender and cultural norms regarding intimate relationships

Many African communities have strong religious and cultural principles and beliefs that guide sexuality. Although parents, community and religious leaders were clear that young African women should only be having sex within the confines of marriage, they recognised that this was not always the case.

You can't have any relationship with anyone until you get married.

(Parent)

Girls are usually coy about sexual relationships; they don't approach boys commonly. Unless it's exceptional; sometimes it may be an exception. But in general, girls are not forthcoming. They are not so open about their sexual relationships because they are under the wings of their mothers.

(Religious leader)

In my culture and religion it is not allowed, but as a mother myself I would like my children to tell me everything, so that I can tell them the safe way of having all of these ... if there is dating, I want it to be safe, and at the end it is going to lead into a marriage.

(Community leader)

Our culture and beliefs do not allow our girls and boys to have relationships before marriage. This can only happen after the marriage, as our culture is based on Islamic belief. Before the marriage, it's parent and community's responsibility to safeguard their young one's welfare and wellbeing.

(Community leader)

Many participants reported that there is social stigma for young women having sex or children outside of marriage. The gendered differences and expectations of young women and men in intimate relationships was a strong theme throughout the consultations.

We are concerned a lot about our young people's sexual and reproductive health, but what can we do? We are just living in fear. You know if something bad happen to them we don't know how to talk to them about it.

(Community leader)

Let us not forget my community is Muslim by faith; they are very concerned about sexual importance of their children, whether girls or boys. And in Islam, as in old past, Christianity was like Islam, they didn't allow sexual relationship, extra marital relationship they didn't allow. But now that has changed, but in Muslim faith it doesn't change. It's always a taboo. That is the concern; that is why mothers are very very cautious whenever girls come home late. They are very concerned as to what she was doing or where she was, and assuming she was hanging out with boys. The boys it's to a minor extent, the parents have same concern, but boys it is minor. They say boys are boys, but for girl there is more stigma.

(Religious leader)

There is a different expectation on how girls and boys behave in relationship, because a boy in my culture if he had [sexual relationship] he is not going to be pregnant and have children, but a girl takes the responsibility of being pregnant and having children.

(Community leader)

Female genital mutilation/cutting and its impact on women

We should challenge culture, not destroy it, but to improve it by removing practices that harm women and girls and replacing it with those that empower us as women (Wolde Giorgis, 2014).

The World Health Organisation (WHO) states that female genital mutilation/cutting (FGM/C) of any type is associated with long-term health implications, though the risks increase with the severity of FGM/C (WHO, 2011). For example, FGM/C is associated with an increased risk of complications for both mother and child during childbirth. Rates of caesarean section (29 per cent increase for type II and 31 per cent increase for type III) and postpartum haemorrhage (21 per cent for type II and 69 per cent for type III) were higher among women who had experienced type III FGM/C than those who had not (WHO, 2011). Additional severe and long-term health risks are documented for the most extensive form of FGM/C (type III), such as infertility (WHO, 2011).

Women who participated in this consultation had migrated from Ethiopia, Eritrea, Somalia and Sudan. In Eritrea, Somalia and northern Sudan, FGM/C type III is universally practiced, while in Ethiopia it is estimated that 74 per cent of women are circumcised, with a higher prevalence of types I and II (WHO, 2011). All of the women who participated in these consultations had undergone FGM/C.

The young women were asked for their perspective on projects designed to prevent FGM/C. All five young women condemned FGM/C, as they had all been subjected to the practice at an early age in their country of birth. In line with research from WHO and other health institutions, young women stated that the practice is not religious, but rather is deeply embedded within their culture.

It is good idea to stop it. I think to start educating mothers and young girls; the parents are the ones who are performing it, so start educating them. Sometimes parents feel that this is the only way to prevent kids from having sex or having sexual desire. You just need to educate them that this is not right.

(Young woman)

Young women spoke about the physical and emotional implications of FGM/C for their bodies, and the need for information regarding the practice and its impact on women's health and wellbeing.

I just found out a few months ago that I had FGM/C performed on me, which made me realise that I need to know more about it. I want all women like myself to have full knowledge and understanding about the procedure and also its physical and mental health consequences.

(Young woman)

Women spoke about their experiences of FGM/C before and after marriage, as well as their experiences of childbirth and deinfibulation. Young women emphasised the importance of incorporating conversations about the impact of FGM/C and other options, such as

deinfibulation, into a health promotion project for young African women. They also spoke about the need to educate health professionals about the clinical and psychosocial implications of the practice.

[There is a lot of] emotional and mental things you go through when you are circumcised: side effects of being circumcised, also when you undo (deinfibulation), what happens to your emotions, how you are feeling, the stress and the pain that you go through. A program that helps you, supports you before and after the operation ... I think you need someone to support you and help you get your feelings out.
(Young woman)

There are also health implications for FGM/C: the physical and mental health, and depression, infection, and pain sensitivity associated with it.
(Young woman)

Help them to deal with the issues [of FGM/C], talk about their experiences and what would be useful for them.
(Young woman)

There should be information available to young women who have been circumcised, information about childbirth, and to give them emotional support, which is very important. Because there is no point of saying 'you have been circumcised' and just talk about the clinical aspect, but to concentrate to overcoming the emotions, and also to educate the health providers when they see the young women with circumcision to look after them and also to give women more information and support.
(Young woman)

One young woman also stated that there was a need for resources to support young women to have conversations with their partners about FGM/C and sexual and reproductive health.

In addition, educating women married and unmarried about the short- and long-term impacts of FGM/C on their health and wellbeing is crucial; providing the women with resources and skills in starting up conversations with their partners about the issues they undergone due to the impact of FGM/C on their bodies. Communication skills on sexual and reproductive health for young couples are very important.
(Young woman)

All of the young women interviewed outlined the importance of preventing FGM/C through educating parents about the sexual and reproductive health implications of the practice. Young women believed that an essential component of this work involved dispelling the cultural norms that are cited for the practice occurring, such as protecting young women's virginity, preventing their sexual desires, and promoting marriageability.

Educating mothers and teaching them [about the implications of FGM/C] so they can stop.
(Young woman)

It's done to protect the girl before she gets married. It's a cultural practice or norm. Parents perform the procedure.

(Young woman)

It's done so girls won't be sexually active. It is to prevent them being sexually active, but I think it is wrong. It is been done to me and it's wrong.

(Young woman)

The consultation process identified a need for primary prevention of FGM/C work to be undertaken with women, parents and community leaders. Young women also emphasised the importance of sexual and reproductive health promotion projects that include support for young women and their partners to understand the physical and psychosocial implications of FGM/C and options such as deinfibulation.

Sexual and reproductive health literacy

Participants spoke about the poor sexual and reproductive health literacy of young women, their mothers and other women within the African communities, and the need to redress this.

I was missing this side from my life. My mum did not tell me anything about sexual and reproductive health and I felt that I am missing something as I was growing up and my body changes. So I do not want my children to go through this, I do not want them to be lost. I want them to know what sexual and reproductive health is.

(Parent)

Puberty and menstruation

Four out of the five young women consulted stressed the need for health information about puberty and adolescence, as some young women hadn't had any sexual and reproductive health education in Australia or in their country of origin. These women spoke about their challenges as teenagers and not having information about puberty and menstruation.

I think it's very important for the young girl to know about sex and what getting a period does mean for her.

(Young woman)

Knowing the body changes during puberty and the need to adapt to the shocking experience of the change that occurs in the body is very important.

(Young woman)

I remember when I got my first period and I was in grade six. I was shocked when I got it and there was no one at home to speak about it. It was so confusing, as nobody spoke to me about it. Even at school we only did sexual health. I only learnt about puberty when I was in grade eight.

(Young woman)

Sexually transmissible infections

Sexually transmissible infections are common in Victoria and contribute to a significant burden of ill health, particularly among women. Sexually transmissible infections such as chlamydia are often asymptomatic in women and if left untreated can cause infertility (Department of Health, 2011).

Young African women experience similar sexual health concerns as their Anglo-Australian counterparts. However, for young refugee and migrant women, various factors mean that they are more vulnerable to poor health outcomes, including sexual health morbidity.

If a woman who had type III FGM/C is raped in Ethiopia, there is an infection or disease called fistula, which is a blood infection caused by the injury that the victim incurs during the rape.

(Young woman)

Experiences of sexual assault and torture are common among many young women who have spent time in refugee camps or war-stricken regions, which significantly increases their risk of sexually transmissible infections. Many young women and their families do not seek support or services because of the stigma and shame associated with rape, loss of virginity, and fear of their future husband finding out.

Women who have had FGM/C are also at increased risk of HIV/AIDS transmission, because the procedure causes blood loss and often one instrument is used to perform a number of operations (UNFPA, 2014). In addition, due to the damage to the female sexual organs, sexual intercourse can result in laceration of tissues, which greatly increases the risk of sexually transmissible infections, including transmission of HIV (UNFPA, 2014).

Three young women stated the importance of more information and knowledge about sexually transmissible infections and how they are contracted, prevented and treated.

Sexually transmitted illnesses are one of the things that women need to know about, its types and the symptoms, so that women would know what to look out for.
(Young woman)

Young women must be educated about sexually transmitted diseases and particularly their consequences of STI among young women.
(Young woman)

Two community leaders also expressed concerns about sexually transmissible infections and blood-borne viruses, and the need for young women to understand the risks and how to prevent transmission.

We would like that our young people to get education about STDs, HIV/AIDs, hepatitis and cervical cancer, and protecting themselves from all of these diseases focusing on what is going to improve their general health.
(Community leader)

Contraception

In many African cultures having children is widely considered to be a blessing and provides women with social status. The more children a woman has, the more community respect they receive. Contraception is therefore not widely practiced among African women.

Aside from cultural norms, there are other barriers can limit African women's, and particularly young women's, ability to access contraception. These include lack of knowledge about contraceptive use; fear of side effects; fear of the reactions of others; their partner's decisions; socioeconomic, employment and education status; and limited access to culturally appropriate health services.

There is a big gap, which remains huge, in knowledge. There are a lot of myths about contraception.
(Academic)

Contraception is a complicated topic among young and old women. There are a lot of misconceptions and perceptions on using contraception.

(Parent)

Of those consulted, two of the five young women, all parents and the academic stressed the need to have information about contraception, including how to use it and potential side effects. They highlighted their confusion regarding the right contraception to use.

For family planning, I think choosing the right contraception is important, and women need to be educated about the different types of contraception.

(Young woman)

Social stigma

Although many participants noted that health literacy was low, as one young woman noted, the social stigma about sexual and reproductive health, and even mental health and wellbeing, is a key factor that requires consideration for effective health promotion project delivery.

Stigma on topics such as breast cancer, FGM/C and mental health, we cannot talk about it and it's very important that we focus on, as it comes with stigma among the African community.

(Young woman)

Sexual and reproductive health information and education

Peers as providers of sexuality information

In the absence of accurate, culturally appropriate sexuality education and information, some participants raised concerns about young people accessing misinformation from their peers.

All information they get is from sources that are not very reliable. Perhaps through their networking they may go online and search any information that they want. So I don't think that they get the right information. We want them to have it to do well without causing any harm to their parents and to themselves. I don't think they have that and I am not aware of anything that is specific to my community.

(Religious leader)

Yes, they live in Australia, but they live in their little sphere; their knowledge come from their bound thing of their peers and if the needs are there and that is what they get.

(Academic)

Indeed, the importance of young people having access to accurate, relevant and reliable information for themselves, and to share with their peers, is evident.

Parents as sexual and reproductive health educators

Educating young people about the interacting areas of sex, reproduction, sexuality, sexual health and relationships can be complex, and there is debate about what, when and how young people need to know about these matters (Dyson, 2008). Research with young people has shown that they want to be able to talk with their parents about sex and relationships, but that they also prefer to talk to their mother (Dyson, 2008).

Young women saw parents' role as sexuality educators, particularly mothers, as critical. Many stated that health promotion programs also need to target parents to ensure that they have accurate sexual and reproductive health knowledge.

I think what's important is that our parents are educated first, because if they are not educated and don't know anything about sexual and reproductive health, they can't help their kids.

(Young woman)

I didn't have any [sexual and reproductive health] information or knowledge to pass to my own daughter, not only in English but even in my own language.

(Young woman)

Mothers also agreed that they played a pivotal role as educators. Three parents reported that they felt comfortable to talk to their daughters about puberty and their sexual and reproductive health and wellbeing, with one acknowledging that she required additional information to do so properly.

Yes, I feel comfortable. I need her to know and understand the change of her body.
(Parent)

I will let them know about sexual and reproductive health beforehand. Because of that we are from a different cultural background and aspect, so I would explain to them as my culture and religion tells me.
(Parent)

I do feel comfortable educating my children about sexual and reproductive health and talk about their changing bodies and effect it has on their body.
(Parent)

If I got [sexual and reproductive health] resources and information, I will talk to all girls and boys and talk to them in a fun and safe way. Because we cannot restrict them from something that is very allowed, but we can meet in the middle between what I believe in and where their beliefs are to make the road safe at the end.
(Parent)

Another mother reported that she found talking about sexuality difficult, but did see educating her children as her parental duty.

To be honest it is so difficult to do it, but I think it is my duty, so I have to find a way to get that information for them. I prefer to explain it to them before they get it from the school.
(Parent)

School-based sexuality education

Good health promotion practice affirms that sexuality education needs to be a shared responsibility between school-based programs, the local health and welfare community and parents. Sexuality education also needs to be delivered using a whole-of-school approach, fostering school environments that support young people to develop knowledge, skills and resources for healthy relationships and sexual choices (Women's Health West, 2012).

Some parents voiced concerns about school-based sexuality education programs, particularly in relation to their cultural and religious acceptability.

Sometimes at school now from grade four they teach what is changing about their bodies and all about puberty. But sometimes I don't feel safe and I am not comfortable to talk about contraception and how to protect herself. You know this country everything is free, even sex, it's not like our country. I can give my daughter information about sexual and reproductive health.
(Parent)

Three of the five parents also expressed concerns about the age appropriateness of programs and the need for this information to come first from them or someone of the same cultural background.

I might give them before year six or early in year seven, but it has to come from me first.

(Parent)

I prefer to explain to them before they get it from school. Because that we are from a different cultural background. So I would explain to them as my culture and religion tells me, but still I will let them go to school sessions as well. They might fill something that I have missed from Australian culture and perspective.

(Parent)

We would like to see our high school girls participate in sexual and reproductive health programs if led by someone from our culture and belief who understands where we coming from to give them the information.

(Community leader)

It was also evident that some parents held opinions about school-based sexuality education programs and what their children were beginning to be taught.

You know because for [teachers], they are just saying you can do [sex] with anyone. In my way, it is not like this, it is not [permissible], but when the right time comes she can do this, like when she marries. Until she is married she can't do anything about [sex].

(Parent)

However, one mother supported qualified providers in schools delivering sexuality education to her children.

Having someone hired from the government qualified to talk about [sexual and reproductive health] and the information to be available in all of the communities and schools and then we can ask for. But we have to trust the information first. We want it to be contained advice with restrictions.

(Parent)

Unlike many parents and community leaders, young women were in favour of age-appropriate sexuality education programs, in schools or in the community, that support young African women to gain further knowledge about sexual and reproductive health.

Some people might think teaching young people about using condoms or pills opens up doors for young people to have sex. However, it's useful information, and helping young people to protect themselves from the consequences of unprotected sex is overlooked.

(Young woman)

The suitability of school-based sexual education; yes and no, it can be useful for people whose culture and belief are different. In our culture and religious beliefs, young girls are not told about [sexual health] and are not allowed to engage in these acts, so it is not useful early on like in primary school, but later on it would be useful for them, like before they get married or when they getting ready for marriage, it would be appropriate.

(Young woman)

It is good and appropriate for young people aged 17 and 18 as some young people are able to make choices.

(Young woman)

Yes, it is useful because children, regardless of their background, they need to know about sexual and reproductive health, but it is not appropriate the way they present to the state schools. I don't feel comfortable at school talking about these issues, and I would like my children to be presented by African workers generally and mainly Muslim person.

(Young woman)

Culturally appropriate sexuality education

Consultation participants strongly stressed the need for culturally appropriate sexuality education for young African women and men. All participants discussed the importance of having such a project delivered by a worker or young woman who was African, and therefore able to deliver a project that complied with shared culture and religious values.

It is good to have an African worker or workers from similar cultural background to deliver the session on sexual and reproductive health, as it allows parents to know that the information is culturally appropriate, due to the information being delivered by a person who has a full knowledge about the cultural norms of the community.

(Young woman)

I would prefer if it comes from young African person; I think young people will feel more comfortable and will have confidence, because that person understands them. They have the same culture; they will have respect for the religion and understand.

(Young woman)

It would be good for the boys and girls to receive health education, if there is someone who has more knowledge than us, which is in accordance with our culture and beliefs to give them any education or skills, which enable them to be part of Australian community as citizen. We would give it our full support if the people who are giving these education programs are respecting and complying with the religion and culture, specifically the religion.

(Community leader)

I will be very comfortable and happy if someone from my community and religion do it for me.

(Parent)

I would not recommend my children finding this information from outsider or from other places where this kind of things could be misinterpreted into different ways that they don't understand.

(Parent)

One young woman noted that a key strategy to support the project's endorsement by the community might be to invite mothers and aunties; however, she also stated that this could affect the project's ability to engage young women.

Allowing mums and aunties to attend the session when delivering the information to young women, but sometimes it might backfire, as some of the young women might not want to participate.

(Young woman)

The academic also stated the importance of culturally appropriate sexuality education, with a strong recognition of how young women's refugee status impacts on their psychological and physical health, safety and wellbeing.

I am talking about understanding the girl or the person from a cultural perspective, providing education in a way that is understandable to them, taking into consideration their culture, their background. Not only that, there are so many issues, especially for a child coming from refugee background, looks at the different interruptions that they have in their lives.

(Academic)

The need for service providers with specific knowledge and expertise in areas such as FGM/C was also noted as an important component of a culturally appropriate sexual and reproductive health program for young African women.

Schools or health services should look for someone from their culture, or providers who have experience with FGM/C, or someone who have inside to both the culture who has FGM/C and those who do not. It's about giving a balanced view rather than imposing what actually people think, and getting people to see what FGM/C actually is like.

(Academic)

Barriers to accessing sexual and reproductive health services

Participants noted that refugee and migrant women who had experienced wars, trauma, rape and torture in their home countries or refugee camps have specific sexual and reproductive health needs. These women also experience an array of complex settlement needs such as access to housing, education, employment and health services, which impact on their health and wellbeing.

Sexual and reproductive health service accessibility was viewed as a significant community concern. All five parents, three community leaders and the religious leader reported that, as far as they were aware, there were no sexual and reproductive services available to young African people in Melbourne's western region.

I do not know any services that are available in our community that help sexual and reproductive health information for families or girls.

(Parent)

If there is one there wouldn't be any barrier.

(Parent)

I am not aware of any services. Maybe there are services, but people access services individually and it is not something that works for everyone. People just look for anything that has some interest to them so it is individual based services.

(Religious leader)

No, my community have nothing.

(Community leader)

Young women also noted that referral pathways to culturally appropriate services and information were a barrier for many young women accessing services.

It's hard for newly arrived woman because they don't know where to go. So services need to make it accessible and should have multilingual workers or resources in order to access.

(Young woman)

Recommendations from community consultations

The purpose of this consultation process is to ensure that the voices and perspectives of young African women, parents and female community leaders are heard and inform the development of a culturally sensitive and appropriate sexual and reproductive health program for young African women.

The consultation findings clearly demonstrate the need for health promotion programs that work to empower young African women to make informed decisions regarding their own sexual and reproductive health; to develop young African women's confidence, independence, leadership skills and pride in their African and Australian identity; and to promote attitudes and behaviours among young women that support and promote the elimination of FGM/C so they later choose not to practice FGM/C on their daughters.

Informed by these findings, the following recommendations have been made, many of which will inform Women's Health West's health promotion programs.

1. Mainstream sexuality programs in school must use a whole-of-school approach that engages parents in the design and delivery of sexuality and respectful relationships education.
2. Young African women require tailored sexuality education that:
 - a) Is delivered by someone from a similar cultural background
 - b) Increases their health literacy, skills and knowledge about FGM/C, puberty, contraceptives, sexually transmissible infections and other aspects of health, safety and wellbeing
 - c) Works to redress social stigma and cultural and gender norms that lead to unequal health outcomes among young African women.
3. Parents, community and religious leaders require culturally appropriate sexuality education delivered by a worker from a similar cultural background and who speaks their language so that they can better support the sexual and reproductive health of young African people.
4. African women who have undergone FGM/C require specialist clinical support and advocacy, information, and referral to support programs for them and their partners that are designed to respond to the psychosocial impacts of FGM/C.

Conclusion

We undertook consultation with a small group of community members who have migrated from communities with a high prevalence of FGM/C practice. It became clear through the consultation that young African women who have undergone FGM/C require a tailored sexual and reproductive health project that responds to their different health, safety and wellbeing needs.

Young African women aged between 16 and 25 years who live in Melbourne's west and who have migrated from countries where FGM/C is practiced will benefit from this holistic, culturally sensitive sexual and reproductive health promotion project. In accordance with best practice, the CBTC project will develop a participatory approach that works to increase young women's individual, social and civic decision-making power as a mechanism to support sexual and reproductive health and prevent the practice of FGM/C. Prioritising the self-empowerment of young women is central to this project, as is building broader community consensus for the rights of women and girls.

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Appendix One: Consultation questions for young women

The numbered questions are the key consultation questions, while the dot-point questions were designed to be used as a prompt if necessary.

1. What is it like for young African women to live and grow up in a western country like Australia?
 - Are there differences between the African and Australian culture?
 - Are there any differences in the way that women and men behave?
 - Are there different expectations for young women? If so, how do these different expectations affect your life as a young African woman? How do you manage them?
2. When we talk about 'African women's health', what important health topics do you think young African women or girls need to know about?
 - What does the word 'health' mean to you?
 - What does 'African women's health' mean to you?
 - As a young African woman, what health topics do you want to know more about? How might you seek information about those topics?
3. Can young African women or girls get health information easily?
 - Where do you think is the best place for you or other young African women to get health information in the western suburbs? For example, when you first got your period, how did you know what to do, who told you about the changes to your body, and what did they say?
 - Who do you think young African women talk to when it comes to women's health?
4. When we talk about the sexual and reproductive health needs of young African women, what are the important things to think about?
 - Do you think sexual and reproductive health education is important?
 - Do you or people you know have certain religious or cultural concerns about young women learning about sexual and reproductive health? What are these concerns?
 - What topics do you think are important to include in sexual and reproductive health programs for young African women?
 - How would you feel if the health information came from an African worker? Would you feel comfortable?
5. What do you think about the sexual and reproductive health information provided at schools? Do you think it's useful and appropriate?

- Would your family allow you to go to sexual and reproductive health education programs? What can be done for your parents to allow you to attend the education program?

6. Do you know what female genital circumcision is?

- Do you know why it's performed?
- Do you believe it's important for your culture?
- What do you think about the idea of stopping female genital circumcision?
- Do you know or have you heard about the health issues that female genital circumcision can cause?

7. Do you think that there should be programs for young women who have experienced female genital circumcision?

- What sort of information do you think should be included in the program?

Appendix Two: Consultation questions for community leaders

1. Is sexual and reproductive health something that is openly talked about in your community?
2. What are the barriers to openly talking about this topic?
3. Who has the responsibility of educating young people about sexual and reproductive health?
4. Is it left to mothers, schools or health care professionals in your community to deal with these matters?
5. Does your community have any concerns about the sexual and reproductive health of its young people?
6. Is dating or having relationships before marriage acceptable?
7. Is there a different expectation on how girls and boys behave in relationships?
8. What about the young women, are there any particular issues for them?
9. Do you believe enough information is being provided to these women to make informed choices?
10. What services are there in your community to help young women make decisions concerning their sexual and reproductive health?
11. What role would you, as a community leader, play in educating young people and what can organisations working with African communities do to help?

Appendix Three: Consultation questions for parents

1. Do you feel comfortable talking to your children about their changing bodies in terms of their sexual and reproductive health and wellbeing?
2. What would make you more comfortable when talking to your children about sexual and reproductive health as they grow?
3. Do you feel that if you had more education about the sexual and reproductive health of teenagers it would be easier for you to talk about?
4. Would you allow your girls to attend workshops where sexual and reproductive health is discussed or would you rather they learn this from you in the family setting?
5. What services in the community do you know of that can help you and your daughter make informed decisions about sexual reproductive health?
6. What other services or information would you like in the community to help young women make safe choices about their sexual and reproductive health?