CONTRACEPTION, TEENAGE PREGNANCY, CULTURE AND MOTHERHOOD AMONG AFRICAN-AUSTRALIAN TEENAGERS WITH A REFUGEE BACKGROUND IN GREATER MELBOURNE, AUSTRALIA

Submitted by
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8 November, 2012
Declaration of Authorship

I declare that except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis or any other degree or diploma. No other person’s work has been used without acknowledgement in the main text of the thesis.

I also declare that this has not been submitted for the award of any degree or diploma in any other tertiary institution. Work related to the study, including study design, data collection and analysis was carried out by myself at the Centre for Mother and Child Health Research and the School of Public Health, La Trobe University under my supervisors’ guidance, Professor Pranee Liamputtong, Dr Celia McMichael and Dr Charles Mphande. My previous supervisors guided my initial research at Victoria University and later at La Trobe. All research procedures reported in this thesis were approved by the Human Research Ethics Committee at Victoria University (HRETH 09/77) and affirmed by the Faculty of Human Research Ethics Committee at La Trobe University, Bundoora Australia. The views expressed in this thesis are the views of the researcher and not of the institution.

Signed by date

Mimmie Claudine Ngum Chi (Watts)
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAT</td>
<td>African-Australian teenagers</td>
</tr>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistic</td>
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<tr>
<td>AFR</td>
<td>Adolescent fertility rates</td>
</tr>
<tr>
<td>ARC</td>
<td>Action for the Rights of Children</td>
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<tr>
<td>BR</td>
<td>Birth Rate</td>
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<tr>
<td>CAAWI</td>
<td>Centre for African-Australian Women’s Issues</td>
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<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Surveys</td>
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<tr>
<td>FARREP</td>
<td>Family and Reproductive Rights Education Program</td>
</tr>
<tr>
<td>FC</td>
<td>Female Circumcision</td>
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<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
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<tr>
<td>FR</td>
<td>Fertility Rate</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immuno Virus /Acquired Immuno Deficiency Syndrome</td>
</tr>
<tr>
<td>ICEPA</td>
<td>Institute of Community Ethnicity and Policy Alternatives</td>
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<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>KI</td>
<td>Key Informants</td>
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<tr>
<td>MCH</td>
<td>Maternal Child Health</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Rate</td>
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<tr>
<td>PGR</td>
<td>Population Growth Rate</td>
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<tr>
<td>POEM</td>
<td>Positive Orientation towards Early Motherhood</td>
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<tr>
<td>QR</td>
<td>Qualitative Research</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SDH</td>
<td>Social Determinants of Health</td>
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<tr>
<td>SES</td>
<td>Socio Economic Status</td>
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<tr>
<td>SEIFA</td>
<td>Socio Economic Indexes for Areas</td>
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<tr>
<td>SP</td>
<td>Service Providers</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>---------</td>
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<tr>
<td>STD</td>
<td>Sexually Transmissible Diseases</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infections</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNDESA</td>
<td>United Nations Department of Economic and Social Affairs</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Plan</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commission for Refugees</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>VU HREC</td>
<td>Victoria University Human Ethics Committee</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Abstract

Worldwide, 11 million teenage girls give birth annually. The majority of these pregnancies occur among African teenagers, with a proportion of those teens who are living in diasporas due to migration by ‘choice’ or by force. In Australia, the large majority of people with African backgrounds have arrived via the refugee and humanitarian programmes. Of Australia’s total migrant population, 5.6 per cent are African by descent. Protracted experiences of war, displacement, social instability and challenging migration pathways all affect the health and wellbeing of teenagers with refugee backgrounds, including their sexual and reproductive health (United Nations High Commission for Refugees [UNHCR], 2010).

This qualitative research was concerned with contraception, teenage pregnancy and culture issues among African-Australian teenagers who migrated to Australia through the refugee and humanitarian programme or through the family reunion programme. Sixteen young women who had experienced teenage pregnancy and six service providers were interviewed using in-depth questionnaires. Another two separate focus groups were conducted with six service providers and six African mothers who were at the same time key informants.

Intersectionality, phenomenology and cultural competency frameworks informed the conceptual framework for this research. Intersectionality recognises the trajectories and the multiple axes within which African teenagers, migrants and refugees exist. Following data collection, the findings were analysed using thematic analysis.

The findings revealed that African-Australian teenagers exist within an interdependent social system whereby gender, family, community, culture and myths all play a role in determining their health. Teenage pregnancy occurs amid many social and cultural intersections. Subsequent motherhood brings both happiness and challenges. This research recommends, among other suggestions, an Austrafrocentric model of providing sexual
health information and education to African-Australian teenagers and Sub-Saharan African families, with the African teenagers at the centre of education.
Chapter 1: Introduction and Research Overview

My family and I were hiding in a room during an attack when a rebel broke in. My mother was asked to give one of her children up or else the entire family would be killed. My mother gave me up. The rebels took me with them, and on our way to their camp I was raped by seven of them. I was bleeding heavily and unable to walk any further. They threatened to kill me if I did not go with them. I was held by them for one year. I became pregnant and decided to escape. Upon my arrival in Freetown, I was rejected by my family and my community. I asked myself, ‘Who will help me now?’

(Marion, Sierra Leonean internally displaced girl, aged 17; UNHCR, 2008, p. 7)

1.1 Introduction, background and rationale for research

This research is about the teenage pregnancy (TP) experiences of Sub-Saharan African refugee girls living in Melbourne, Australia. TP among African-Australian teenagers (AATs) has become an issue of concern to both the African-Australian community and mainstream Australian society (McMichael & Gifford, 2009a+b). TP has been defined as pregnancy occurring in girls between the ages of 10 and 19 years (World Health Organization [WHO], 2004). There is a perception among African parents in Australia that many teenage girls of African background who came to Australia via the humanitarian programme are experiencing high rates of unplanned pregnancy, often out of wedlock, compared to Anglo-Australian and Asian-Australian teenagers (Southern Sudanese Women, 2007). Previous research on African youths with refugee backgrounds living in Australia (McMichael & Gifford, 2009a) has also documented elevated rates of TP among African girls, compared to the wider Australian population (Gifford, Correa-Velez et al., 2009). Other research has documented broader concerns around the sexual health literacy and the role of culture among AATs, including in relation to pregnancy prevention (Cassity & Greg, 2005; Gifford, Correa-Velez et al., 2009). African-Australian parents associate the occurrence of TP with the inability to raise and discipline their children in ways they consider appropriate (Levi, 2010) and in line with the authoritative, strict disciplinary style
of parenting expected and encouraged within many African cultures (Mellor, Renzaho et al., 2012; Khawaja & Milner, 2012).

1.1.1 How common is TP?

TP is significantly higher in Sub-Saharan Africa than other regions of the world (WHO, 2012), although low age at marriage can explain some of the pregnancies (Dei Wal, 2004; Manda & Meyer, 2005). For example, in Sudan, Chad and Niger, girls marry as young as 13 years; the birth rate among teenagers aged 15 to 19 years in Sub-Saharan Africa in 1998 was 143 births per 1000 females (WHO, 2004). These figures vary between and within countries and world regions. The figures in brackets indicate the birth rate among teenagers in various African countries: Somalia (208); Democratic Republic of Congo and Niger (206); Sierra Leone (201); Ethiopia (168); Cameroon (140); Eritrea (128); Sudan (52) and Mauritius (45) (WHO, 2010). These rates for pregnancy per 1000 females aged 15 to 19 years are significantly higher compared to rates in East/South Asia and the Americas in the same period (regional average 56 and 68 respectively/1000 females). In contrast, country specific figures for teenagers aged 15 to 19 years show Japan and the Korean Republic (4); Singapore (8); Sri Lanka (20); Australia (22); Canada (24) and Sweden and Spain (10) (WHO, 2004), although abortion can be attributed to some of the low teenage birth rates.

In the United States of America (USA) in 2006, black teenagers aged 15 to 19 had a pregnancy rate of 126.3/1000, compared with 44/1000 for non-Hispanic white teenagers (Kost, Henshaw et al., 2010). African-American teenagers are 1.6 times more likely to have a second baby within 18 months of the first pregnancy than white teenagers (African-American Women and Adolescent Pregnancy, 2011). While African-Americans may have lived longer in the USA compared to the time refugees of African background have lived in Australia, the two groups share the same African heritage, identify as black and are more likely to live in resource poor settings in their respective countries of settlement. Hence, there is a connection in both their cultural heritage and socio-economic contexts. Teenagers with unstable life situations are more vulnerable and more at risk of sexual abuse and exploitation (UNHCR, 2008), which may lead to TP. Protracted experiences of war,
displacement, social instability and challenging migration pathways all affect the health and wellbeing of teenagers with refugee backgrounds and their families, including their sexual health (UNHCR, 2010).

1.1.2 The refugee’s journey, settlement and challenges in Australia

African migrants to Australia have followed diverse passageways prior to arrival; some have migrated as skilled migrants, others as refugees. This research is concerned with the second category, refugees. For African refugees and their families, the journey to Australia is not always a straight-forward and direct route (Dumenden, 2007; Khawaja & Milner, 2012) with initial countries of asylum en route to Australia being Ethiopia, Kenya, Libya, Uganda, South Africa, Ivory Coast, Egypt (Levi, 2010) and others. Australia is the second, third, fourth and, in some cases, the fifth country of settlement following displacement from country of birth. The experiences of refugees in these countries, while waiting for a decision on refugee and humanitarian visa applications, are both positive and negative. They are positive in that some asylum seekers have the opportunity to attend schools or some form of education and to learn another language, such as English, Swahili, French or Arabic in the refugee camps and other temporary settings. However, experiences of life in these countries brings many different challenges, including torture and trauma, being raped or at risk of being raped and disrupted education and employment (Pittaway, 1991; Richardson, Miller-Lewis et al., 2002; Pavlish, 2005; Sheikh & MacIntyre, 2009). These experiences have direct and indirect influences on refugee settlement and adaptation in Australia (Richardson, Robertson et al., 2001). Many refugees have had limited educational opportunity and many households have single parents, often with women heading the families. Their husbands may have gone missing in war, died or been left behind with other wives, particularly in the case of Sudanese refugees (Dumenden, 2007; Levi, 2010).

In general, people with African backgrounds living in Australia experience many disadvantages irrespective of migration status, particularly in the areas of housing, health and higher education attainment. They are more likely to have lower socio-economic status compared to the general population (Richardson, Robertson et al., 2001; Richardson,
Miller-Lewis et al., 2002; Murray & Skull, 2003; McDonald, Gifford et al., 2008; Moroney, 2009; Neumann, 2010). Structural disadvantages within work places remain a problem and a concern, with unemployment higher among African migrants in Australia, particularly among African refugees (Junankar & Mahuteau, 2004). Refugees of African background on arrival in Australia have very low socio-economic status and are faced with challenges settling into a new culture and new country.

Post-migration settlement and gaining English language skills are a priority for refugees and other migrants with little or no English, although they may be fluent in several other languages. The sexual and reproductive health needs of AATs are not a priority area of policy and programmatic concern on arrival (McMichael & Gifford, 2009; Neumann, 2010). Settlement issues, integration, schooling and social support for refugees following traumatic situations and torture due to war and displacement have been the priority for governments and settlement organisations (Macintyre & Dennerstein 1995; Pittaway, 2002; Cassity & Greg, 2005; Department of Immigration and Multicultural Affairs, 2006; Tiong, Patel et al., 2006; Atwell & Gifford, 2009; Pittaway & Muli, 2009). Enrolling children in English language schools and mainstream education systems remains the priority (Ngum Chi, 2006) compared to sexual health literacy acquisition.

Africa is a very diverse culture, but there are many similarities within it, including the limited attention given to preventative health (Burns, Imrie et al., 2007; Mellor, Renzaho et al., 2012). Sex is not a normal conversation topic between parents and children in Africa. Talking about sex with your children or in front of them is regarded as rude and irresponsible parenting (Adeyemo & Brieger, 1994–1995; Posel, 2011). Such cultural barriers and norms inevitably limit the level of sexual education that parents can provide to their children, and this may create a gap in their sexual health knowledge acquisition.

In Australia, health research on African refugees has focused on infectious and communicable diseases for new arrivals (Royal College of Obstetricians and Gynaecologists, 1997; Richardson, Miller-Lewis et al., 2002; Murray & Skull, 2003; Guerin, Allotey et al., 2006; Tiong, Patel et al., 2006). The management of female genital
mutilation (FGM) and support for service providers caring for women affected by FGM, and the psychological mental welfare of refugees, has remained the priority for researchers (Ngum Chi, 2006; Tiong, Patel et al., 2006). Little is known about the uptake and use of contraception, TP, sexual health knowledge, cultural effects and practices of AATs with refugee backgrounds. In Australia, no specific studies have been carried out to document the rate of TP among African migrants and specifically teenagers with a refugee background, or the challenges and the resilience of young mothers and their families (McMichael, 2008; McMichael & Gifford, 2009; McMichael & Gifford, 2009). This research aims to explore the issue of culture and TP among Africans with refugee backgrounds in greater Melbourne.

1.2 Africa, a brief overview

Today Africa is spoken of only in pessimistic terms. The sum of its misfortunes—wars, its despotisms, its corruption, and its droughts—is truly daunting. No other area of the world arouses such a sense of foreboding, and few states have managed to escape the downward spiral. What went wrong? (Meredith, 2006, inner front page.)

Africa is a vast continent comprising 57 independent countries, including the new state of South Sudan (United Nations, 2011). Africa is blessed with diverse cultures and an abundance of natural resources and is the cradle of human life and civilisation. Each African country comprises a few ethnic groups or hundreds of different ethnic groups who speak multiple to hundreds of dialects (Meredith, 2006; Cook, 2008; Oppong, 2010).

Historically, Africa was a civilised continent with thriving kingdoms and empires until the arrival of the Europeans in the early 1700s. Ethiopia was the only country in the continent to have fought invasion by the Europeans. The most powerful kingdoms were those of Mali, Songhai and Ghana, followed later by the Benin, Ife and Oyo kingdoms in the west (Haywood, 2008), with the Ethiopians, Nubians and the Kosoni empires in the south (Mutua, 1994–95). The African empires were at their height between 1200 and 1600 AD (Haywood, 2008). Prior to the arrival of Europeans and colonisers, Africa comprised
thriving independent economies, and Africa’s rich cultures are described as having ‘awesome royal ceremonies, fantastic festivals, exciting music and dance, great wildlife and more gold than you ever dreamed of’ (Haywood, 2008, p. 7). The above description given by Haywood and other historians is different to the notion of the ‘Dark Continent’ that colonisers and most European historians often associate with Africa (Fage & Tordoff, 2002; Meredith, 2006).

Currently, many countries in Africa—particularly those in Sub-Saharan Africa—have poor development and health indicators. Globally, African countries have many of the highest fertility and maternal mortality rates across all age groups comparable only to the poor nations of South-East Asia (WHO, 2012). The above indicates the unmet need for contraception in Africa directly linked to low sexual health knowledge (see Table 2). High birth rates are directly related to high maternal and infant mortality (WHO, 2011). The risks are even higher for teenagers whose bodies are still developing and also for their unborn children. Poor health outcomes for young mothers and their babies are common in Africa, particularly those living in poor conditions and rural areas (WHO, 2012). This is in addition to low health literacy levels, particularly among young women, with direct health implications to both the mother and her children. This happens because health infrastructures (human and economic) are under-resourced in many African countries, making it difficult for pregnant teenagers and women to receive the level of care they may otherwise receive (United Nations Development Plan [UNDP], 2012). Lack of resources and infrastructure has direct implications on poor health outcomes (WHO, 2012) and this is particularly true in regions experiencing social and political instabilities.

To understand the reality of what is happening in Africa today, including wars and instability, with the subsequent creation of millions of refugees, one has to go back to the period of colonisation before and after World War I and examine the ‘scramble for Africa in the 18th and 19th centuries and its subsequent, often devastating and catastrophic, effects on the people and the continent as a whole (UNDP, 2012). The scope of this thesis does not allow for such details, but it is worth noting that the history of Africa, and past policies by African and international governments—including the colonial governments—have
devastating effects on the people, contributing to current instabilities and refugee issues. Due to bad governance, the healthcare systems, education, development and progress of the people, the continent in general remain in crisis (Mutua, 1994–95; UNDP, 2012). People fleeing their countries as refugees is another outcome of the bad policies and governance in Africa. Refugees and asylum seekers leave their countries not by choice but due to persecution often, from their own governments (UNHCR, 2010; UNDP, 2012). This is particularly true for Africa, which has abundant resources, including fertile soil, yet is the most food insecure region in the world (UNDP, 2012). Helen Clarke (former New Zealand Prime Minister and chair of the UNDP) said:

While famines grab headlines and periodically jolt national authorities and aid agencies into action, the silent crises of chronic malnourishment and seasonal hunger do not receive nearly enough attention. The effects, however, will be felt by generations of Africans, robbing children of their future and parents of their dignity and holding back advances in human development even amid Africa’s newfound economic vitality (UNDP, 2012, p. v).

It is regrettable that African governments in the last three decades have failed to meet their people’s needs, such as ensuring food security, providing basic infrastructures and essential health services. The result is that Africa and Africans continue to make news headlines around the world, not by their own fault or lack of resources, knowledge, expertise and will-power, but because of lack of resources and failed establishments (UNDP, 2012). Worse still, a quarter of Africans reportedly go to bed hungry each day, not because of food unavailability alone but because of the inequality, which then leads to unequal distribution of resources (UNDP, 2012) and substantially affects health and health outcomes. Women and children are most at risk of poor health outcomes (UNDP, 2012). Most African women are at the bottom of the social structure, directly associated with cultural norms that give men power over women (Drummond, Mizan et al., 2011; Khawaja & Milner, 2012; Mellor, Renzaho et al., 2012). High fertility rates, high birth rates, high infant mortality rates and high death rates pose both health and social challenges to women, with teenagers particularly at risk.
A summary of fertility rates and contraception needs, use and knowledge in selected countries is provided in Table 2. The figures in Table 2 indicate that the adolescent fertility rates (AFR) in all the Sub-Saharan African countries are significantly higher than that of Australia. The total AFR in the African region is almost three times higher than the global AFR. The contraceptive prevalence rate (CPR) for all women of reproductive age 15 to 49 years old is significantly lower in all the African countries compared to Australia. The unmet needs for women who want to use a contraceptive method but are unable to do so remains high in all the African countries represented in the table. The prevalence of condom use among females and males engaging in high-risk sex behaviour is high compared to other countries (Cherutich & Brentlinger, 2008; Westercamp, Mattson et al., 2010). High risk sex behaviour is described as a person who has had sexual intercourse with more than three serial or concurrent partners in the last year (WHO, 2012).

Following migration to Australia, often with a history of protracted situations of social and political instability and forcible migration, AATs may not be meeting their sexual and reproductive health needs (McMichael, 2008). This is further compounded by disrupted education prior to arrival, inadequate sexual health literacy and inequitable social structures in sites of settlement (Mellor, Renzah et al., 2012; Khawaja & Milner 2012). Many African women, including AATs, are more concerned with the health of their family members than that of their own. The life and welfare of many African-Australian females could be different if more women had a voice or were given an outlet where their voices, feelings and experiences could be heard or expressed (Pittaway & Muli, 2009) in order that adequate and appropriate resources could be made available to them. I intend to give the AATs and fellow women just that voice in this research.

1.3 Personal motivation for this research

My motivation for this research came about through various influences. First, my motivation came from my African heritage and my own position as a migrant and an academic; and second, from my experiences and interactions with African women and their
families in Australia. Third, my previous research on FGM provided me with a background into the issues and challenges faced by migrant women and refugees in particular.

As an individual, I am the third in a family of nine children and one of four girls. I grew up in a community setting where everyone knew each other and, through your surname, an older person could describe your family lineage going back five or more generations. We shared everything, and religion played a very important part in our daily lives. Traditional values and respect for everyone, especially those older than you, was paramount. Culture, traditional practices and religion were an integral part of my childhood.

After migrating to Australia, through my community volunteering work, I was elected as chair for the Centre for African-Australian Women’s Issues (CAAWI). CAAWI was a coalition of women’s groups from many African countries now living in Victoria. Within this work context, I began to see and understand the similarities and differences that existed among Africans in diaspora. I was exposed to other cultural groups, but also to the issues that Sub-Saharan African refugees faced following migration and settlement. I realised I wanted to explore some of these issues in greater depth. One evening, I was invited by the local church minister to speak with a Sudanese religious women’s group about ‘how to best support their teenage children, particularly girls’. During the discussion, one of the mothers asked me, ‘What are the Australian girls doing to themselves and not having babies like our daughters?’ In many ways, this question became the foundation of my doctoral research.

1.3.1 Situating the thesis

Many studies have explored migration, refugee health issues and settlement needs among African migrants and refugees in Australia (Royal College of Obstetricians and Gynaecologists, 1997; Richardson, Robertson et al., 2001; Richardson, Miller-Lewis et al., 2002; African Women, 2008; McDonald, Gifford et al., 2008; Moroney, 2009; Murray, Windsor et al., 2009). Some focus has been given to maternal and child health issues, but most of that focus was on support for health practitioners caring for women who have had circumcision, FGM or traditional cutting (Royal College of Obstetricians and
Gynaecologists, 1997). Through other research, including the literature review (conducted in 2005), it became apparent that there were no studies focusing on the experiences of the FGM-related needs of women using hospital services (Ngum Chi, 2006). Other health research has focused on sexually transmissible diseases (STDs) and human immunodeficiency virus infection (HIV) (Lemoh, Biggs et al., 2008), the settlement needs and wider social issues of refugees people and the lost boys (Pittaway, 1991; Pittaway & Bartolomei, 2002; McDonald & Kennedy, 2004; Pittaway, 2004; Luster, Qin et al., 2008).

Carolan has researched Sub-Saharan African women’s perceptions about maternity services and birthing in Melbourne (Carolan, 2010a+b). Foundation House and other researchers have conducted research on exploring the sexual needs of African refugees and young people (Victorian Foundation for Survivors of Torture, 2005; McMichael, 2008; McMichael & Gifford, 2009a+b). However, there is a need for more research on the sexual health issues and needs of refugees, particularly those from Africa (McMichael & Gifford, 2009). Little research has focused on the AAT girls’ attitudes to contraception, and the higher incidence of TP and unwanted pregnancies. Levi (2010) sought to understand the challenges that Sudanese mothers, mostly single, had trying to raise their teenage children in Australia after arrival as refugees. However, the influence of culture and beliefs of AATs has not been explored elsewhere in any depth. The AATs’ attitudes towards contraception in addition to culture, beliefs and gender influences over AATs’ decision making abilities are unexplored.

There has been extensive research on migrant women and motherhood, especially Southeast Asian women (Liamputtong, 2006), migrant women’s health (Macintyre & Dennerstein 1995), African refugee women and social issues (Pittaway, 1991; Pittaway, 2002; Victorian Foundation for Survivors of Torture, 2005; Carolan, 2008; McDonald, Gifford et al., 2008; Murray, Windsor et al., 2009; Pittaway & Muli, 2009), mothering and raising teenage children by African mothers (Levi, 2010) and refugee health, including that of young men (Murray & Skull, 2003; Morland, Duncan et al., 2005; Luster, Qin et al., 2008). Attempts have been made to research promoting health and the sexual health knowledge of African-Australians and refugees, but no research has explored the knowledge of AATs in relation to their sexual health, their knowledge of contraception and
the role of gender and culture in AATs’ decision making within the context of sexual relationships (Pittaway & Bartolomei, 2002; McMichael, 2008; McMichael & Gifford, 2009a). Chris Lemoh and colleagues (2008) have conducted research on HIV/acquired immunodeficiency syndrome (AIDS) with members of the African community and have written a piece on working specifically with West African men regarding their sexual health. No research has examined the issue of contraception, TP, motherhood and the role of culture with African teenage mothers.

In this research, I seek to close this knowledge gap by investigating and exploring the contraception knowledge of AATs and African mothers, the role of AATs in decision making regarding contraceptive use or non-use, AATs’ attitudes towards contraception use, AATs’ experiences during pregnancy and the joys and challenges that subsequent motherhood brings. I explore the various roles played by the family, sexual partners, friends and peers, the fathers of teenagers and the fathers of the babies born to teenagers. Culture is an important aspect of African people’s lives and being (African Women, 2008; Victorian Equal Opportunity and Human Rights Commission, 2008; McMichael & Gifford, 2009a; Levi, 2010), and this aspect of life needs consideration when dealing with the health issues of Africans. It was important that I investigated the role of culture in the context of contraception uptake and use among African teenagers with a refugee background.

An Australian Bureau of Statistic (ABS) study examined changes in sexual development, sexual behaviours, sexually transmissible infections (STIs), teenage birth rate and abortion rates, including other relevant data regarding young mothers and young people living in Victoria. One of its key findings was the historical decrease of the age of onset of first sexual intercourse over a 30 year period (ABS, 2004). Another study found that in today’s society, many young people become sexually active at a younger age, and also people are marrying later and so have longer periods to engage in sex up to 10–20 years before marriage, which increases their risk of TP and STIs (Jordan, Bayly et al., 2006). The same study showed an increase in TP and abortion rates among young people, despite the development of modern and reliable methods of contraception and education on sexual and reproductive health issues (Jordan, Bayly et al., 2006).
Some of the recommendations from this report included developing strategies for more sexual health education to young people in schools, and providing more access to services that address the social needs of young people (Jordan, Bayly et al., 2006). These findings are similar to the findings of Coory (2000) with adolescents living in disadvantaged areas in Queensland Australia. Though these studies were not specifically about African teenagers, they present a disturbing picture of the context into which the aforementioned factors that predispose African teenagers to unprotected sexual activity exert their effects. While issues of sexual health have been broadly identified as an important area of need, there is a paucity of research that explores the sexual and reproductive needs of young people in Victoria (Jordan, Bayly et al., 2006). Tiong identified the particular need for more research into the specific health needs of African refugees (Tiong, Patel et al., 2006). Recommendations from other recent research points to studies to solicit further understanding of the sexual health and reproductive needs of Sub-Saharan refugees in Australia (Sheikh-Mohammed, Macintyre et al., 2006; Gibney, Mhrshahi et al., 2009; Carolan, 2010), including the cultural influences on the health of these migrants. I contend from the above research that there is a knowledge gap regarding the sexual health, contraception knowledge, pregnancy experiences and motherhood experiences of African teenage refugee girls in Melbourne. This research attempts to close that gap and provide insight into the contraceptive knowledge, attitudes and pregnancy and motherhood experiences of refugee girls from Sub-Saharan Africa in Melbourne, Australia.

1.4 Aim of the research and research questions

Australia has relatively high rates of TP and STDs compared to other developed countries (Agius, Pitts et al., 2006). Teenagers and migrants from Sub-Saharan Africa living in Australia have elevated rates of unintended TP relative to the wider teen population (Gifford, Correa-Velez et al., 2009). However, there is very limited research about teen pregnancy among AATs and little is known about their sexual health. Further, their sexual and reproductive health needs have not been a priority for service providers during and
after settlement because of other priorities (Tiong et al., 2006). The purpose of this research is to explore the issue of TP involving AATs under the following broad headings:

a. Attitudes and knowledge of sexuality, contraception and pregnancy
b. Cultural and intercultural issues
c. Intergenerational issues.

The specific aims and objectives were to:

1. Explore the role of culture in selected African communities in the uptake and use of contraceptives and eventual TP among teenagers of African-Australian descent
2. Identify and explore the effect of TP to teenagers of African-Australian descent and their families
3. Explore the effects of migration, settlement and the acculturation processes on the sexual health needs of AATs
4. Identify policy and service responses to the issue of TP among AATs.

In particular, the research asks the following key questions:

1. What influences the decision about contraceptive uptake and use by teenagers of African-Australian background?
2. What are AATs’ experiences of TP?
3. What are the implications of TP on the lives of AATs and their families? What current role do service providers (SP) play in supporting AATs in relation to sexual and reproductive health needs?
4. What can SPs do to best support AATs?
5. What are the broader policy implications of the research findings for other refugee young people?

The findings from this thesis will be significant in providing greater insight into the issue of TP within the Australian and African community in general, but specifically among African-Australians. It will inform health researchers and social scientists about the African culture and its influence on young people’s behaviour before and after migration, and it will add to the body of literature and research on African teenagers and women in diaspora. The
research findings aims to further contribute to the development of culturally appropriate tools or models for teachers, health and SP to use when providing care and support to African teenagers and their families. Through the dissemination of the research findings, the study is hoped to empower teenagers in regards to decisions about sex, and allow African parents to broaden their knowledge of contraception uptake and use, including support for their children.

1.5 Thesis outline and structure

Chapter 1 introduced the research. It provided a background on Africa, its people and some of the causes of social and political instability. My motivation for this research was stated. A brief review of other relevant research was included and I provided aims for the research together with the research objectives and questions.

Chapter 2 comprises a detailed review of literature on topics relevant to this research. In particular, I discuss refugees and the Australian humanitarian programme, African migrants and refugees, including relevant issues following migration and settlement, TP trends, modern and traditional methods of management of unwanted pregnancy and perspectives on motherhood.

Chapter 3 covers the different theories and frameworks that inform the research. I discuss intersectionality theory, the social model of health, gender and gender roles, scripting theory and responding to TP.

Chapter 4 discusses the research design and methods, including ethical issues, research participants, data collection and data analysis.

Chapter 5 is the first of the analysis chapters and focuses on gender, culture and marriage. Young women’s narratives of fertility regulation and management of unintended pregnancies within African settings are discussed.
Chapter 6 focuses on AATs’ knowledge of contraception, uptake and use. Myths and misconceptions about contraception are discussed, followed by AATs’ experiences in sexual relations.

Chapter 7 provides analysis on pregnancy and motherhood. In this chapter, I discuss the reaction to the news of pregnancy and support systems during pregnancy and after childbirth.

Chapter 8 forms the research discussion based on the analysis of the research from the three previous chapters. In particular, I discuss gender equality and health, culture and sexual and reproductive health, pregnancy regulation, knowledge and contraception decision making, sexuality and experiences of sexual relationships and experiences of motherhood.

Chapter 9 provides a review of key research findings, the strengths and limitations of the research and the recommendations. Suggestions for future research are made, with this chapter further providing the overall thesis conclusion.
Chapter 2: Literature Review

This chapter provides an overview of forced migration and discusses the Australian humanitarian programme, with particular focus on African intake. I discuss the health of African-Australian refugees and migrants, including the healthy migrant effect and perspectives on child bearing. I go on to present pregnancy trends among teenagers around the world, including Australia. The knowledge and attitudes of teenagers towards contraception are also described. A description of the management of TP is presented from different parts of the world, including [sexual] health services for teenagers who are recent migrants in Australia. Finally, I discuss the perspectives and marriage expectations of African parents, including other migrant communities; family name, family honour and motherhood among migrants is discussed. A conclusion is provided at the end of the chapter.

2.1 Background: Forced migration

Five million people cross international borders every year from developing countries to more developed countries, and within this group 1 per cent are Africans, although more people move between developed countries and within developing countries (UNDP, 2009). Migrating from one country to another or within the same country was and continues to be part of the human story. An outcome of migration is the diversity in the population group of the host countries in the western and developed countries. In Australia, the most recent diversity observed is among refugees from Asia, the Middle East and Sub-Saharan Africa. There are two groups of migrants: those who leave by choice and refugees who are forced to, often after suffering discrimination, with their human rights abused (Rees & Pease, 2006). Migrants leaving of their own free will do so with the hope of improving their life, health and/or education prospects. This ‘free will to leave’, is often because of high unemployment levels, and little or no opportunities. Most importantly, migrants hope to improve life opportunities after migration into a higher income country (UNDP, 2009). The people who are likely to move are those who are already successful or have acquired a
certain level of education in their countries of origin. These groups of migrants are often skilled and aim to improve their lives and that of their families. While most skilled migrants choose to emigrate, one can argue that if they had the same life prospects at home, that looked as promising as abroad, many would rather stay with their families and within their own borders because of the family isolation that comes with migration (UNDP, 2009).

According to the UNDP report (2009) dedicated to human mobility, ‘moving across borders can greatly expand the opportunities available for improved wellbeing (p. 9). Improvements are not only seen among the migrants who move, but their countries of birth and the host countries all benefit. Mobility or migration matters because mobility fosters human development. The country of birth benefits from remittances, which eventually filter into the economy, while the host countries benefit through new skills, new ideas, new technologies, cuisines and job creation by migrants (UNDP, 2009).

There are adverse consequences to the migration story. In the current globalised world, there is ‘brain drain’, a term commonly associated with skilled professionals from developing and middle income countries who move to wealthier developed countries, mainly because of their skills. The countries where migrants leave from risk losing their middle classes, who have often been responsible for change and development throughout history. Recipient or host countries, conversely, may be faced with increased crime and the perceived fear of losing low paid and unskilled labour to migrants, although in most cases the latter rarely happens and often it is the reverse: migrants help create jobs and boost the economy (UNDP, 2009). Within this same report, the UNDP (2009), it is highlighted that the benefits of migration outweigh its disadvantages. There is significant evidence to show that migrants play a large role in the development and economy of the host country (UNDP, 2009), and this is true for Australia and the USA. While skilled migrants leave by choice, another significant group of migrants are asylum seekers and refugees.

According to the United Nations Convention on Human Rights (United Nations, 1951) an asylum seeker is someone who leaves their country of birth because of fear for their life,
poor human rights treatment, and persecution of their political views, race, culture or beliefs, to seek protection from another country. A refugee is:

any other person who is outside the country of his [or her] nationality or, if he [or she] has no nationality, the country of his [or her] former habitual residence, because he [or she] has or had well-founded fear of persecution by reason of his [or her] race, religion, nationality or political opinion and is unable or, because of such fear, is unwilling to avail him [or her]self of the protection of the government of the country of his [or her] nationality, or, if he [or she] has no nationality, to return to the country of his [or her] former habitual residence (United Nations, 1951, p. 6).

Refugee women and girls from Sub-Saharan Africa have migrated to Australia, selected under the humanitarian programme that awarded up to 13,500 humanitarian visas to refugees and asylum seekers each year (Department of Immigration and Citizenship, 2012). In the last decade, visas under the Australian humanitarian category have prioritised Sub-Saharan refugees from Ethiopia, Eritrea, Sudan, Somalia, the Democratic Republic of Congo Democratic Republic, Liberia, Sierra Leone and Burundi (Department of Immigration and Citizenship, 2008). Women are highly represented in this group (Dumenden, 2007; Levi, 2010) because they belong to the at risk group (Pittaway, 2004), with some women (and boys) experiencing rape, torture, the killings of relatives and friends and overall poor treatment (Victorian Foundation for Survivors of Torture, 1998; Victorian Foundation for Survivors of Torture, 2005).

2.1.1 Definition of a refugee

The definition of what makes a refugee and who should be given refugee status continues to be contested and debated. However, the first definition of a refugee, which stems from the 1951 underpinning refugee laws, followed the end of World War II, which left millions dead and 1.5 million people displaced in Europe. On page five of the UNHCR’s refugee determination document, a refugee is defined:

as a result of events occurring before 1 January, 1951 and owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his [or her] nationality and is unable, or owing to such fear, is unwilling to avail him [or
her]self of the protection of that country; or who, not having a nationality and being outside the country of his [or her] former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it (UNHCR, 2005, p. 5).

This definition has its merits because it is broad and encompasses different aspects of human rights and existence, such as race, religion and political or social affiliation. However, the limitation of this definition is that it refers to the refugees as people who were affected by the events prior to 1951 (World War II). Also, it is limited to the geographical area of Europe alone. It is known today that refugees come from all over the world and particularly from Africa, the Middle East and parts of Asia (UNHCR, 2005). Africa in particular has a serious refugee problem because of wars (Sudan, Somalia, the Democratic Republic of Congo, Liberia, Sierra Leone, Rwanda and so on); recent droughts in the Sahel region, including the Horn of Africa, has resulted in famine, hunger and even death. The Middle East has also been another region with instabilities, with wars in Afghanistan and Iraq in the last decade. Owing to this and previous wars, the definition of a refugee is continually updated and the working definition of a refugee in this research is that according to the UNHCR (2010):

Any person who, as a result of events occurring before 1st January, 1951 and owing to well-founded fear of being persecuted for reasons of race, religion, nationality or political opinion, is outside the country of his [or her] nationality and is unable or, owing to such fear or for reasons other than personal convenience, is unwilling to avail him [or her]self of the protection of that country; or who, not having a nationality and being outside the country of his [or her] former habitual residence, is unable or, owing to such fear or for reasons other than personal convenience, is unwilling to return to it (p. 7).

This last definition is more inclusive and acknowledges the different aspects of life for a person that would make them refugees. For example, this definition acknowledges that being of a particular political group, belonging to a particular race and belonging to or being part of certain religious groups can lead to persecution.
2.1.3 The Australian humanitarian programme and refugee resettlement

Australia is a signatory to the United Nations Refugee Convention of 1951, and is thus bound by international law to provide protection to people who claim asylum or refugee status in Australia and Australian islands and territories (United Nations, 1951). Australia provides 13,500 persons with refugee status annually (Department of Immigration and Citizenship, 2012). This number may increase in the future, as Australia deems necessary. The Australian humanitarian programme has two components: onshore and offshore. The onshore component provides refugee status and protection to someone who has arrived in Australia and claims that they may be persecuted if they return to their country of origin. The offshore component resettles people who have fled from persecution or other disasters and their lives are at risk if they return to their countries of birth (Department of Immigration and Citizenship, 2012). Before the person is given refugee status under the Australian humanitarian and immigration laws, the person has to satisfy and pass a security clearance and pass a series of health examinations regardless of their status (Department of Immigration and Citizenship, 2012). It is only after these checks and health clearances have been met that an individual is given refugee status.

Refugees can sponsor and reunite with their families after settlement in Australia. However, the sponsor will take responsibility for paying for all the medical fees, travel to Australia, and pickup from the airport and provide initial accommodation to the person on arrival. All refugees are entitled to the Australian government’s social security payments immediately, like all other Australians (Department of Immigration and Citizenship, 2012).

The numbers of refugee status awarded to refugees from different regions who come to Australia every year depends on the area considered by the Australian government to have the most need. In the last two decades, because of famine and wars in the Horn of Africa, most of the refugees from Africa came from Ethiopia, Eritrea, in the late 1980s, 1990s and early 2000s; this was followed by Somalis in the mid-1990s and early 2000s. Most recently, there have been refugees from the Sudan, mostly from South Sudan, who came because of the war in Sudan. In the period of 2005 to 2006, over 60 per cent of the
Australian humanitarian visas were awarded to Sudanese people. In the 2000s, the humanitarian visas awarded to Africans were for refugees mostly from Liberia, Sierra Leone, Guinea and the Democratic Republic of Congo (Department of Immigration and Citizenship, 2012) after Sudan. Australia prioritises visas to girls and women at risk. It is well documented that rape has been used as a weapon of war, the victims being mostly women and children (UNHCR, 2012). Thus, a significant proportion of the African refugees in Australia have migrated because of risk status. Importantly, refugees do not choose where they go, but are chosen by their host country, which makes it even more difficult for young people with protracted issues (Gifford, Correa-Velez et al., 2009).

2.2 African migrants/refugees in Australia

2.2.1 Sources and numbers of African born refugees in Australia

African-born Australians account for 5.6 per cent (248,699) of Australia’s overseas born population (ABS, 2007). Among this group, a significant number of the African migrants in Australia came under the humanitarian programme, having been displaced by conflicts (mostly internal), famine and general instabilities in their countries of birth (ABS, 2007). Approximately 80,000 refugees were resettled in Australia between 2003 and 2009, with African refugees amounting to approximately 52 per cent overall (Department of Immigration and Citizenship, 2010). Other Africans came into Australia as skilled migrants and for family reunions, and some accompanied their spouses (Department of Immigration and Citizenship, 2012). This research focuses on African teenagers and women who came to Australia under the humanitarian scheme or their family or sponsors came to Australia under the humanitarian programme.

2.2.2 The African refugee and settlement experiences

Most of the refugees from Africa now living in Australia have lower socio-economic status and live in less affluent areas, and so do their children (Department of Education and Early Childhood Development, 2011). This refugee status report highlights challenges faced by refugee children in the areas of literacy and education (Dumenden, 2007), housing
(McDonald & Kennedy, 2004; Ingamells & Westoby, 2008) and future employment prospects and opportunities (Junankar & Mahuteau, 2004), though the children have positive views of themselves and future aspirations are mainly positive (Gifford, Correa-Velez et al., 2009). Parity among the African refugees mostly from Sudan and Somalia is high (Carolan, 2010b); and with large families averaging six or more children, the children will grow up in overcrowded homes (Dumenden, 2007; Levi, 2010). This finding of high parity among migrant women and close births in Australia (Carolan, 2010b), together with lower age at first pregnancy, are consistent with research in other western host countries where Sub-Saharan African refugees and migrants from other developing countries have settled. For example, in Italy, where the total fertility rate (TFR) for Italians is 1.32 per woman, and the mean age at childbearing was 31.7, for foreign born Moroccan, Albanian and Romanian women, the equivalent figures were 2.31 and 27.9 years respectively (Mussino & Strozza, 2012).

In Spain, there are an estimated 15,745 Gambians, with over 11,000 born in Gambia, and 83 per cent concentrated in Catalonia. Most have little education, because the more educated Gambians tend to migrate to the United Kingdom (UK) and Germany and other more industrialised European countries, while those with low education, often working in agriculture and other black-collar jobs, stay in Spain (Bledsoe, Houle et al., 2007). In this study, the fertility pattern of Gambian women according to the 2001 Spanish census was 3.67, compared to 1.5 and 1.28 TFR for Moroccans and Algerians respectively (Bledsoe, Houle et al., 2007). According to Bledsoe and colleagues, this TFR, while almost double that of Spanish born persons, is still lower than that of Gambians living in Gambia, which was 5.45 in 2004. Women from rural backgrounds tend to have more children than women who are more educated, even if they are from the same country, a finding consistent with international figures on fertility rates by the WHO.

The recent Australian census data indicates that most of the Sudanese refugees and Ethiopians, including other recent migrants, mostly refugees from the Horn of Africa, living in Victoria are concentrated in the western suburbs of Melbourne, where migrants with similar background initially settled and where accommodation is comparably cheaper.
in Melbourne. More specifically most of the refugees from Africa are concentrated in Footscray, Braybrook, Maidstone, Werribee, Maribyrnong and Melton; and in the Eastern suburbs, most African refugees live in Dandenong and Noble Park (ABS, 2008). African refugee migrants are highly represented in the government supported housing and high-rise flats around Melbourne. These areas where recent migrants and refugees live have lower socio-economic status compared to the affluent inner city suburbs of Toorak and Brighton in the east, and even Williamstown and Caroline Springs in the west of Melbourne.

Refugees and migrants face great challenges during the migration period and after migration (UNHCR, 2012). For teenagers who have migrated from Africa as refugees to Australia, there are greater challenges as a result of their visible physical differences, language barriers, lower education attainment prior to migration, low financial status and unemployment (Victorian Foundation for Survivors of Torture, 1998; Victorian Equal Opportunity and Human Rights Commission, 2008). This may lead to low self-esteem, low self-expectations and lower levels of achievement. It has been well documented that refugees and specifically refugees from Africa who have resettled in Australia in the last decade have experienced trauma, rape, loss and grief within their families and communities, dislocation from their homelands and erosion of their culture, famine, hunger, and have suffered from poor health as a result of all or most of the above (Pittaway, 2004; McDonald, Gifford et al., 2008; Gifford, Correa-Velez et al., 2009; Victorian Foundation for Survivors of Torture, 2009). Teenagers who have come from or whose families have experienced the above circumstances and suddenly find themselves in a country like Australia without the right support and direction are more likely to get lost or make detrimental choices.

After arrival, the focus is on settlement for the families, language needs and school attainment for the children. The sexual health of the teenagers, and even that of their parents and guardians, is not the priority (McMichael, 2008; McMichael & Gifford, 2009a). The parents, particularly mothers who migrated as sole parents to Australia, are themselves lost with respect to methods of discipline towards their children and the amount of authority they have (Levi, 2010; Mellor, Renzaho et al.). In Africa, families and
communities, live interdependently and have a communal lifestyle, while in Australia, individualism and independence are advocated (Levi, 2010). Meredith Levi’s (2010) thesis on *Mothering and Experiences of Sudanese Women Raising their Teenage Children in Australia* describes the dilemma she faced when a woman in the group asked her why they could not discipline their children by hitting them, as was common practice in their culture (Levi, 2010). In their homeland of Sudan and most parts of Africa, hitting and other physical methods, such as using a whip or a cane, are widely accepted and used by parents to ‘discipline’ their children. This is not the case in Australia; if a parent uses physical force or hits a child as a form of discipline, they risk losing that child to the social workers from the Department of Human Services, and so the parents receive an even harsher punishment themselves for punishing their child.

Parents in such instances, like their children, are caught up in two cultures, and they must negotiate these appropriately in order to move in the right direction. Teenagers may often not find this negotiation easy or, in some cases, relevant or possible. African parents and their children come from a culture where children are told when and what to do by the adults, and there are many eyes from the external family members and community watching over them. This is similar to most Asian cultures, where the parents have full authority over their children and the children follow parents’ directions. This applies to the sexual and reproductive health needs of the teenagers; the cultural and social norms, including discipline from the parents, are used to direct teenagers towards the ‘right’ path. In Australia, there seems to be something missing in directing teenagers towards that path, coupled with a culture and traditional values whereby discussions on sex and sexuality are considered sacred and matters for adults to discuss in their bedrooms, together with other social problems. Therefore, it is not surprising that teenagers engage in risky behaviours, such as unprotected sexual intercourse. The consequence of such risky behaviour is TP.

### 2.2.3 African refugees in Australia

Most African refugees and asylum seekers have been displaced by war and famine. Famine, wars and civil instabilities in Sudan, Liberia, Burundi, Sierra Leone, the Democratic
Republic of Congo, Somalia, Ethiopia and Eritrea in the last two decades and over 40 years of civil war in Sudan, now South and North Sudan, led to an increase in the number of African-born refugees in Australia (UNHCR, 2012). During the 2002–2005 period, Africans were prioritised when awarding refugee protection visas in Australia; specifically people from South Sudan (Department of Immigration and Citizenship, 2008). The African countries with the most people in Australia with humanitarian visas categories excluding South Africa are Ethiopia, Somali, Sudan, Eritrea, Sierra Leone, Liberia, the Democratic Republic of Congo and Guinea. The period that the African refugees entered Australia en masse reflects when the greatest need and instabilities were at the time in the African region. For example, in the early 1990s, after the independence of Eritrea from Ethiopia, coupled with famine, which seems to be a regular occurrence in the Sahel region, many Ethiopian and Eritrean people were awarded refugee status in Australia (Department of Immigration and Citizenship, 2008). Between, 1996 to 2008, up to 7,695 Sudanese people were resettled in the state of Victoria alone as refugees under the Australian humanitarian programme. Refugee status was given to 1,460 Ethiopians and 1,272 Somalis according to information published in a Refugee Status Report (Department of Education and Early Childhood Development, 2011).

Most refugees have gone through physical and emotional trauma and torture; they may lack formal education (Richardson, Miller-Lewis et al., 2002; Department of Education and Early Childhood Development, 2011), they experience discrimination and racism (Victorian Equal Opportunity and Human Rights Commission, 2008), they have higher levels of unemployment (Birrel & Jupp, 2000; Richardson, Robertson et al., 2001), they have language barriers (Borland & Mphande, 2006; ABS, 2007; ABS, 2008) and they may lack essential needs, such as housing. Most importantly, they lack extended family network and support. While the refugee experience can bring resilience and resourcefulness (Levi, 2010), adaptability, a desire to achieve academically and a strong sense of family and community (Victorian Equal Opportunity and Human Rights Commission, 2008), anecdotal evidence suggests the opposite for most African young people. Older new arrivals and teenagers face particular challenges entering and achieving in the Australian education system. In a departmental report about African refugees in Melbourne, refugee
children are described as being in an education system with which they are unfamiliar, and some arrivals have never attended school before. Interrupted schooling or low literacy skills make it difficult for the schools to match them to the appropriate year level at school, and this may lead to education disengagement on the part of the young person (Department of Education and Early Childhood Development, 2011). It can be said that the refugee child needs to adapt to personal, family and educational life during and after arrival in Australia (Gifford, Correa-Velez et al., 2009). This adjustment is easier when services and care providers have in-depth knowledge of the migrant/refugee person’s background and services are sympathetic towards the migrant person’s broad needs, including sexual and reproductive health (Carolan, 2010).

2.2.4 Life experiences of African teenagers with a refugee background

Many of the women in their 20s and mid- to late-teenage years now arrived in Australia as children and/or minors. They were accompanied either by family members, friends, neighbours or their biological parents. Many refugee children from Africa were born in refugee camps in Kenya, Libya, Egypt and other surrounding countries around the Horn of Africa. These children and other refugees, mostly from the Horn of Africa and Sudan (now South Sudan), have been influenced in food and cultural practices by the Islamic religions of North Africa and the east, because of their close proximity and living within these regions. Some of these practices include early marriage, virginity at marriage and bearing many children. Some of these children have lived in refugee camps for up to 10 years or more, some all their lives prior to arrival in Australia (Victorian Equal Opportunity and Human Rights Commission, 2008; Department of Education and Early Childhood Development, 2011). In research in New South Wales, Australia, involving Sub-Saharan African refugees mostly from Sudan, Burundi, Liberia, Sierra Leone, Ethiopia and Guinea, participants had spent between one and 26 years (average seven years) in refugee camps (Sheikh-Mohammed, Macintyre et al., 2006), with at least one transit or living experience in a country other than that of their birth (Gibney, Mihrshahi et al., 2009).
Due to these vital years of childhood and adolescence spent in refugee camps, education, literacy and life skills are often low (Sheikh-Mohammed, Macintyre et al., 2006). Most Sub-Saharan African teenagers in Australia have had no lived experience of their parents’ home country and are not versed in the traditional cultural practices and social norms (Victorian Equal Opportunity and Human Rights Commission, 2008; Levi, 2010). Expectations to live and act like their parents or like Australians could be high expectations for these teenage persons.

In the refugee camps, children help with chores, such as building tents, fetching water, wood, caring for siblings and supporting the family overall to meet the daily needs for existence. Thus, most of them live for the day, often with no future aspirations even when they may have dreams. Education in refugee camps is a luxury, and most families do their best to help their children have the little education they can in the refugee camp as it is often free (Dumenden, 2007). Some families have resisted returning ‘home’ after peace deals because of the availability of free education in camps. However, there is no social security—people rely on each other and aid for survival while in these camps. It should be noted that the experiences of teenagers and families differ, because some have had good quality education depending on the transit country prior to migration to Australia. Through sharing stories, most Sudanese speak very positively about their lived experiences in Libya, Uganda and Kenya, while the opposite is said of Egypt, where they experienced great deals of racism and poverty.

For the children, now young women and men, being born in or migrating to a country that was not considered their parents’, and being thought of as having no rights, makes them wonder about their own identity, and also makes them aim to create an identity for themselves. It is not uncommon to hear these children say, for example, ‘I am not Sudanese and I am not Australian; I do not know what I am’. Such identity conflict only increases the vulnerability of these children, who then turn to their peers (who may have similar identity issues) for comfort and acceptance. In the case of young girls, there are often young men willing to provide the ‘care and love and inspiration’ they are longing for, yet not getting at home. Identity conflict, culture clash, intergenerational conflict combined with race and
youthfulness greatly increases the risk of social exclusion (Victorian Equal Opportunity and Human Rights Commission, 2008). This creates immense pressure on teenagers to adopt the ‘western lifestyle’ of their Australian teenage peers in order to feel included, including pressure to indulge in risky sexual behaviours.

Culture is learnt through lived experiences, handed down from one generation to the next through interactions (Papadopoulos, 2006). After migration to Australia, the children who migrated with their parents attend Australian schools, learn to speak and write English and quickly learn and adapt to Australian culture, while their parents hold on to their traditional values and customs. This leaves the parents with the perception that their children are being ‘left behind’ (WHO, 2004). This is true for other migrants groups who arrived in Australia: the Greeks, Italians, Lebanese and Vietnamese. Parents may adhere to their ‘traditional beliefs, customs and values’ to an even greater extent than people from the same background living in their countries of origin (Johnstone & Kanitsaki, 2005). There are cultural implications for the young women’s family. For example, in the case of most Sudanese migrant groups and some of the African groups in Australia, a girl’s sexual behaviour prior to marriage and having a baby out of wedlock negatively affects the ‘bride price’. The bride price is a cultural requirement given to the parents of a ‘virgin’ girl when she is married. This bride price increases according to the girl’s academic achievements and social standing within the community, and is normally paid in cows, pigs, sheep, crops or sometimes in cash (Dei Wal, 2004).

After arrival in Australia, migrants prioritise housing, school attendance, learning English, attending screenings and medical appointments and gaining employment. While there is the excitement of being in Australia, this can be masked by the challenges of this settlement phase, trying to meet the basic daily needs. In the course of doing this and because of the stress involved on the part of the parents and guardians, the relationship and sexual health needs of the young person are left unmet. When children feel they are not loved or do not understand the circumstances in which they find themselves, they turn to their peers for support or where they feel this need can be met. Engaging in risky behaviour, or simply not understanding the world around them, places the young person or teenagers at risk.
Pregnancy is possible, and when teenage girls become pregnant, they not only add an extra financial burden to their parents, but they leave school and do not finish their education. Research has noted that TP leaves girls (and the babies’ fathers) with fewer future employment opportunities because of their lower education levels; hence, lesser future prospects and they and their children risk a lifetime of poverty (Henderson, 1975; Card & Wise, 1978; Coory, 2000; van der Klis, Westenberg et al., 2002). However, the resilience of some of these girls and the good that TP may bring to them has been undervalued or underdocumented. Nevertheless, the level of support available to the girls, their status within the family and the community and their socio-economic background all play a significant role in their success or failure, whether teenage mothers or not.

2.2.5 Sub-Saharan African refugees and the ‘healthy immigrant effect’

The health of migrants is described as better than that of Australian-born persons on arrival in Australia, but this effect diminishes as the migrants ‘assimilate’ into the Australian culture and diet (Biddle, Kennedy et al. March, 2007). On arrival in Australia, migrants (including refugees) are said to have better health status overall compared to the native-born population; this is commonly referred to as the healthy immigrant effect (Johnstone & Kanitsaki, 2005). There is a large body of literature on this effect, which focuses on the changes and the diminishing health of migrants following migration. These changes have been observed by comparing the health of migrants to the health of people from the same country living in the country of ‘birth’ or born in the ‘new’ country (Marmot & Syme, 1976; Laroche, 2000; McDonald & Kennedy, 2004; Johnstone & Kanitsaki, 2005; Department of Education and Early Childhood Development, 2011; Biddle, Kennedy et al. March, 2007).

Megan-Jane Johnstone and Olga Kanitsaki (2005), in their research on nurses and Greek migrants in Australia, demonstrated that on arrival, migrants report their health as being good and very good, but this positive attribution diminishes as the their length of stay increases in Australia. This is a trend observed in other developed refugee host countries around the world. Biddle et al. (March, 2007) measured the health of the migrants using
information provided by the migrants about their health and chronic diseases. Chronic diseases refers to long-term health conditions, such as cancer, diabetes and heart disease, that are not often curable but for which treatment is available and symptoms can be well managed to give the person a good quality of life (Biddle, Kennedy et al. March, 2007). Trends show that migrants often enter with none of these chronic conditions, but this healthy effect diminishes over time in their ‘new’ country. However, the health of migrants does not usually reach the same levels of poor health as the native-born persons, especially if the migrants adhere to their cultural foods and diets (Marmot & Syme, 1976; McDonald & Kennedy, 2004; Biddle, Kennedy et al. March, 2007).

The healthy immigrant effect is not limited to health alone, education can be affected too. In a Canadian systematic study involving 210,000 children in the USA, in the late 1990s and early 2000s, a similar effect was shown. This was seen not only in the health of children from ‘language minority’ backgrounds in the USA, but also in regards to their academic achievement being affected over time if they are put in an English as a Second Language class with minimal support. Most of the children in this research, though belonging to ‘minority’ groups in the USA, had come from middle and upper class backgrounds in their countries of origin, indicating they had an affluent life prior to migration (Collier, 1992; Thomas & Collier, 2002).

For recent refugee migrants in Australia, the healthy migrant effect has been observed not only in their health status but also in the areas of education (Department of Education and Early Childhood Development, 2011). In the Refugee Status Report on refugee children and young people in the state of Victoria, there is significant discussion on the health status of refugees on arrival. There is a particular focus on non-communicable conditions, such as vitamin deficiencies, modifiable and communicable diseases, such as tuberculosis, hepatitis and HIV, mental health issues, immunisation and oral health. This report shows that the refugees are behind in some areas, but immigrant women are faring better in areas of breastfeeding. Mary Carolan (2010) corroborates this noting that breastfeeding rates among African-Australian women are notably higher because of associated amenorrhoea with breastfeeding as the primary method of family planning and birth spacing (p. 380). The
Refugee Status Report further states that, immigrant women predominantly from Sudan and Somalia breastfed their babies for 12 months on average. This report further highlights the issues of antenatal and prenatal health, including maternal child health (MCH) service usage and FGM. Regarding TP, the report states that ‘no data have been identified on the rate of TP in Victoria for young women of refugee background’ (p. 51). In a longitudinal study of refugee young people aged 12 to 19 years from Melbourne (85 per cent African), it was found that 14 per cent (8/58) reported a pregnancy during their first two years in Australia. Family and Reproductive Rights Education Program (FARREP) staff identified TP as a significant issue among their clients (Department of Education and Early Childhood Development, 2011).

The concerns of FARREP are equally shared by McMichael, who through other research with refugee youths noted there appeared to be higher rates of unplanned pregnancies among refugees of African descent (McMichael, 2008; McMichael & Gifford, 2009a). This increased risk of TP can be associated with difficulties staying, engaging and achieving at school because of poor literacy levels and because of protracted issues (Department of Education and Early Childhood Development, 2011). Without research regarding TP among refugees and, in particular, TP among African-Australians, the healthy immigrant effect will inevitable have a negative effect on this group of immigrants.

### 2.3 Teenagers, adolescents and pregnancy trends

In this section I provide the definition of a teenager, adolescent and TP. I go on to describe pregnancy trends among teenagers around the world. The effects of TP on the health of the mother and the baby are discussed.

#### 2.3.1 TP and trends

A teenager is someone between the ages of 13 and 19 years of age inclusive (WHO, 2012). This is the period when childhood is coming to an end, and adulthood begins (McMurray, 2007). The teenage person is at a junction or intersection where the direction they take may
have lifelong ramifications. The teenage years (13 to 19 years) are considered some of the most challenging years of an individual’s life. They are part of the adolescence period (10 to 24 years according to WHO, 2012), though this period of adolescence has been described by some researchers as an abstract or imaginary period (Arai, 2012). In Africa, the adolescent period was almost non-existent because of early marriages. Therefore, adolescence can be context and culture specific.

During the teenage years, biological, physiological and physical changes occur in both boys and girls, though this may occur earlier in some children. Some of the changes include the development of breasts and pubic hair for girls, and the enlargement of the scrotum and testes, deepening of the voice and presence of facial hair for boys. There is no specific start time or end point of the adolescent period; these changes occur over time and with varying onset. Another important aspect or occurrence during the teenage years is menstruation or menarche for girls. Historically, menarche has been used as a marker for the beginning of adolescence (Zabin & Hayward, 1993).

TP is pregnancy that occurs to teenage girls. TP has been described as the number one killer of teenage girls worldwide (Rowe, 2012). Worldwide, 16 million girls aged 15 to 19, and two million girls younger than 15, become mothers annually worldwide (WHO, 2012). Among the teenage births, 95 per cent occur to teenagers in developing countries, with the odds that girls living in poorer conditions are more likely to become teenage mother (WHO, 2012). Another 50,000 girls aged 15 to 19 die as a result of their pregnancy, with 60 per cent of babies born to teenage mothers more likely to die compared to babies born to older women (Rowe, 2012; Singh & Darroch, 2012; United Nations Children’s Fund, 2012).

TP trends vary between regions, between countries and within countries worldwide. However, the birth rates for teenagers in Africa and Southeast Asia are disproportionately higher compared to Europe and North America (United Nations, 2010). Similar disparities in trends are observed between countries in the same region and within the same countries. Japan has the lowest teenage birth rate among adolescents, 4 per 1000, closely followed by
the Netherlands at 7 per 1000 (WHO, 2010. The English-speaking developed countries have higher TP rates, with the USA and New Zealand topping the list compared to Scandinavian countries and Mediterranean countries (Mussino & Strozza, 2012).

The TP rates in the USA is 64 per 1000 (WHO, 2010). In the USA, there are 400,000 births to teenagers each year (Wilson, Samandari et al., 2011), accounting for about 51 per cent of all adolescent pregnancies (Klein 2005). The remainders of the pregnancies are terminated. Recent figures show that the number of TP in the USA are declining. The TP rates for girls aged 15 to 19 in Australia was 18.1 per 1000 in 1999, much lower than New Zealand’s 29.8, and the UK’s 29; Canada was 20.2 within the same period (van der Klis, Westenberg et al., 2002). TP rates continue to decline worldwide, but trends remain high in developing countries (Mpanza & Nzima, 2010; Rowe, 2012). Women in their late teens and 20s have the highest rates of unintended pregnancies (Frost, Lindberg et al., 2012). The risk of STIs and TP among rural black youth is high (Rowe, 2012), including those with low socio-economic backgrounds.

2.3.2 TP effects on the teenager, including contested rationales

Teenagers who become mothers face both biological and socio-economic effects. Because their bodies are still developing and changing, teenage mothers are at higher risk of delivering pre-term, and their babies are at an increased risk of prolonged labour, increasing their risk of having a still birth compared to older mothers (Rowe, 2012). A million children born to adolescent mothers die each year before their first birthday, and in developing countries this rate is higher (up to 60 per cent) when the mother is younger than 18 years compared to older girls and mothers (WHO, 2010; Rowe, 2012). Thus, while it may be arguably not a problem per se (Arai, 2012), it has direct health consequences for the mother and her baby, so there is a need to delay pregnancy until maturity is reached.

TP has been associated with low education completion rates for teenage mothers, fewer future employment opportunities and negative health outcomes, such as injury and death of the mother (Coory, 2000; van der Klis, Westenberg et al., 2002). Due to this low education
attainment and the high skills levels required for employment, especially in professional occupations, teenage mothers and their children risk a lifetime of poverty (WHO, 2012). Some researchers suggest that the economic responsibility to society associated with early or TP and the fear of society and governments to take responsibility is the issue, not the pregnancy in itself (Arai, 2012). Teenagers living in disadvantaged condition are particularly at risk of teenage and unintended pregnancy (Mpanza & Nzima, 2010).

The teenage mothers are most affected by the TP, prompting some researchers to say that the fathers fade out of the picture, as if unplanned fatherhood is not a problem (Mpanza & Nzima, 2010). However, historically, pregnant teenage girls drop out of school and are more likely to stay single, while the fathers of the babies are more likely to work in blue collar jobs or low-prestige professions (Card & Wise, 1978; Coory, 2000; van der Klis, Westenberg et al., 2002; Rowe, 2012). In addition, when a girl becomes pregnant while still a teenager, her physical, social and educational life are all affected and could be significantly altered (Mpanza & Nzima, 2010). While teenage mothers today are encouraged to go back to school and gain the necessary qualifications and desirable employability skills, they are unlikely to do so; only about 1 per cent of teenage girls return to college and complete a degree after an unplanned TP (McWhiter, McWhiter et al., 1998).

Research in South Africa (Mpanza & Nzima, 2010) identifies government policies, including negative attitudes from some educators towards pregnant teenagers, that do not support teenage pregnant girls and mothers to stay in school, suggesting these as the reason for school dropouts, not the pregnancy in itself. In the same study, some teachers noted that having pregnant teenagers or childcare centres in school would send the wrong message to other girls, and that teenagers would be tired because of morning sickness, which is common in the first trimester of pregnancy, would miss school because of antenatal and post-partum visits and tiredness after the birth of the baby, leaving teenage mothers with no time for school work, bringing down the overall school score (Mpanza & Nzima, 2010). While such teachers were in the minority overall, it is still significant, because educators should follow government policies, which officially allow pregnant girls to continue school (Mpanza & Nzima, 2010). The biases noted above and the pre-existing disadvantages,
including lower socio-economic status associated with cultural factors, such as low status of the female child, and cultural beliefs where contraception is not supported, are to blame (Gibney, Mihrshahi et al., 2009; Rawson & Liamputtong, 2010; Drummond, Mizan et al., 2011). Further, poor healthcare seeking behaviours are the norm (Burns, Imrie et al., 2007; Lemoh, Biggs et al., 2008).

According to Rowe (2012, p. 1) many girls, especially those living in resource-poor settings, often with little status within their families and communities, have little or no knowledge of contraception or family planning. The unmet need for contraception is particularly high in developing countries and Sub-Sahara and Latin America (WHO & United States Agency for International Development, 2008; WHO, 2012). Teenagers and youths in Sub-Saharan African have the most unmet need for contraception and the most TP (Okonofua, 2007; United Nations, 2000; United Nations Children’s Fund, 2011; Rowe, 2012). This links early/unplanned pregnancy to the socio-economic status of the teenager, though girls from affluent backgrounds may also become pregnant, showing that knowledge and financial ability does not necessarily translate into practice (Frost, Lindberg et al., 2012). Recently, there has been a ‘trend’ among celebrities to become single and or young mothers, prompting religious and other activists to renounce such actions because it is perceived not to be good role modelling for young girls, who may not have the same resources to support them if they follow the ‘trend’ of such public figures or ‘role models’.

Mpanza and Nzima (2010) reiterate that TP rates around the world are increasing, but that the problem is worse in developing African nations (p. 431). However, there is an emerging body of research that questions the problematic nature of TP (Arai, 2012), with Catriona Macleod referring to it as a socially ‘constructed problem (as cited in Arai, 2012, p. 565). Macleod further reiterates that adolescence, of which teenagers are a subset, is an imaginary construct and that focus has shifted from unwed mothers to teenage girls. It is further noted that ‘early motherhood is not the problem, rather poverty and a lack of opportunity pre and post teenage pregnancy per se, further, it is not a significant problem either in its scale or consequences, but that it may be the social contexts’ that TP occurs in (Arai, 2012, p. 565). This is a view shared by other researchers in terms of the cultural
context in which pregnancy occurs (Carolan, 2010). Through such a lens, the pre-pregnancy conditions of the teenage persons leading to the pregnancy are under scrutiny, not the pregnant teenager. Other researchers support the view that TP in itself is not the problem but rather low education and high unemployment levels, including low future prospects (Hanna, 2001; Katz, 2011), poor communication between teenagers and parents, low morale because of low self-esteem and no future aspirations (Katz, 2011) are the perceived problems.

Children born to teenage mothers risk an early life of poverty or living in poverty most of their lives, thus continuing the poverty cycle (Dennison & Hadley, 2005; WHO, 2012). In some cultural groups, it is even believed that TP is infectious, and this would be true if the view of continuing to live in the poverty cycle is considered. This is a view echoed by Katz (2011), who noted that pregnant teenagers state that they became pregnant because TP was common within their family, and their pregnancies can only be described as continuing the family tradition. Further, non-parental engagement and poor family relations are associated with TP (McWhiter, McWhiter et al., 1998; Mpanza & Nzima, 2010; Katz, 2011). Such justifications do not resolve the issue (Katz, 2011) particularly among teenagers living in poor settings.

Teenage mothers living in middle income economies and more advanced economies like Australia have some opportunities and future prospects after the birth of their baby. These prospects include continuing education opportunities (Mpanza & Nzima, 2010), financial support from social security services and employment when compared to their counterparts in developing countries, where unemployment levels are already high even among tertiary qualified persons (UNDP, 2009). Girls who are pregnant while still at school are discriminated against and mocked, with some educators expressing the need for such girls to be expelled from school (Mpanza & Nzima, 2010). Despite these opportunities in developed countries, teenagers from the poorest regions in these countries and with low socio-economic backgrounds have higher rates of TP and birth in comparison to teenagers from more affluent backgrounds (Coory, 2000; Hanna, 2001). The risk of TP does not seem to diminish after migration to a developed country, including Australia for refugee Sub-
Saharan African girls (McMichael, 2008). For example, black adolescents in the USA start sexual activity early and have one of the highest STI incidence and prevalence rates in the country (Akers, Gold et al., 2012). Research has shown that Sub-Saharan Africans in Australia also have higher incidence and prevalence of STIs (Sheikh-Mohammed, Macintyre et al., 2006; Lemoh, Biggs et al., 2008; Gibney, Mihrshahi et al., 2009; Carolan, 2010; Drummond, Mizan et al., 2011). High STI incidences are commonly associated with risky sexual behaviour and unintended pregnancies. Suck risky behaviours are associated with norms and social behaviours about sex.

2.4 Sex and cultural norms in African families

Discussions about sex and sexual matters between African parents and their children is low because sexuality matters are considered sensitive and private (Sheikh-Mohammed, Macintyre et al., 2006; Drummond, Mizan et al., 2011; McMichael, Gifford et al., 2011). Parents that are ‘silent’ about sexuality with their children in cultures that hold traditional mores of silence on topics relating to sex have been described in several cultures (Nguyen, Liamputtong et al., 2006; Rawson & Liamputtong, 2010). The perception is that teenagers who know about contraception or sexual matters are sexually active, a finding that is complete fiction (Drummond, Mizan et al., 2011). Nevertheless, sex remains a taboo subject in many African cultures. African parents tend not to discuss sex, or even use the word ‘sex’ openly with their children (Sheikh-Mohammed, Macintyre et al., 2006; Nwankwo & Nwoke, 2009; Drummond, Mizan et al., 2011). Parents design mechanisms, including traditional social structures that discourage socialisation with the opposite sex.

In traditional African culture, ‘keeping’ girls away from boys is possible and easy; it is a communal responsibility rather than individual (WHO, 2004). The child is raised by the community collectively (Hanna, 2001; Katz, 2011) rather than the individualistic approach in western society. Within such a structure, girls spend most of their time with their mothers and female relatives (Victorian Equal Opportunity and Human Rights Commission, 2008; Rawson & Liamputtong, 2010), but when they have to attend school
and with the changing world and increasing globalisation, protecting teenagers within such traditional structures becomes difficult (Rawson & Liamputtong, 2010).

In African culture, the family name and honour are preserved through traditional processes and safety nets. Safety nets include having several members of the family living together or in close proximity to each other, making it easy to know where every member of the family is (Rawson & Liamputtong, 2010), especially the daughters. Girls are expected to marry young to ensure virginity, though age at marriage depends on the family and the particular culture. Such measures are aimed at controlling teenagers’ sexuality although these are often ineffective (Nwankwo & Nwoke, 2009; African-American Women and Adolescent Pregnancy, 2011; Adhikari, nd). Virgins and younger girls are desired, and high fertility and frequent parity is common (Adanu, Seffa et al., 2009; Carolan, 2010; Mussino & Strozza, 2012).

In Melbourne, South Sudanese families are large, up to eight children, with families averaging four children. Such high fertility rates are also seen among Malians in Spain (Mussino & Strozza, 2012). In the era of HIV and AIDS, including high incidences of STIs among Sub-Saharan Africans (Moore, Awusabo-Asare et al., 2007; Nwankwo & Nwoke, 2009; Wagman, Baumgartner et al., 2009), and high incidences of STIs among black adolescents (Akers, Gold et al., 2012), risky sexual behaviours among Sub-Saharan Africans, including teenagers remains a concern. Misconceptions about sex and STIs are also common among Sub-Saharan Africans (Drummond, Mizan et al., 2011), predisposing teenagers to risks of infections and unintended pregnancies (Moore, Awusabo-Asare et al., 2007). For example, in a study involving 5,236 participants in Botswana, ‘older partners believed that they are cleansing their bodies when they have sex with young partners because younger partners are free of STDs and HIV/AIDS’ (Dintwa, 2010, p. 49). The literature is inundated with concerns about the high incidences and prevalence of STIs and HIV/AIDS in Sub-Saharan Africa. Misconceptions and attitudes remain even after migrations from the society from which they arise; thus, these misconceptions need to be addressed following migration. In Australia, myths among Sub-Saharan Africans include that STIs are only spread in the presence of symptoms, that HIV/AIDS is caused by spirits
or supernatural powers, that the contraceptive pill protects against STIs, that a person can get rid of HIV/AIDS by having sex with a virgin and so on (Drummond, Mizan et al., 2011, pp. 197–198). While the proportion of people who believe such myths may not be significant, it is important that these are corrected through education, and a culture shift whereby sexual matters are discussed freely is encouraged (Drummond, Mizan et al., 2011).

Parental reluctance to discuss sexual matters with children (Sheikh-Mohammed, Macintyre et al., 2006; Rawson & Liamputtong, 2010) makes it harder for teenagers to understand or react appropriately to unsolicited sexual requests from men, especially those much older, considering cultural norms enforce respect for males and adults in particular (Boileau, Vissandjee et al., 2008). Such respect for adults is not restricted to African cultures alone, but is observed in many Asian cultures (Rawson & Liamputtong, 2010), though young people today are questioning such unquestionable conformity. Teenage girls ‘obeying adults’ without question should be discouraged, especially in light of the fact that most of the incidences of HIV/AIDS occur among heterosexual couples in Sub-Saharan Africa (Brou, Djohan et al., 2008; Dintwa, 2010) and after migration to western countries, similar trends are observed (Burns, Imrie et al., 2007; Brou, Djohan et al., 2008).

Conforming and ‘respecting’ adults qualifies the girl and her family as good, though this may have adverse effects on the girl due to her diminished ability to negotiate safer sex, or to say no outright to sexual requests from males irrespective of age (Moore, Awusaboa-Asare et al., 2007; Nwankwo & Nwoke, 2009). Females are less likely than males to express their sexual feelings or bring up the topic of contraception before sexual relations with their partners (Nguyen, Liamputtong et al., 2006; Drummond, Mizan et al., 2011). This is even more common when the sexual partner is older, as often in the case of teenage girls (Dintwa, 2010). Teenagers, who commence sexual activity early, and have sex with older men, are at an increased risk of STIs and unplanned pregnancy in young adulthood. In Western Australia, Drummond, Mizan et al. (2011) noted that Sub-Saharan Africa women are more ‘vulnerable to STIs, because of low education and health information, suffer
inequality in marriage and sexual relations, and are part of a cultural traditional that reinforce gender inequalities.

2.5 Teenagers’ contraception knowledge and fertility

2.5.1 African teenagers’ knowledge and research to elicit knowledge, and attitudes towards contraception

Contraception has been described as an empowerment tool for women because it increases women’s autonomy and control over their sexual health (Rowe, 2012). Rowe adds that contraception should be seen as every woman’s right. At the launch of the Family Planning Summit in London, WHO Director General, Dr Margaret Chan, said a fundamental right of every woman is to be able to freely access contraception (WHO, 2012). This access to information and contraception remains a challenge to women around the world, particularly in Sub-Saharan Africa.

The contraception knowledge of African teenagers and adolescents has been described in the literature as low and in most cases incorrect (Sheikh-Mohammed, Macintyre et al., 2006; Brou, Djohan et al., 2008; Lemoh, Biggs et al., 2008; McMichael, 2008; Adanu, Seffa et al., 2009). This is particularly disturbing as the age of onset of sexual activity among teenagers in Africa is low and continues to drop (Wamoyi, Fenwick et al., 2011). More so, the reproductive health needs and sexual needs of adolescent girls in Africa have been widely ignored (Okonofua, 2007; WHO & United States Agency for International Development, 2008). Eighty per cent of Sub-Saharan African girls are sexually active by age 20, with a third estimated to have engaged in sex before marriage (age at marriage is low), though parents continue to hold the belief that their daughters are virgins and are abstaining from premarital sex (Okonofua, 2007). ‘First sexual exposure takes place outside marriage, under circumstances of low and inaccurate knowledge of sexual and reproductive health and with little use of family planning or other protective measures’ (Okonofua, 2007, p. 7).
The consequences of such low knowledge is high rates of STIs and HIV (Burns, Imrie et al., 2007; Okonofua, 2007; Brou, Djohan et al., 2008; Lemoh, Biggs et al., 2008; Adanu, Seffa et al., 2009; Carolan, 2010), high fertility (Carolan, 2010; Mussino & Strozza, 2012; Phakathi, 2012) and unwanted/TP (Nwankwo & Nwoke, 2009; African-American Women and Adolescent Pregnancy, 2011; Adhikari, nd). Further, girls who have or are shown to have knowledge of contraception can be perceived to be sexually active; thus, the girls would rather limit their knowledge (Rawson & Liamputtong, 2010; Drummond, Mizan et al., 2011) than be associated with premarital sex. Even though the literature is clear that knowledge of contraception does not necessarily encourage sexual activity, this belief persists among some Sub-Saharan migrants (Drummond, Mizan et al., 2011). Further, a lack of contraception knowledge or unwillingness to use contraception or ask a male partner to do so leads to unwanted or unplanned pregnancy among teenagers and women (Marie Stopes International, 2008). Low education and low contraceptive knowledge are connected with risky sexual behaviours (Shearer, Hosterman et al., 2005; Cherutich & Brentlinger, 2008; Nwankwo & Nwoke, 2009).

In a Nigerian study involving interviews with 478 adolescents aged 10 to 19 from four secondary schools in Imo state, Nwankwo and his team (2009) found that: 63.2 per cent had sex more than four times in the previous six months, over half the group had had sex with more than one partner, 13.3 per cent had more than two to three different partners, 53.6 per cent gave an affirmative answer when asked about their likelihood of having sex with an unknown partner, 77.4 per cent of the respondents reported to using condoms frequently, 12.6 per cent have never used a condom, while 10 per cent were regular users. Sexual health information was received from peers (55.6 per cent), from the mass media (30.1 per cent), schools (7.9 per cent) and parents were the least providers of information (6.3 per cent). There was some awareness about contraception but knowledge was generally low and the rates of risky behaviours were high (Nwankwo & Nwoke, 2009). Other research in Africa has found similar low knowledge and risky sexual behaviour among adolescents (Cherutich & Brentlinger, 2008). Similar low knowledge on sexual health, contraception and risky sexual behaviours among Sub-Saharan Africans have been highlighted in New Zealand (Worth, Denholm et al., 2003) and Australia (Lemoh, Biggs et
In light of the high incidence of unintended pregnancies and HIV/AIDS in Sub-Saharan Africa, Cherutich and colleagues (2008) sought to understand contraceptive use, specifically condoms, among a group of adolescents in Nairobi, Kenya. Sexual activity started at about 16 years of age, 20.4 per cent (148) had sex before 15, a third had sex by age 20, with 50 per cent having had a baby; over 31 per cent (258) of participants had a baby and wanted more. Only 40.1 per cent (291) had used contraception, with 21.4 per cent (157) having ever used a condom, and this was primarily aimed at preventing pregnancy rather than STDs. This is similar to findings elsewhere (Frost, Lindberg et al., 2012). In the Kenyan study (Cherutich & Brentlinger, 2008), 90 per cent knew of the male condom, while 60 per cent knew of female condoms, 30.5 per cent knew of the emergency contraception pill, and 18 per cent of the pregnancies were unwanted or unplanned. Of the participants, 7.3 per cent (52) were HIV positive; 3 per cent of all Kenyan adolescents are infected with HIV (Kenyan Central Bureau of Statistics, cited in Cherutich & Brentlinger, 2008).

The key finding in this study was that ‘condom use was inconsistent and rare’ (p. 928); 68 per cent of teenagers in this group were either married or living with a partner. Their education level was quite low and most had only completed primary education. The findings from this study are consistent with other study findings, which indicate low contraceptive knowledge among African teenagers/adolescents (Wamoyi, Fenwick et al., 2011; WHO, 2012), including low or no education. Younger age and low education were both associated with low or no condom use (Brou, Djohan et al., 2008). In a study involving 1,241 African American young men and women aged 18 to 29, while knowledge of condoms was high, about 29 per cent thought using condoms each time one had sex was a hassle (Frost, Lindberg et al., 2012). Hence knowledge of condoms does not necessary equate to use.
Cherutich’s Kenyan research findings are similar to the findings of Nwankwo and Nwoke (2009) in Nigeria. In both studies, sexual activity commenced early; both adolescent groups had some knowledge of contraception but it was quite limited; condom use was low and both groups showed high levels of risky behaviour. The studies differed in that the Nigerian group seemed to have better information and sexual health knowledge than the Kenyan group, but this did not necessarily translate into practice; risky sexual behaviour, intent and low contraception use was common, as with the young adults in America (Frost, Lindberg et al., 2012). These findings are consistent with other research carried out with Sub-Saharan Africans, including teenagers (Carroll, Epstein et al., 2007; Adanu, Seffa et al., 2009; Bishai, Falb et al., 2009; Carolan, 2010; Dintwa, 2010). Sexual health knowledge is low and contraception use is low, leading to STIs, HIV infections and unintended pregnancies. The WHO calls for dual contraception use to be incorporated into family planning education messages. Dual contraception use protects against STIs and HIV transmission for both sexes, and against pregnancy in women (WHO & United States Agency for International Development, 2008).

Another observation in research carried out with African teenagers was the frequent sexual coercion that occurred, often associated with gender structures (Ojwang & Maggwa, 1991; Okonofua, 2007; Boileau, Vissandjee et al., 2008; Nwankwo & Nwoke, 2009; Dintwa, 2010; Adhikari, nd); because of the lower status of females and a culture in which gender inequality is ingrained (Drummond, Mizan et al., 2011). Such gender imbalances limit women’s contraception negotiation abilities, further compromised by cultures that limit the woman’s independence, often resulting in gender violence (Kaye, Mirembe et al., 2005; Bishai, Falb et al., 2009). For example, in a Ugandan study (Kaye, Mirembe et al., 2005) to appraise the relationship between bride price, domestic violence and sexual risk taking, the authors revealed that the payment of a bride price or gifts from the grooms family to the bride’s family, which could be in the forms of goats, cows, or money, ‘involves a loss of a woman’s control over her sexual life’ (p. 149) and fosters domestic violence.

In Bishai and Falb’s (2009) study on bride price in 12 Ugandan districts, involving 594 women and 430 men, the payment of bride price was directly related to non-spousal sex for
66 out of the 346 men, and 26 out of the 556 (4.7 per cent) women. The women who were more likely to have extra-spousal sex were those that the bride price had not been paid for compared to those whose spouses had paid bride price to the family. Men who were in polygamous relationships were not considered having extramarital sex, as they could ‘legally’ have sex with the other wife, and so are not included in the extra-spousal sex numbers above. Gender imbalances directly related to bride price payment were evident in this research. The sexual and reproductive rights of women who live within such traditional settings, bound by traditional norms, may be compromised or taken away. The consequences being high incidence and prevalence of HIV/AIDS (Okonofua, 2007; Carolan, 2010; Dintwa, 2010; WHO, 2010), other infectious diseases (Tiong, Patel et al., 2006; Lemoh, Biggs et al., 2008; Gibney, Mihrshahi et al., 2009) and unplanned pregnancies.

Women’s contraception decision making is weaker within such traditional institutions, under the pretext of culture and silence. Such ‘silence’ on issues of sex and contraception use is not limited to African cultures, as revealed by Nguyen and Liamputtong (2006) in their research with Vietnamese youth in Vietnam. In their research, parents’ discussions on sexual matters with their children were culturally not acceptable, and when it was conducted it was limited (Nguyen, Liamputtong et al., 2006). Such ‘silence’ leaves the young people ignorant or with little and inaccurate contraception knowledge and minimal negotiation techniques when faced with unsolicited sexual demands or in situations where they may have risky or/and unsafe sex (Rawson & Liamputtong, 2010). Research shows that good communication between parents and children, including discussions on sexual health, have positive outcomes for the teenager, such as delaying sexual activity onset and them having responsible sex when they do, which reduces their risk of unintended pregnancy (Katz, 2011).

In the absence of such quality communication, teenagers will seek information from alternative sources like peers, magazines, radio and the media overall (Nguyen, Liamputtong et al., 2006; Cherutich & Brentlinger, 2008). Information from friends may not always be accurate, but a combination of sources could be an alternative if parents are
not providing it. Further, with the disappearing role and influence of families managing and controlling the sexual information for their children and ‘chaperoning’ girls, (Nwankwo & Nwoke, 2009; Rawson & Liamputtong, 2010), due to the erosion of traditional systems coupled with migration, teenage girls are left even more vulnerable to unplanned pregnancy. The above studies indicate that the contraception knowledge of Sub-Saharan teenagers, while present, is low, and there are other factors that influence attitudes to contraception use. Norms and cultural influences means knowledge and use of contraception of Sub-Saharan African teenagers remains poor. The need therefore arises for further research in teenagers’ knowledge and attitudes to contraception, including cultural influences and why they use or do not use contraception post-migration to western countries (McMichael & Gifford, 2009; Carolan, 2010; Drummond, Mizan et al., 2011). The unmet need for contraception for adolescent girls is not limited to knowledge but includes structural, social and cultural barriers. Below, I discuss barriers to contraception use by teenagers and women from Sub-Saharan Africa living in Africa and Australia.

2.5.1.1 Brief background on Sub-Saharan African migrants and STIs following migration and barriers to contraception uptake and use

The increase in HIV/AIDs, STIs and perceived high TP incidences and high fertility rates among Sub-Saharan Africans (Mussino & Strozza, 2012; UNDP, 2012) is linked to barriers such as low contraception use or inaccurate knowledge and myths about contraception (Worth, Denholm et al., 2003; Drummond, Mizan et al., 2011). Other systemic barriers, such as gender, myths and misconceptions about contraception, persist among West African persons (Klein 2005; WHO & United States Agency for International Development, 2008; Drummond, Mizan et al., 2011) even after migration to western countries, compromising contraceptive use.

While there is no direct research that shows contraceptive prevalence for African refugees and African migrants in Australia, because research with African migrants is mostly concerned with settlement, language acquisition and education (Sheikh-Mohammed, Macintyre et al., 2006; Tiong, Patel et al., 2006; Gibney, Mibrshahi et al., 2009), there is a
growing body of literature about the sexual health behaviour of Sub-Saharan African refugees in Australia. This research is linked to perceived higher prevalence of STIs and HIV infections (Worth, Denholm et al., 2003; Sheikh-Mohammed, Macintyre et al., 2006; Burns, Imrie et al., 2007; Carolan, 2010; Drummond, Mizan et al., 2011); and unplanned TP (McMichael & Gifford, 2009) following migration and pregnancy experiences among African refugee women (Carolan, 2010). Concerns about higher rates of STIs, HIV and high parity among Sub-Saharan African refugees and migrants are reported elsewhere.

In the UK, Sub-Saharan African migrants have the second highest prevalence rate of HIV as a social group; the UK has an estimated 58,300 HIV infected persons, and Africans account for 73 per cent of all HIV infections among heterosexual couples (Burns, Imrie et al., 2007). In New Zealand, African migrants from the Horn of Africa accounted for 22 per cent of new HIV infections between 1996 and 2002 (Worth, Denholm et al., 2003).

In Australia, between 2003 and 2006, a group of 375 patients from Sub-Saharan Africa, Sudan (118), Somalia (79), Ethiopia (78), Liberia (21), Eritrea (19) and other (60) were screened for infectious diseases and non-infectious diseases in Melbourne. The prevalence rate for the hepatitis B virus was 19 per cent (32/167) and for HIV 12 per cent (26/215) among those who were tested (Gibney, Mihrshahi et al., 2009). The above three studies, though carried out in different countries, provide insight into the prevalence of STIs and HIV among this minority population group of Sub-Saharan Africans. Further, the above prevalence rates are higher than those of all three host countries on HIV and STIs, and this raises concerns about the sexual health, attitudes outlined earlier and barriers.

Low education and ingrained cultural factors are primary barriers to meeting the contraceptive needs of women (Worth, Denholm et al., 2003; Kaye, Mirembe et al., 2005; Sheikh-Mohammed, Macintyre et al., 2006; Ryan, Franzetta et al., 2008; Gibney, Mihrshahi et al., 2009; Drummond, Mizan et al., 2011). This is because the other factors build on the knowledge of the woman, in terms of access, service information, attitudes to contraception uptake and use, and the ability to negotiate safe sex.
Traditional mores that encourage gender inequality (Sheikh-Mohammed, Macintyre et al., 2006; Wagman, Baumgartner et al., 2009) are barriers to contraception use. Bride price payment was one of these barriers. Kaye and colleagues (2005) found in their Ugandan study that gender imbalances within relationships existed in the decision making abilities of women, especially those for whom a bride price had been paid. This often led to domestic violence and men who had paid a bride price for their wife were more likely to be farmers, and have a low education level (completed primary education only). However, bride price gave the women status in her community and provided her with a sense of security in the relationship (Kaye, Mirembe et al., 2005). As there are no social security payments for unemployed women, marriage becomes a status and a security institution for her and her children.

The age of a partner is identified as a barrier to contraception use. When the partner is older than the teenage person, combined with gender and low education, a teenager’s position regarding contraception negotiation and safe sex is compromised (Ryan, Franzetta et al., 2008; Wamoyi, Fenwick et al., 2011). In Sub-Saharan Africa, sex by older men with teenage girls is perceived to provide higher status to the girl among her peers. Such relationships limit a teenager’s ability to negotiate safe sex, because of the power imbalance and because of transactions in the forms of money and/or gifts that she may otherwise not have (Ryan, Franzetta et al., 2008; Wamoyi, Fenwick et al., 2011). Further, sexual coercion, forced sex, rape and passive acceptance to engage in sex all compromise safe sex and contraception use (Wagman, Baumgartner et al., 2009; Wamoyi, Fenwick et al., 2011). Teenagers who engage in sexual relationships with older men/adults over three years older experience higher morbidities, such as STIs and TP, in early adulthood compared to teenagers whose partners were not more than three years older on average (Ryan, Franzetta et al., 2008; Wamoyi, Fenwick et al., 2011).

Condoms are a dual method because they are a contraceptive and a barrier from STIs if used correctly. Condoms are unpopular among Sub-Saharan African women and men, because of a perceived reduction in sexual pleasure and sensation (Lemoh, Biggs et al., 2008; Nwankwo & Nwoke, 2009; Drummond, Mizan et al., 2011). Others see condoms as
a sign of promiscuity and unfaithfulness. In a Western Australian study with Sub-Saharan African refugees, myths and misconceptions were barriers to contraception and condoms and limited their use (Drummond, Mizan et al., 2011). The feeling of being insulted if a partner wanted to use a condom, the feeling that the partner is suspicious of one’s sexual past and the feeling that people who carry condoms are promiscuous were common (Worth, Denholm et al., 2003; Drummond, Mizan et al., 2011). In this same study, after peer training, there was an increase in the respondent knowledge of condoms and some respondents affirmed that condoms were a sign that the partner cared, although it was questionable if they had cheated on them (Drummond, Mizan et al., 2011). Women still saw a partner using condoms with them as an insult.

Similar perception and rejections of condoms by women were seen by Worth et al. (2003) in New Zealand in their research with refugees from Africa who were HIV/AIDS positive. Miriam, a participant, said, ‘If the man wants to use condom he does not love her; we need his sperm inside because we have value and we don’t like men to come in condom.’ Mary said, ‘I don’t need to use condom as I only had one boyfriend. We loved each other. I used birth control but never condom, while Leah said, ‘No, I don’t want condoms (Worth, 2003, p. 351).

Other barriers to contraception were the costs associated with it and the inconvenience of having to take a pill daily (Dennis & Grossman, 2012). Perceived side effects of contraception and young people not knowing how to respond will deter contraceptive use (Dennis & Grossman, 2012). Research with physicians in rural Pennsylvania, USA, to elicit perceptions of their patients’ barriers to contraception indicated that ‘community norms that do not support family planning’ (Chuang, Hwang et al., 2012, p. 81) were perceived as the greatest barrier. Community norms were built on notions that unintended pregnancies, early pregnancy, wanting a large family to help on the farm and low future aspirations were reasons for low contraceptive use. The participants reported that low preventative reproductive health seeking behaviours could be seen as a culture where people just do not plan their families, because they live on the farm and their mothers and siblings have large families, with none of the significant people in their lives worrying about family planning.
or contraception. To the physicians, regardless of their gender, the problem was neither cost nor access, rather the barrier was home culture and ‘total intentional negligence’ where people never plan anything and contraception is seen as not important (Chuang, Hwang et al., 2012, p. 81).

Most of the African refugees from Sub-Saharan Africa migrated from rural areas, and have low levels of education (Gibney, Mihrshahi et al., 2009), including linguistic and communication barriers to information (Sheikh-Mohammed, Macintyre et al., 2006). Worth noted that African refugees arrived with their own cultural notions of sex and health practices. While there was awareness among most about contraception and condoms, women in particular rejected them (Worth, Denholm et al., 2003). While African women are more responsible for the overall health of the family members, male partners often are the primary decision makers (Drummond, Mizan et al., 2011), and that includes using contraception. All the above may be barriers to contraception use and positive attitudes to contraception.

2.5.2 Fertility regulation and management of unwanted pregnancies
2.5.2.1 Why fertility regulation?

Fertility is the ability of a woman who is fecund and having regular sex to conceive or get pregnant (WHO, 2012). Fertility rate refers to the number of children one woman will give birth to in her lifetime (see Table 1. for epidemiological definitions). In Africa, the fertility rate remains high at 5.2 children per woman. Fertility regulation is essential for every woman because of the complications associated with pregnancy and childbirth. Women in different parts of the world are affected differently, with developing countries and Sub-Saharan Africa having the highest maternal mortality rates (MMR). MMR is defined as the total ‘number of maternal deaths within a given period per 100,000 women of reproductive age during the same period’ (WHO, 2010, p. 5). The MMR in developed countries like Australia is one in 4,300; in developing and middle-income countries this risk increases to one in 120; and in Sub-Saharan Africa the risk is one in 31 (WHO, 2010). Of the estimated 358,000 maternal deaths worldwide, 204,000 occurred in Sub-Saharan Africa alone, while
Southeast Asia accounted for 109,000 maternal deaths (WHO, 2010). This risk of a woman dying because of pregnancy and related causes is higher for women in specific countries within the Sub-Saharan African region. For example in Chad, the MMR is estimated at 1,200/100,000 live births, women’s risk increases to one in 14 compared to one in 7,400 in Australia in the same period.

Women’s fertility can be managed using both traditional and modern methods of contraception. The reasons for controlling women’s fertility is because, while pregnancy is good for the woman and ensures continuation of the species, without appropriate management, pregnancy and childbirth puts the life of the women and that of her children at risk.

The fertility period in a woman’s life is said to span from puberty at menarche to menopause. This can range somewhere between the ages of 15 to 49 years in the woman’s chronological age, depending on when menstruation starts and when menopause commences. Thus, there is a need for women to regulate their fertility in order not to spend all of their productive life bearing children. Fertility regulation and pregnancy management has been recognised as a women’s rights issue (United Nations, 1979) and for the fight to end discrimination against women and to advance women’s rights and control the world’s population, the number of children per women have to be reduced. Small families are good for the mother, for the children and for the society, from both health and economic perspectives (Rowe, 2012). To further highlight the importance of fertility regulation and the benefits to the mother and the children, Millennium Development Goal (MDG) five calls for the improvement of maternal health, with specific directions to reduce maternal deaths by three quarters or 75 per cent between 1990 to 2015, and to aim at achieving universal access to reproductive health by 2015 (United Nations, 2000; United Nations, 2010).

About 287,000 women lost their lives in 2010 alone due to pregnancy and childbirth complications, with 56 per cent of all deaths occurring in Sub-Saharan Africa and 29 per cent occurring in Southern Asia (WHO, 2012). Nigeria and India account for 14 per cent
(40,000) and 19 per cent (56,000) of all maternal deaths in 2010 respectively (WHO, 2012, p. 23). Overall developing countries account for 99 per cent of all maternal deaths (WHO, 2012, p. 22). Table 4 and Table 5 show the MMRs by regions and some countries around the world.

Since the launch of the MDG, significant health gains have been achieved, especially for women in the worst affected areas of Asia and Africa. The drop in maternal deaths worldwide was 47 per cent in 2010 (WHO, 2012). Some countries had a maternal death reduction of over 80 per cent. However, there were some countries in Africa, such as Cameroon, where no progress was made, and Botswana, where there was an increase in maternal deaths. Two reasons were given for this stagnation and increase: population growth and deaths due to the HIV/AIDS epidemic respectively. With 99 per cent of all maternal deaths, and 90 per cent of neonatal deaths, occurring in developing countries (United Nations Department of Economics and Social Affairs, 2011), there is a need for fertility regulation and contraception use as these have direct effects on the woman and her family.

2.5.3 Contraception methods and use in Africa
2.5.3.1 Traditional and modern methods of contraception

Traditional and modern methods of contraception are used throughout Africa for family planning reasons. Access, affordability, availability and the woman (and her partner’s) knowledge and acceptability of contraception contribute to uptake and use (Agyei & Epema, 1992; Agius, Pitts et al., 2010). Recent research has revealed that more women in developed countries use traditional methods compared to women in developing countries (WHO, 2012).

Women in Africa commonly use traditional methods of contraception, but these methods are unreliable, with women ending up with unwanted pregnancies. Traditional methods include abstinence before marriage and after marriage, such as using the ‘safe period’, whereby women abstain from sex for about 20 days from their last period. Withdrawal or
coitus interruptus, whereby the man ejaculates outside of the vagina, is commonly practiced. Women have relied on post-partum amenorrhoea and breastfeeding as a means to space their families, and to avoid unwanted pregnancies (Wilson, Samandari et al., 2011). In some cultural groups, women eat herbs and medicinal plants to prevent conception. While the above methods look easy, and cost effective, unfortunately except for abstinence, they are all unreliable; there is a chance of recall bias by women and their partners. Traditional methods were, commonly used by adolescents in Rawson and Liamputtong’s (2010) study with Vietnamese youth in Ho Chi Minh City, even when they lacked correct knowledge of the menstrual cycle. In addition, they do not protect women and their partners against STIs, including HIV transmission. This is because modern methods of contraception that are more reliable are often expensive (United Nations Department of Economics and Social Affairs, 2011).

The modern methods of contraception recommended for women are: the intrauterine contraceptive device, injectable contraceptives like depot-medroxyprogesterone, tubal sterilisation, oral contraceptive pills, implanon, condoms (female) and emergency contraception, known as the ‘morning after’ pill, for use within 72 hours post coitus (United Nations Department of Economics and Social Affairs, 2011), but could be recommended for up to 120 hours in the absence of an intrauterine contraceptive device (Rodrigues, Grou et al., 2000). The controversial contraceptive Mifepristone or RU-486 (an antiprogesterone and levonorgestrel) is available in some countries, but its use is restricted (Rodrigues, Grou et al., 2000; United Nations Department of Economics and Social Affairs, 2011) because it is perceived to be an abortificient. Unfortunately, some women confuse RU-486 with the emergency contraceptive pill, thereby compromising their use of an effective method of contraception (Rodrigues, Grou et al., 2000).

Male contraceptive methods include vasectomy and the use of male condoms (United Nations Department of Economics and Social Affairs, 2011). Condom use among African men is reportedly low, and so is vasectomy (Phakathi, 2012). African men’s perceptions of vasectomy are mostly negative; they perceive that a vasectomy may render them impotent and may cause other health issues. For some, it is the psychological effects, because a ‘real
man’ should be able to impregnate a woman, and the perception is you are no longer a man if you cannot do this. Further, vasectomy takes away the option of having another wife and fathering more children in cultures where polygamy is practiced and/concurrent partnerships are the norm for men (Wamoyi, Fenwick et al., 2011). Conversely, women want to use contraception, space their births and have less children (Phakathi, 2012). Pakathi reveals that men are the main obstacle to contraception use because a man with many children reportedly has a higher status within his community (Phakathi, 2012). In Africa, large families are desired, evident in the TFR of 5.2 children per woman, the highest in the world (WHO & United States Agency for International Development, 2008).

Condoms, while available, are unpopular. Condoms are perceived to reduce sexual enjoyment during intercourse and are used depending on the type of relationship (Boileau, Vissandjee et al., 2008; Bishai, Falb et al., 2009; Westercamp, Mattson et al., 2010; Wamoyi, Fenwick et al., 2011). For some, condoms are to be used with casual partners only, as they are perceived to be a sign of disrespect and distrust, despite their effectiveness in protecting both men and women against HIV/AIDS and other STIs (Boileau, Vissandjee et al., 2008).

In the absence of contraceptives or when a method fails and a woman has an unplanned and unwanted pregnancy, she has the option to terminate the pregnancy, known as abortion (WHO & United States Agency for International Development, 2008). Abortion is recommended within the first trimester of pregnancy, though abortions should be carried out only by skilled practitioners and in safe environments. Unfortunately, either or both skilled professionals or safe environments are unavailable in many developing countries. According to Sedgh, Henshaw et al. (2007) in their research on the number of legal abortions worldwide, spanning 60 countries, not many countries in the developing world have legalised abortion, and more so in the African continent but those countries in Africa where abortion is legalised have some of the most progressive laws. The researchers found that in South Africa, for example, where abortion is legal, the legal abortion rates were very low at six per 1000 women, compared to Cuba with 57 per 1000 within the same period. (Sedgh, Henshaw et al., 2007). The researchers noted that abortions are mostly performed
illegally, and that the estimated rates of unsafe abortions for the southern African region in 2000, mostly illegal abortions were three times higher than the legal rates. This was the case in South Africa which happens to account for about 90 per cent of the region’s total population’.

Unequal and low access to abortion services, lack of knowledge about services, including hostility of health personnel towards women wanting to have an abortion, deterred women from safe abortion services and drove them to unsafe abortion services and providers (Sedgh, Henshaw et al., 2007). This further illustrates the unmet need for contraception for this region (Rodrigues, Grou et al., 2000), with developing countries accounting for 13 per cent of all maternal deaths due to unsafe abortions worldwide (WHO & United States Agency for International Development, 2008).

2.5.3.2 Contraception use and unmet need in Africa

The unmet need for contraception has been defined as the percentage of fertile women who are married or live with a male partner, and express their need to control their family but cannot do so (United Nations Department of Economics and Social Affairs, 2011). Africa has the lowest contraception prevalence use compared to other regions of the world. In the recent report by WHO and UNDESA (2011), it was noted that ‘sub-Saharan Africa has yet to complete its demographic transition—a shift to low births and high deaths’ (p. 1). The same report highlighted the high fertility rates in the region, and this was attributed to the low use of modern methods of contraception: 17 per cent for Africa in comparison to 60 per cent and 69 per cent in Asia and western Europe respectively (WHO & United States Agency for International Development, 2008). This indicates an unmet need for contraception for all women of reproductive age.

The unmet need for contraception remains high in the developing world, hindered by cultural non-acceptance of contraception, little admiration and respect for small families and a lack of understanding about the benefits of contraception to the health of the mother and her family (Phakathi, 2012). Table 5 shows the unmet need for contraception and fertility rates in selected African countries.
For women, this unmet need for contraception further exposes them to unwanted pregnancies, STIs and HIV. More women in Sub-Saharan Africa are infected with HIV, and STIs rates are highest in Sub-Saharan Africa, compared to all other world regions (WHO, 2012). The problem with STIs is not only the immediate burden on the woman, but her risk of infertility increases. Sub-Saharan Africa has the highest amount of infertility, and in a region where motherhood is imperative, infertility can have devastating consequences on the woman medium and long term. High rates of infertility have been directly associated with high levels of STIs resulting in pelvic inflammatory diseases and subsequent infertility. Research in Africa has revealed participant concerns about the high rates of STDs, such as chlamydia and gonorrhoea, within their communities; they are a common cause of secondary infertility in women (Oladokun, Arulogun et al., 2009). In this research, participants stated that ‘out of every 20 men, there is a possibility that 15 may have gonorrhoea’ (Oladokun, Arulogun et al., 2009, p. 84). Infertility and other health concerns, such as premature delivery, stillbirth and miscarriages were the other main health concerns of the research participants. Infertility rates among women in Sub-Saharan Africa are among some of the highest in the world, and STDs are thought to be one of the main underlying causes (WHO, 2012). As a result of their infertility status, women may suffer from some or all of the following health conditions: depression, personal and interpersonal loss and a total sense of loss (Remennick, 2000; Oladokun, Arulogun et al., 2009). Meeting the contraceptive needs of women has health, social and economic benefits for the woman.
2.5.4 An overview of sexual and health services for recent migrants in Australia

In Australia, healthcare is significantly subsidised through Medicare and refugees who qualify for greater subsidy because of family income are given a healthcare card, which gives them an even greater subsidy. Primary healthcare is provided to migrants within existing healthcare institutions in Australia, with specialised or trained staff to care for the needs of refugees and recent migrants. For example, in the Western Region Health Centre, there is a refugee health nurse and other support staff who provide services to refugees and asylum seekers. However teenagers are not high users of health services and this is especially the case when the services are not teenage friendly or teenagers feel judged by the SP (Magadi, Agwanda et al., 2007; Katz, 2011).

As a healthcare provider myself and an educator, I have insider knowledge of the services for migrants and women in particular. Women’s Health West in Melbourne’s west runs programmes for girls and women of all ages related to their health. Further, there are sister services in Melbourne (Women’s Health North, East and South) who provide similar programmes. At the Royal Women’s Hospital, which is the main provider of women’s health services in Victoria, there is an African women’s clinic, and the FARREP services, which cares for women affected by FGM and other needs as they arise. Similarly, the Western Hospital in Sunshine, Melbourne, runs an African women’s clinic that caters for the needs of women from Africa and other migrants. Similar services are dotted around Melbourne and Victoria in general. Other services that migrant women use include: migrant resource centres and migrant women’s health, including, cultural and private care services provided through community groups, religious organisation and non-governmental organisations in Victoria and around Australia.

The Visy Hub Cares is another organisation that provides healthcare services to youths in general, including refugees. This service is a ‘one stop shop’, as it houses a nurse, medical doctors, psychologists, counsellors, social workers and other support and education workers as required. The nurse within this service runs sexual health workshops for teenagers and young people as they deem necessary.
There are refuges for battered, abused, at risk women and their children. There is a breadth of services that refugee women and migrant women can use. However, there is no research that indicates how user-friendly these services and SP are. Exploring TP, culture and contraceptive uptake and use will provide insight into the challenges faced by AATs and the surrounding issues. The findings of this study will be used to design a culturally appropriate sexual health education tool for mothers of AATs and SP who are in direct care of these teenagers, and will contribute to knowledge and inform future policy.

In 2006, as part of a quality assurance process, a process evaluation tool was designed following interviews with SP rendering services to FGM affected women at the Royal Women’s Hospital in Melbourne (Ngum Chi, 2006). The tool was to be used as an interview guide for women who had used the FARREP services, and to solicit their experiences. Prior to the tool being designed, this service, although in existence for almost a decade, had no official documented feedback or evaluation from the services users. There is no evidence that the tool was used later for the intended purposes though other factors further influence service usage.

Cultural sensitivity of services and SP features highly in the literature, including understanding of the services users’ background in relation to care providers (Sheikh-Mohammed, Macintyre et al., 2006; Carolan, 2010; Katz, 2011). Past traumatic experiences of refugees and disregard for authority as a consequence of war and trauma may influence their attitudes towards providers (Sheikh-Mohammed, Macintyre et al., 2006), although knowledge of services and communication play a vital role in service usage (Sheikh-Mohammed, Macintyre et al., 2006; Magadi, Agwanda et al., 2007; Drummond, Mizan et al., 2011). Services should be sympathetic and understanding towards its users (Carolan, 2010; Rawson & Liamputtong, 2010); this is important in matching a user with someone from a similar ethnic or cultural background. Gender is another important aspect of care provision; services should aim at matching the gender of the user with that of the providers to maximise service usage (Rawson & Liamputtong, 2010).
2.6 Perspectives on motherhood

Motherhood in Africa remains an essential duty for women, with family and social life almost always orientated towards children. Large families are preferred and child bearing starts early. Motherhood remains central in societies where traditional gender roles remain even post-migration (Drummond, Mizan et al., 2011). Biological children are desired and preferred over adopted children. Motherhood and childbearing among Sub-Saharan African women is accepted and seen as a normal occurrence and a normal duty of a woman’s life (Carolan, 2010). Research on African teenage mothers and their motherhood experiences is almost non-existent in the Australian literature. The scant literature that is closely related to African women is on birthing experiences and antenatal care, and profiling of health issues (Carolan, 2008; Carolan, 2010; Carolan, 2010) and STIs/infectious diseases. Other Australian literature with African women and reproductive health is on FGM (Ngum Chi, 2006) and Sudanese women mothering/raising teenage children (Levi, 2010). In the absence of literature on motherhood AND African teenage mothers, literature from other pro-natalist societies related to TP in Australia was reviewed for this research.

Early positive orientation towards motherhood has been associated with TP (Afable-Munsuz, Speizer et al., 2006). By orientation, I mean girls being made to feel that motherhood is a prerogative in their lives as women and within the paradigm of female gender roles (Afable-Munsuz, Speizer et al., 2006). Afable-Munsuz and colleagues conducted a study with 332 African-American teenagers aged 13 to 19 years in New Orleans. The research participants were categorised into four main domains: intended pregnancies, unintended pregnancies, both unintended and intended pregnancies and never pregnant. The aim of the researchers in this study (conducted as part of a larger study) was to identify and understand the determinants of unintended pregnancy risk in New Orleans. The measure that researchers used was called Positive Orientation towards Early Motherhood (POEM).

The findings revealed that TP was closely associated with early orientation towards motherhood because some teenagers saw pregnancy as a means of achieving an identity for
themselves, pregnancy made them closer to their families and boyfriend and they could have someone they loved and who loved them back (Afable-Munsuz, Speizer et al., 2006). Motherhood was perceived to bring self-identity and love to the teenage girls. Afable-Munsuz and colleagues (2006) said that for some teenagers, motherhood was seen as an opportunity to become more ‘intimate with their boyfriends’ (p. 267) with one of the participants saying ‘my life is more meaningful now. I’m not trying to get the guy anymore, wasting my time. Now I’m trying to get through my classes. I’m focused; I’ve got to support the baby’ (p. 274). After controlling for socio-economic background, the results of POEM remained unchanged. This POEM was seen to have a strong association with and increased the risk of unplanned pregnancy (Chuang, Hwang et al., 2012).

The authors of the above study did note that the results should be interpreted carefully. First, because of the small scope of the study; second; because the never pregnant participants had been recruited from a family planning clinic, while the pregnant, both intentional and unintentional, were recruited from family planning and prenatal clinics; there was a chance that the teenagers attending family planning clinics were more likely to use contraception compared to teenagers not attending family planning clinics and whose mothers were also college educated. Third, another limitation was the homogeneity of the participants: they were all African-American; and finally, there was a chance that women’s responses supported POEM because they were expecting a child or were already mothers (Afable-Munsuz, Speizer et al., 2006).

Though this study was conducted in the USA, the results are comparable to African-Australian teenagers because, first, participants in my research share the same African heritage, irrespective of the history of slavery in America. The setting for POEM was a low socio-economic area of New Orleans, and this is not dissimilar to the background and living situations of participants in my research: they all come from low socio-economic settings in Melbourne. I note that being a refugee in Australia comes with many challenges and associated risks, with TP being one of them (McMichael, 2008). When teenagers live in protracted situations, lack basic amenities and live on a survival basis, when teenagers do not see a future for themselves and have no control over their lives and futures, motherhood
remains one of the few things the teenagers feel they can still control (Hanna, 2001; Afable-Munsuz, Speizer et al., 2006).

In contrast to the POEM study, teenage girls whose mothers completed college or had a degree were less likely to have a TP and early motherhood compared with girls whose mothers had not been to college. Education of the mother acts as a protective factor against TP (Katz, 2011). The children of women who were educated at college or university level, and planned their families were less likely to want to have an early pregnancy themselves (Arai, 2012). This finding is consistent with other research where females who had future aspirations were more likely to protect themselves from unplanned pregnancy, avoid early motherhood and to plan their family sizes (Chuang, Hwang et al., 2012).

In another study, Barbara Hanna (2001) carried out ethnographic research with five homeless teenage mothers with low SES over a 12 month period in a regional area in Australia. Hanna used observation, interview journals and in-depth questionnaires in this research, with the aim to explore how these teenage mothers negotiated motherhood, and how they constructed their identities and relationships through teenage parenting. The five teenagers who had six children between them all had a history of abuse in their lives. One was taken from her mother at age three and placed in state care, all but one came from broken families and step-parenting, which they all hated, none had completed school or had any employability skills, they experimented with drugs and had unprotected sex from an early age (Hanna, 2001). The findings from this research revealed that all five teenage mothers perceived motherhood and having a child to be the one thing they still had control of in their lives, despite the struggles and challenges that they faced as young single parents. The limitation for this study was that all participants were Caucasian, and the scope of the study was small (Hanna, 2001).

When this Australian study by Hanna is compared with the American POEM study described above, there are both similarities and differences. The similarities were that participants were young, pregnant and/or had a baby, were unemployed, some were in school, had low SES, low education and were more likely to come from a family with a low
education background of the parents, had suffered or had a difficult childhood. The major difference was that teenagers from the American study had a lot of support from their mothers, an aspect completely missing in the lives of the teenagers from Hanna’s Australian study. From the studies above, it is plausible to say that teenagers who live in low socio-economic situations, have little future aspiration, want to feel loved or give love, want a sense of purpose and identity, have mothers with low or no education, lack a personal sense of security and are unsure of their futures are at increased risk of early motherhood when compared to teenagers who do not share these factors. In these two studies, motherhood was perceived to be the one thing that teenagers felt they could still control or influence in one way or the other. Having a child was seen by the teenagers to have a positive influence in their lives, and was something they could live for.

Israel is an example of a developed country that has a ‘pro-natalist ideology’ (Remennick, 2000), with life and community activities orientated towards motherhood and family (pp. 821–822). As a result, motherhood is a main goal for all women. Remennick’s (2000) research with 26 infertile Jewish women living in Israel provides insights into the daily challenges and anguish women live in, knowing they may never be mothers. Within the sample of 26 women, 25 per cent were born in Europe, 25 per cent were born in the Middle East and 50 per cent were born in Israel. Their ages ranged from 25 to 46 years with 36 being the mean age (Remennick, 2000). Among these women, 20 were married and six divorced. All women had some sort of qualification or had finished high school with five women working as professionals in occupations, such as law, journalism and medicine. Only a third of the women did home duties full time. Using semi-structured in-depth questionnaires, the researcher sought to understand the women’s experiences of childlessness and wanting to be mothers in a pro-natalist society; infertility was observed through the ‘lens of stigma’ (Remennick, 2000, p. 826). The findings from this research put motherhood at the top of the list of all the participants, with participants saying:

In Israel, the children are at the top of personal priorities list; the whole life centres on them … maternal instincts are essential in every woman, and Jewish woman it is double. If we want to be true to our nature we have to become mothers, there is no other way in life. Women who don’t want children are barren, selfish, unable of love … but they are few.
Without children family life is empty … here there is no option of being single, rich, and childless like America.

(Liora, age 29, participant)

I just don’t feel as a whole woman, something very essential is missing. Nothing else I have can make up for it, neither my high-paid job, good looks, nor success with men … the moment you tell people you do not have children, you become an outcast in a way.

(all quotations from Remennick, 2000, pp. 827–828).

Remennick (2000) states that childbearing and motherhood is perceived to be both a ‘religious and a moral’ duty for women (p. 821), though unfortunately some women will never be able to bear children regardless of availability of assisted technology. While this paper focused on Israel, which is considered an advanced economy compared to African countries and the protracted circumstances where my teenage mothers came from, motherhood is central to Israelites and the survival of Jews (Remennick, 2000), a view common among Africans (Oladokun, Arulogun et al., 2009). Motherhood is central and, like Israel where the birth rate of 3 to 4 per woman, this is high for a high income country, and is comparable only to African countries (low income) that birth rates remain high (WHO, 2012).

2.7 Conclusion

Sub-Saharan African migrants, including refugees in Australia, are now a significant group within the Australian population. The population is growing and expanding rapidly, a factor related to migration, high fertility and frequent parity within this group. Among the many challenges and health issues identified in this group, STIs and HIV infections remain a growing concern. African refugees, continue to face disadvantages in the areas of sexual health. There is some knowledge and awareness of contraception and STIs among African teenagers, but this is not necessarily translating into practice. Existing myths and
misconceptions about health and health practices remain alive even after migration to western nations. Gender roles and practices ingrained in culture, such as bride price payment, disadvantage African women in their reproductive health decision making. While there is a dearth of literature about the disadvantages of TP to mother and child, the context in which TP occurs should be considered, including the culture and the intersectionalities within which Sub-Saharan teenagers/migrants come from and/or exist. Barriers to contraception use and risky sexual behaviours exist within the intersectionalities and cultural background of Sub-Saharan Africans. Motherhood then remains a goal for girls who lack the necessary tools, such as education, sexual health information and future aspirations, and are surrounded by societal pressures that make motherhood almost mandatory.
Chapter 3: Intersectionality—Conceptual Framework

3.1 Introduction to intersectionality and chapter overview

In this chapter, I discuss the key theories underpinning the research being intersectionality or intersectional theory, which I shall use interchangeably. My aim is to orientate the reader towards the theoretical landscape in which my research developed.

Intersectionality uses a holistic approach to describe a person or an issue and looks at the multiple axes within which it occurred (Crenshaw, 1989; Bates, Hankivsky et al., 2009; Mazzei & O’Brien, 2009). This theory was developed by black feminist from North America and developing countries because they felt western feminist theories were more focused on the experiences of middle-class white women to the exclusion of race, ethnicity, culture that women of colour faced in addition to gender and race discrimination (Crenshaw, 1989; Collins, 1990; Rees & Pease, 2006; Hankivsky, 2012). Intersectionality has been defined as the various interactions and interconnections that exist between gender, race, other categories of differences, social practices, institutional arrangements and cultural ideologies and the potential product of these interactions in relation to power (Trahan, 2011; Hankivsky, 2012; Weber, Hilfinger et al., 2012). Intersectional theory draws from postcolonial and feminist viewpoints, which argued that issues faced by black women cannot not only be analysed from a one-axis gender or race perspective using western white feminist perspectives, that gender and race are interconnected but further that there are other identities of the black woman that should be considered when dealing with black women issues (Crenshaw, 1989) and women of colour (Crenshaw, 2001).

Crenshaw who is credited for constructing the term intersectionality using her legal and feminist background argued that black women received little justice in front of the courts because when the women in a particular firm were laid off, the companied argued that they did not discriminate against these black women because they could prove that there were other women (White) who were not laid off, hence gender was not the issue; and that black
men who were working in the same firm had not been laid off hence it was not a race issue either (Crenshaw, 1989). However, other black scholars specifically Bell Hooks (1981 cited in Trahan, 2011) had questioned feminist literature that was gender-based but seemingly focused on discrimination of white women or black men. This let Hooks to question if she was not a woman (Trahan, 2011). Crenshaw (1989) and Collins (1990) identify injustice in the treatment of black women with little recognition simultaneously given to their race and gender, but also to their socio-economic backgrounds and positions as black women. Crenshaw disagrees in the manner in which the black women had been treated in court after being sacked and the courts failed to see the injustice to these women because race and gender rather than each in isolation of the other were at play. The argument is that the women could not have been made redundant because of race, the company continued to employ black men and it could not be gender because women (white) continued to work for the company. The problem was these women’s issues were analysed from a single axis of race or gender rather than race and gender, hence multi-axial approach and these axes are many. Unlike feminist approaches that uses a one-axis approach to gender issues intersectionality uses a multi-axes approach, as it is acknowledges that women have multiple identities that are not limited to race and/or gender alone (Collins, 1990; Yuval-Davis, 2006; Bose, 2012). African women and girls in Australia in like manner have several identities, which may include all or some of the following: being black, migrants, refugees, young, have low SES, have low or no education attainment and so on.

Intersectionality theory focuses on the different interconnections that influence decision making, behaviours, beliefs and subsequent outcomes in individual’s lives (Crenshaw, 1989). According to Sepali Guruge and Nazilla Khanlou (2004, p. 33), intersectionality theory is ‘a new way of inquiry, which creates space for the exploration of how various dimensions of social identity, such as race, gender, and class, as well as education, citizenship, and geographical locations, intersect to influence the health of immigrant and refugee women’. Intersectionality theory recognises the different layers and dimensions that contribute to discrimination (Crenshaw, 1989) resulting in inequalities and inequities (Guruge & Khanlou, 2004; Phoenix, 2006; Rees & Pease, 2006; Davis, 2008). Intersectionality does not only focus on black women it encompasses all women of ‘colour’
and the different identities within which they exist and experiences of discrimination, which include but are not limited to race, gender, migration, language, sexual orientation and class (Trahan, 2011; Tsouroufli, Rees et al., 2011; Hankivsky, 2012). Intersectionality provides a more in-depth and complex understanding of the many identities and experiences of racism by women of colour, and the degrees of discrimination that they experience but it also helps to prevent the homogeneity of categories like race or gender. This is because same person can have advantages but could still be oppressed (Collins, 1990; Crenshaw, 2001; Yuval-Davis, 2006; Bose, 2012).

Intersectionality has been critiqued for various reasons, it is too open or it is too closed (Trahan, 2011). Intersectionality itself came about because western feminist theories fell short in capturing the challenges faced by black women and women of colour (Crenshaw, 1989; Guruge & Khanlou, 2004; Trahan, 2011). Hence intersectionality is not only another way of thinking and seeing women’s issues but a form of critiqued of feminist theory as it aimed to capture the nuances and differences, such as ethnicity, language barriers, religion that were easily overlooked by western feminist (Tsouroufli, Rees et al., 2011). It is therefore not surprising that intersectionality will have many admirers and critics too. Critics of intersectionality as a theory have described it as too open (Rees & Pease, 2006) although as Phoenix (2006, p. 187) states ‘feminists are both attracted to, and repelled by intersectional analysis‘. The openness and inclusive nature of intersectionality is considered a major strength as this lends itself to inclusion of several theoretical frameworks when conducting research with women with multilayered and diverse backgrounds. More so the gender, race and class are not independent constructs by themselves, they are interdependent and interconnected hence it will not be realistic to say each one of the above categories influences individuals without the other (Trahan, 2011). Intersectionality since its emergence in the last decade has been used in medical education research, gender health studies, criminology, and qualitative research as it offers a broader and in-depth explanation into the multiple axes and experiences of oppressed persons and the various forms this take, including how the person is affected (Guruge & Khanlou, 2004; Mazzei & O’Brien, 2009; Trahan, 2011; Tsouroufli, Rees et al., 2011; Hankivsky, 2012; Weber & Hilfinger Messias, 2012).
AATs with refugee backgrounds have migrated from settings very different to the current Australia setting. Prior to migration refugees spend lengthy periods in refugee camps with children now teenagers born in camps or in transit countries with often no recognition of their status and citizenship. Lack of or limited access to basic amenities, such as housing, food, water, and elementary education were not uncommon in the lives in refugees, but most importantly political instability, famine and/or war have been the main pushing factors for these refugees from their countries of origin. Authoritarian style discipline by parents towards their children, obedience and loyalty to elders in the community, culture and interdependency in everyday living were the norm pre-migration. Following settlement the refugees are faced with new sets of challenges, such as, immersing in a totally new culture where individuality, self-expression and independence are the norm. While there is sufficient food and clean water, including electricity, and quality education following settlement, access and affordability are documented constraints that refugees face particularly soon after migration; living standards and conditions are low compared to that of the majority of people in the host population. For young people who attend education institutions finding themselves in capitalist cash economy and not being able to afford what many of their peers have in itself poses difficulties to the young person’s trying to settle and fit in. Young refugee persons have many challenges, which are interconnected and a theory, such as intersectionality provides the outlet through which they can be unpacked and understood.

In her journal editorial on intersectionality, Phoenix, (2006) articulates how intersectional theory has been embraced since Kimberlé Crenshaw coined the term in 1989 (Guruge & Khanlou, 2004). Phoenix (2006) goes on to say that intersectionality ‘provides concise shorthand for describing ideas that have, through political struggle, come to be accepted in feminist thinking and women’s studies scholarship … it foregrounds a richer and more complex ontology than approaches that attempt to reduce people to one category at a time, it also points a need for multiplex epistemologies (p. 187). Within intersectionality theory those aspects of life, such as sexual health, refugee women’s migration issues like language barriers, accessing and affording housing, getting quality education, which may have gone
unnoticed for minority refugee women, they are brought to the forefront and put in the public and political arena. A positive of intersectionality is ‘its simultaneity of discrimination and privilege (Trahan, 2011, p. 2). The above are similar to what feminist through feminist theories did in bringing issues that were considered women issues to the fore, only that intersectionality adds the dimensions of migration and most importantly race and being African as the other dimensions. Intersectionality is a new and efficient theoretical framework that can be used in research with women from refugee and immigrant backgrounds particularly in regards to these women’s health concerns. Migrant and refugee women often exist amidst complex socio-economic, political and social structures and these complexes are present before and after migration (Guruge & Khanlou, 2004).

African refugees and migrants in Australia come from different socio-economic, educational, cultural and linguistic backgrounds. In the last decade, the majority of African migrants to Australia have arrived as refugees (ABS, 2008). The journeys of refugees to Australia have been well documented with refugees having experienced hardships, trauma, and torture, poor access to health, limited or no freedom of human rights, poor and limited access to healthcare and education and for young people the inability to reach their full potential. Research involving African people with refugee backgrounds is complex because of their present and historical background. This is particularly so if the research is about health, specifically the sexual health of refugees, teenagers of a female gender, health issues, diverse cultures, sexual and reproductive health knowledge, including motherhood. As such, a theoretical framework and approach that draws on different theoretical frameworks but also takes into account the various intersects that influence people’s health should be considered (Guruge & Khanlou, 2004; Davis, 2008).

Intersectionality is an inclusive theory and method in the understanding of women social issues and has provided a new window for the understanding and understanding gender. For example, using intersectionality, Tsouroufli and colleagues (2011) shed light to discrimination, which they describe as subtle, gender institutional and interactional practices in a medical school in the UK within the curriculum and habits of some tutors to
refer to doctors only as ‘he’. Another perceived shortcoming in the medical curriculum the researchers elicit, included tutors not going beyond gender and race to gain in-depth understanding of their diverse students identities; for example the same individual being a woman, a woman of colour and a mother (Tsouroufli, Rees et al., 2011), thus having several identities.

Intersectionality has been suggested as an effective approach to consider in gender equality policies when trying to address gender inequalities (Verloo, 2006) because of its ability to deconstruct gender, race and class as independent variables as opposed to being interconnected (Verloo, 2006; Trahan, 2011). Verloo (2006) contends that the European Union is pioneer to women’s inequality policies but risks to fail in properly addressing gender inequalities if different types of inequalities are not uncovered or the European Union assumes unquestionably that experiences of inequality are similar. Verloo (2006) suggests that by using intersectionality the different identities and axis of inequality would be exposed minimising structural inequalities and unequal competition within the European Union. Australian researchers (Rees & Pease, 2006) have used intersectionality theory as an approach into inquiry with African refugees in Melbourne. Intersectionality theory was utilised to unpack the socio-cultural variations and to capture other complex issues, such as migration effect, race, family, community influences together with gender, and class (Rees & Pease, 2006). Within the intersectionality theoretical framework health, gender, and motherhood theories are discussed.

Drawing on intersectionality, in the section below I define health, gender and gender roles. I critically analyse western feminist constructions of gender, and why they are problematic for research within traditional African family networks. I provide information about the implications of gender on the health of women. The section discusses reproductive health and motherhood from a pro-natalist cultural and theoretical perspective followed by practical dimensions in responding to TP situated within the intersectionality theoretical framework. Below I demonstrate that AATs have multiple identities and existence, which are multilayered, complex and these such be considered when addressing issues of health and sexuality, including TP in this group of migrants. There social and cultural
backgrounds form part of the complex existence, including attitudes to accepting and utilising health information.

3.2 Health and the social model of health

In the preamble of the WHO (1948, p. 100), health is defined ‘as a state of complete physical, social and mental wellbeing of an individual and not merely the absence of disease or infirmity’. Health is not just about one’s physical health but includes the social, emotional and physical health. The social and cultural context in which, including their identities and the constraints they afford affect their health. Further, the environment from where the persons come from, their health beliefs and socio-economic status all affect their health directly and indirectly. Public health and population health is concerned with understanding health and disease occurrence in the community, and improving health and wellbeing (Ewles, 2005; Baum, 2008; Greiner and Edelman, 2010). Health gains are achieved through prioritising health approaches and addressing the inequalities in health status that exist between social groups (Lin, Smith et al., 2007). For African refugee teenagers their immigration, and refugee status, literacy levels and socio-economic backgrounds before and after migration contribute in their sexual health decisions and outcomes. While differences may exist among refugees, the above factors affect health as these group of migrants can be referred to as being in the lowest social gradient (Wilkinson & Marmot, 2003) following arrival in Australia. As a result of the above constraints AATs can be described as having multiple roles, which affect their lives and specifically their sexual and reproductive health.

The social determinants of health include early life, poverty, drugs and working conditions, unemployment, social support, food, transports and the social gradient (Wilkinson & Marmot, 2003). The resulting theory from Wilkinson’s and colleagues study with the UK working class was health inequities (unequal distribution of resources) and inequalities exist and occur as a result of the above social determinants, including the social environment (Wilkinson & Marmot, 2003). I add that this also includes ones’ cultural
environment, life opportunities and personal believes (see Liamputtong et al., 2012). These social determinants of health form the basis upon, which the social model of health is built.

The social model of health attempts to understand the social environment and the person’s background when dealing with health and illness. This includes the cultural background and belief systems of the individuals existing in that system (Liamputtong et al., 2012). The social model of health sometimes referred to as the ‘new public health approach’ focuses on health from a societal level, whereby, the places people live and work are considered important to their health; and public health infrastructure, policies and health services are seen to be important in the health of the individual (Baum, 2008; Germov, 2010). The social model of health draws on the social determinants of health (SDH) as a framework. If the SDH are met for all members of the society, there will be healthy gains for all members of the society; a healthy society equates to a healthy workforce and to a healthy nation (Wilkinson & Marmot, 2003; Liamputtong, Fanany et al., 2012). Unfortunately, health disparities continue to occur within and between countries, because of disparities in the SDH, with refugees experiencing many disparities.

Cultural differences, including ethnicity and race (Eckermann, Dowd et al., 2007) have been identified as important elements to be considered when trying to reduce health disparities (Baum, 2008; Germov, 2010). Migrants, including refugees and who come from diverse ethnics groups arrive in Australia with both social and cultural capital of their own. Ethnicity refers to one’s cultural background and in conjunction with the belief systems, world views and values that shape and influence the individual’s attitudes and behaviours (Purnell, 2002; Papadopoulos, 2006; Germov, 2010). In Australia, Ethnicity normally refers to non-Anglo-Australians and/or people from non-English speaking backgrounds or ‘recent’ migrants (Germov, 2010). Race conversely uses an individual’s skin colour, and/or features, such as eyes or hair to describe someone, which may lead to the inclusion or exclusion from a group, depending on the motives (Babacan, 2005; Germov, 2010). Race and ethnicity contributes in the refugee person’s health as it plays a role in their world view and in their perception of health and illness but also how others perceive and relate to them.
The social model of health advocates for the non-exclusion of any members of society in any policies because of their race or ethnicity (Lin, Smith et al., 2007; Baum, 2008). Race, ethnicity and culture have been attributed to the existing health disparity between Australian Aboriginal and Torres Strait islanders compared to the wider Australian population (Eckermann, Dowd et al., 2007). The majority of African migrants in Australia have visibly dark skin; refugees, especially teenagers because of their skin colour, and who may not speak English at all or ‘properly’, or speak English with an ‘accent’ may be at double risk of exclusion from society, and achieving to their full potential (McDonald, Gifford et al., 2008). Without effective inclusive, social and health policies, these groups of migrants may suffer poor health at individual and at population levels. This is because these dimensions, which further include class, race, gender, education attainment, citizenship and geographical location may be transformed into hierarchical dimensions within organisations and institutions leading to inequalities and inequities in health (Pittaway & Bartolomei, 2002; Guruge & Khanlou, 2004; Snow, 2007). These multiple intersections and interconnections in the African teenagers and refugees and life affect their health seeking behaviours, which can be understood through the social model of health and intersectional theory.

### 3.3 Intersectionality theory and women’s health

Intersectionality theory posits that gender, social class, education, race, migration status and citizenship are important aspects of women’s health as they all affect their health (Crenshaw, 1989). While race has been described as a social construct it remains relevant because in today’s society one’s race place a role in their inclusion or exclusion from certain groups either directly or indirectly. Western feminist gender theories, have been successful in bringing women’s issues to public light and providing solutions through research, but is limited because of the inability to deal with issues, such as race, culture, language and migration and to be used within other disciplines that address women’s health issues within its framework (Dhruvarajan & Vickers, 2002; Guruge & Khanlou, 2004). Crenshaw (1989, p. 139) notes that feminist theory uses a ‘single-axis analysis’, which disadvantages black women by ‘distorting their experiences, with race treated and gender
treated ‘as mutually exclusive categories of experience and analysis’. Feminism has dealt well with the subordination of women and the effects this has caused to their health although this has mostly addressed the issues of women within the western context rather than within a global one and specifically an African context. Intersectionality provides the opening to expand and deal with women’s and gender issues using a perspective that is inclusive of women from developing countries, who are migrants, are refugees, are women of ‘colour’, and whose locations pre and post-migration are taken into consideration (Dhruvarajan & Vickers, 2002; Rees & Pease, 2006). To some writers and particularly those of African heritage gender is a western social construct (Oyewumi, 2001; Oyewumi, 2002). One must however recognise the influence that western cultures have had on women of African descent pre- and post-migration. While gender was not African until colonisation, research with African migrants today cannot ignore the aspect of gender in the health of the African woman their health children. Intersectionality theory addresses this as it build and expands on western feminist theory but does not ignore the race, culture, socio-economic, community interactions education and migration status of the African woman and her offspring (Guruge & Khanlou, 2004; Phoenix, 2006; Rees & Pease, 2006; Davis, 2008).

Gender consists of two categories, feminine and masculine. Masculine, the male gender is perceived to be tough and strong, while the feminine or female gender is soft and weak (Oakley, 1980; Oyewumi, 2002; Germov, 2010). Gender can be best described as both a psychological and cultural term, widely used to rationalise the subordination of women globally (Oakley, 2005). Gender is not biological nor genetic, rather gender and the roles one plays within their families and society, are assigned to them, and are shaped by the societal beliefs in which the person is born into or lives in (Oakley, 1980). Within the intersectionality theory, both women and men can be in a subordinate role, depending on context. For example, black men can be privileged at home over their wives, but may be subordinate to their white male colleagues at work; and similarly, white women could be subordinate to their husbands at home but because of their whiteness are privilege over black women (Rees & Pease, 2006). Intersectionality theory addresses this by taking into
consideration the context in which subordination occurs and the races of the individual woman rather gender and class alone.

The male or masculine category is more powerful, strong and takes the lead roles, while the female or feminine category is considered weaker and takes the subordinate or subservient roles. Feminist and the broader society use gender to reflect and categorise the different roles played by men and women. These socially constructed roles tend to reflect the behaviours, activities and attributes that a particular society considers appropriate for males (men) and females (women) (Gerschick & Miller, 1997; Oyewumi, 2002; Oakley, 2005). The result of the above categorisation is that females or the woman becomes a subordinate to the males or man rather than an equal partner, and this extends to their employment limiting promotion at work (Crenshaw, 1989). Historically, gender categorisations were developed by middle class women, based on the western nuclear family systems and the society these women lived in, with western feminist gender theories perceived not to be inclusive of all women because it is Eurocentric in nature (Crenshaw, 1989; Dhruvarajan & Vickers, 2002; Oyewumi, 2002) and the women exist within the context of a nuclear family.

A western family and system is very different to an African family setup. A typical western nuclear family par excellent consists of a man, woman and their children (Oyewumi, 2002). In a nuclear family set up, the man is the head and the woman his subordinate. On the contrary a traditional African family includes the man, his wife or wives and their children plus the members of the extended family. The extended family members are either or both of the couple’s parents, nieces, nephews and cousins. In my research African female teenagers and women share this background of extended family living, but now they live in a western setting, Australia where the nuclear family living is the norm. Within the traditional African family structure, males and females have always played different roles. Roles and position influence health choices and behaviours of African teenagers and women, gender and roles had to be considered, intersectionality theory was deemed most suitable as evident above.
Dominant gender theories, which underpin feminist research, focus on women and empowerment; it assumes that women are subordinate to men (Oakley, 1980). Traditional gender research using a feminist ideology has focused on the consequences of this subordination role of women within a nuclear family and how it affects women’s health. The consequences were that women’s health was affected negatively as a result of this categorisation within such a family system (Oakley, 2005). Using this dichotomy, feminist try to ‘fix’ the problem of female inferiority and male dominance, through advocacy (Oakley, 1980), and women doing research, which benefits women (Liamputtong, 2009). Feminists should be applauded for the development of gender studies but most importantly for bringing the issues that were once considered less important and private matters, into public arena and making these problems to be seen as societies’ problems and for society to take responsibilities (Oyewumi, 2002; Oakley, 2005).

The focus of western feminist theory is on the nuclear family (Oyewumi, 2002) and this family model is very distant from the traditional African family where significant numbers of African who arrived as refugees in Australia hailed from (Dumenden, 2007). Research theories dealing with such African migrants groups should not only take their gender status into consideration but their migration, race, cultural and educational backgrounds should also be considered (Rees & Pease, 2006). Mutua and Swadener (2004, p. 31) describe feminists theories, including western research approaches, methods and frameworks used by western researchers undertaking research with colonised communities and minority groups as ‘a colonizers construct’. Through western colonised approaches and theories, the voice, culture and way of life of the colonised person, indigenous and people from minority groups are lost (Liamputtong, 2010). Liamputtong contends that because dominant or western research theories silence the indigenous people and people from minority groups, there is a researchers risks causing more damage if they undertake research that validates or affirms existing stereotypes (Liamputtong, 2007a). Rather researchers should do ethical research using ‘traditional frameworks’, which portray the minority groups and persons in a realistic way, and at the same time research should aim at empowering the minority person or indigenous person (Rees & Pease, 2006; Liamputtong, 2009). These views are echoed by other researchers who see western theories as abhorrent, because they reject the indigenous
persons way of life, culture, language, beliefs, organisational systems and traditions as normal (Renzetti & Lee, 1993; Smith, 1999; Mutua & Swadener, 2004; Tillman, 2006), and other decolonised methodologies should be considered for research (Smith, 1999). In this research, I focus on African teenagers, African refugee women and SP working and supporting African refugees and their families. I aim to portray the lived experiences of these women and the teenagers in the way they understand it and from a cultural and traditional African perspective as portrayed by them.

Women worldwide may face similar health issues but the level and the degree to, which they will experience these issues and ill health vary considerably (Marmot & Syme, 1976; Eckermann, Dowd et al., 2007). This is because of different environmental, political and social settings within which women live and work, and, which inevitably affect their health in different ways (Lin, Smith et al., 2007; Baum, 2008). Thus, when using gender it is important to appreciate gender from another perspective; the setting and the world views of those involved (Oyewumi, 2002; Boileau, Vissandjee et al., 2008). While dominant theories and research methodologies can answer questions from almost any background, we need not forget that there are alternatives. However, these alternatives need to be considered carefully so that the research acknowledge, respects and if possible give a voice to those represented in the research (Liamputtong, 2010).

African mothers and women, including SP made significant contributions, providing a rationale for the research theories and frameworks to be documented using an African gender perspective. Gender is a western construct and western ‘gender’ theories have been universalised and used for women in all settings (Oyewumi, 2001). The problem this poses is western feminist theories do not fit well into the traditional African setting. In the absence of any theories specific for use when researching African mothers and teenagers in Australia (Carolan, 2008), intersectionality provides the most appropriate theoretical framework deemed appropriate for a multi-dimensional and multi-layered research as it takes into consideration the backgrounds of the participants.
Returning to the family systems, the woman in a historic traditional western feminist research comes from a nuclear family; husband wife and their children. This is the ideal family set up (Oyewumi, 2001). In this model, the woman and the man fall in love and decide to get marry. Within the nuclear family setting the man is the bread winner, the woman the homemaker and the nurturer. Being the bread winner gives the man the role of the head and leader within the nuclear family system (Chazan, 1990). The woman is dependent on him, making her a subordinate. The nuclear family model is a Eurocentric/Anglophone model and cannot be applied to women in all settings and of all backgrounds around the world (Oyewumi, 2002). This nuclear family model was spread around the world during the colonisation eras, when Europeans colonised Africa, the Americas and Asia, which they termed colonies. Prior to the arrival of the Europeans, these ‘colonies’ and the ‘colonised’ people had their own ways of life and family set up (Chazan, 1990; Oyewumi, 2002). Gender was not part of the traditional African family set up, nor was the African family a nuclear family, nor did the women depend on men for livelihood (Chazan, 1990).

The African family is ‘large’, and a woman from an African family setting has a husband, many children, usually co-wives, step children, and her parents to care for. The extended family, which consists of the couples parents, aunts and uncles, cousins, nieces and nephews are significant in the lives of the couple and their children (Oyewumi, 2001). Roles are shared and living is collective within an African family (Levi, 2010), not individualistic like the western nuclear family. In addition members of one’s extended family will normally decide whom and when their children marry. Input is sometimes sought from neighbours and close friends (Mutua, 1994–95; Dei Wal, 2004). Marriage therefore is not based on love alone; marriage is a social event, a cultural event and union of families, with all members of the family and community playing different roles (Dei Wal, 2004). The backgrounds of the potential husband and wife to be are scrutinised to exclude any blood ties, abomination acts, such as suicide, and so on, upon examination the decision about marriage is made (Dei Wal, 2004). Researchers in their quest to understand pregnancy and motherhood and the context, which they occur among refugee groups in
Australia, an understanding of the participants’ pre-migration and post-migration backgrounds is inevitable (Dhruvarajan & Vickers, 2002; Phoenix, 2006).

Prior to colonisation there was a high level of equality and power sharing between men and women, balance of power was ensured through the use of traditional methods of equality and traditional governments (Meredith, 2006). Africans have a natural attachment to the land, which can be through heritage or natural rights and African women were leaders and decision makers like their male counterparts before colonisation (Chazan, 1990; Oyewumi, 2002). African women had both material and non-material power. Colonisation gave men more power over women and in such a process women were gradually disempowered (Chazan, 1990). The consequence was a class society and inequitable distribution of resources, which reflected the order of the time (Meredith, 2006). The consequence is the Africa of today, many poor people living with health problems and morbidities that could be easily addressed if adequate financial, physical infrastructures and resources were made available. Post-migration the effects of these previous experiences continue to influence and shape the lives of African-Australians. An intersectionality theory helps unpacks these and brings to light experiences of this migrant groups and the way it affects their lives in Australia (Rees & Pease, 2006).

3.4 Gender and roles within an intersectionality theoretical framework

Men and women behave differently when involved in a sexual relationship. Gender roles are those behaviours and activities that men and women are to play or do within their families, relationships and communities because of their gender (Shearer, Hosterman et al., 2005; O’Sullivan, Harrison et al., 2006; Boileau, Vissandjee et al., 2008; Dlamini, Taylor et al., 2009). Men and women bring different values and expectations into the relationship, shaped and influenced by different roles assigned to these individuals at birth. These roles affect women and men differently and at varying levels, with women often disproportionately affected. These levels include the relationship level and the actual sexual enactment level (Shearer, Hosterman et al., 2005). The relationship level focuses on the man approaching the woman and initiating the liaison. During the process of relationship
formation or after completion of this phase, the male and the female then move to the sexual enactment phase. This phase involves engagement in actual intercourse. The social environment that the male and female are coming from influences what occurs during both phases. Gender roles and relationships using the above perspectives are thought to be multifaceted, and are domain and context based (Shearer, Hosterman et al., 2005). Gender role theory contends that gender-based family roles and masculinity ideology both influence what occurs in the relationship (Shearer, Hosterman et al., 2005).

Gender-based roles are the roles men and women are to play within their families and subsequent relationships because of them being of male or female sexual category (Maticka-Tyndale, Gallant et al., 2005). For example, some gender-based roles assigned to women like doing the housework, cooking, cleaning, fetching water, sewing, doing needlework and caring for the children. Conversely gender roles assigned to men include men doing paid work out of home, splitting wood, dress up in suits and ties, attend and preside over special traditional ceremonies, dressing up in suits and ties, requesting or asking the woman’s hand in marriage. Some cultures and religious organisations expect women to wear veils and dress conservatively. By conservatively here, I mean not exposing parts of their bodies, such as your legs and arms, and not wearing clothes that may be ‘revealing’ like trousers and skirts because by so doing they risk arousing the men. The mass media also influences male and female behaviours irrespective of where they live and work, although the immediate physical surroundings and geographical location may exert greater demands on the gender-based roles (Boileau, Vissandjee et al., 2008).

In some societies, gender-based roles extend beyond what women can do and wear to what they can eat, where they can go, and with whom they can interact. Such gender roles imposed on women, may inhibit or deprive women of their freedom and liberty, foster poor self-esteem, lower levels of achievements, and may result in poor health outcomes (WHO, 2007). For example, when girls are given dolls, and made to know from an early age that their most important role in life is to care for a baby. She grows up, and thinks of being with a man, procreate, have as many children as she can because children are what give you
status as a woman, rather than your lifetime achievements. Attitudes towards childbearing later on in life irrespective of gender reflect earlier attitudes to childhood roles.

Gender-based roles in traditional and conservative societies are more overt, more distinct, and often reflected in the different positions and roles women hold and play in society compared to men (Wermuth & Monges, 2002). In more traditional societies where gender roles are re-enforced through cultural practices, the level of school attainment and completion, positions held by women in political office and decision making within organisations is considerably lower compared to societies where roles are shared (Boileau, Vissandjee et al., 2008). When women have low or poor participatory rates this affects their health and that of their families negatively. For teenage girls and women this could mean low self-esteem, or engaging is transactional sex for livelihood (Wamoyi, Fenwick et al., 2011). The consequences are poor health decision making, poor outcomes for the girl, and her family (Westercamp, Mattson et al., 2010).

Gender-based roles do change as the society develops and this affects women’s attitudes towards traditional gender roles (Boileau, Vissandjee et al., 2008). An example of a gender role that has evolved and changed significantly is women gaining paid work outside of their homes (Oakley, 2005). This means that women get up in the morning, dress up for work outside of the home; their husbands, or another paid individual or institution, takes the responsibility to care for the children, clean the house, do the ironing, and cook the food for the family (Oakley, 2005). Other gender-based roles that have changed include attitudes towards premarital sex. Traditional societies and traditionalist advocate for abstinence from sex until marriage and encourage arranged marriages. But young women and men, perceive such attitudes towards sex and marriage to be old and outdated (Boileau, Vissandjee et al., 2008). Young females and males see sex, regardless of the context in which it occurs, as an expression of love and affection for each other while traditionalist, see sex out of marriage as a breakdown of traditional values (Boileau, Vissandjee et al., 2008). Gender-based roles, coupled with culture and the social environment shape and influence how females respond to male sexual demands. To understand this we have to examine the masculinity ideology
theory and how the African teenage persons and African women exist within cultural scripts.

3.5 The scripting or script theory

The scripting or script theory has been used widely in sexual health research to identify patterns of behaviours between the different genders involved in sexual relationships and the power structures within such relationships (Gagnon & Simon, 1973). Through Gagnon’s scripting theory (1990), gender and cultural norms embedded in sexual relationships are better understood. Script theory allows the researcher to elicit the hidden meanings around sexuality, which are implicit although often explicit. According to script theory the sexual enactment is an end to a long sequence of events. These events are shaped by cultural norms and values. Dominant cultural practices dominate the scripts but because culture evolves and changes, scripts also change and evolve (Gagnon, 1990). African teenagers have multiple identities (refugee, African, female, young and migrants) and therefore must engage in multiple scripts. The African culture and the Australian cultures within which African-Australians have lived or are living in form part of their several identities. Intersectionality theory provides an outlet by which, the interconnections within which these teenagers and women exist can be effectively explored

‘Traditional sexual scripts’ is a dominant script that involves gender, gender roles and what occurs in the cultural context (O’Sullivan, Harrison et al., 2006). Maticka-Tyndale and colleagues (1991) contend that this form of scripting recognises that ‘sexual activities are understood as constructed from the interplay between cultural messages about sexuality, identification of situations as sexual and interpersonal negotiation’ (Maticka-Tyndale, Gallant et al., 2005, p. 28). Due to the interplay of sexual messages within a cultural context, men get positioned at the helm of their sexual relationships (Lewis & Kertzner, 2003; O’Sullivan, Harrison et al., 2006; Kim, Sorsoli et al., 2007). Men are considered and seen as the initiators, are agile, have high levels of sexual desire and use every opportunity they have to engage in sex (Maticka-Tyndale, Gallant et al., 2005). Women in traditional
scripting theory are recognised as recipients and respondents to men’s desire rather active participants (Maticka-Tyndale, Gallant et al., 2005; O’Sullivan, Harrison et al., 2006).

Scripting is culture specific and influenced by tradition (O’Sullivan, Harrison et al., 2006). In traditional African society, sexual scripting commences at puberty. From a broader perspective, traditional scripting begins with initiation ceremonies, such as rites of passage, circumcision for boys and girls (depending if female circumcision is practiced). Friends and family play a significant role both as ‘maintainers’ of culture and scripting, introducing prospective males and females to each other and arranging marriages (O’Sullivan, Harrison et al., 2006; Boileau, Vissandjee et al., 2008). Courtship is forbidden and virginity is advocated for as virgins are highly desired and priced (O’Sullivan, Harrison et al., 2006; Bishai, Falb et al., 2009). The money or gifts received from a prospective husband and his family is used to support the family, rather for the benefit of the girl alone. Marriage is seen as a union between two families rather than a union between two people to the exclusion of all others (Bishai, Falb et al., 2009).

Scripting also occurs at the individual and personal level (Gagnon & Simon, 1973; Gagnon, 1990). Normally it starts with a friend or family member being the ‘messenger’ and running the errands from the boy to the girl. The girl never makes the move even if she is interested because it will be interpreted as being ‘cheap’ and ‘easy’ to get. The girl initially declines, waits and maybe another message, or a gift, which is normally followed by an agreement. It can be interpreted like a stage play (O’Sullivan, Harrison et al., 2006). Once the introduction phase is completed, the next level is the sexual enactment.

The male takes control while female responses to his requests. The boys are normally older, and more experienced in life and often sexually too, while the girl is thought to be less experienced giving the boy more control over what happens in the relationship (O’Sullivan, Harrison et al., 2006; Boileau, Vissandjee et al., 2008; Bowleg, Teti et al., 2011). The boy takes the girl to his home where intimate sexual enactment occurs occasionally but seldom at the girl’s home. Concurrent partnerships are not uncommon, especially for the boys. Pressure and sexual coercion are not uncommon during this phase of the scripting. This is
even more so if the girl has received gifts from the boy (O’Sullivan, Harrison et al., 2006). Boys existing within such cultural parameters are in a more powerful financial situation because of their age advantage over the girls; they are more sexually experienced and have the ability to work out of the home (Gagnon, 1990; Erhardt & Wasserheit, 1991; Gerschick & Miller, 1997; Shearer, Hosterman et al., 2005). Girls are in a vulnerable situation here because of the traditional roles given to boys and the ‘protection’ of girls that requires them to stay at home, limiting not only their ability to interact with others of similar age, but also their ability to generate income like their male counterparts outside of the home. As a result the power imbalance within the relationship as illustrated in traditional scripting strengthens the position of the males over the girls and the implications being subsequent STDs and pregnancy. In line with script rules when pregnancy does occur, there is denial on the part of boys and the girl often faces rejection from within her own family. With limited choices, including financial independence, the girl has no choice but to do whatever is asked of her by the males or her family, including, accepting a forced marriage, abortion or expulsion from home. Adoption is very uncommon as biological children are favoured. Children who tend to be adopted will be those that the family is unaware of the pregnancy, or babies whose mothers are dead. Fortunately not all girls will respond as above despite the limited resources available to them.

In contemporary society and with the influence of western lifestyles through the mass media and education in general, traditional scripting is continuously changing and evolving. Girls are able to express their desire to have sex, rather than being passive recipients (Lewis & Kertzner, 2003; O’Sullivan, Harrison et al., 2006). Sex is becoming to be seen in traditional Africa as an expression of love rather than for procreation alone (Carolan, 2010). Conversely, because of school attendance, marriage is now postponed until later for girls, meaning the traditional short period between puberty and marriage is prolonged. In traditional culture whereby the adolescent phase, was almost non-existent as girls were married soon after puberty and in some cases before the adolescent period is now well recognised (O’Sullivan, Harrison et al., 2006). While it is of advantage for a girl to have an education and be able to secure a job and a stable future later, this is not often the case. The prolonged period between childhood and marriage means many girls are not going to marry
as virgins in contrast just two or three decades ago when girls were married off in their early or middle teen years. Although in parts of Africa and other developing countries child marriage and marriage during early and middle adolescence remains, and is considered a public health concern (WHO, 2012).

The problem this ‘prolonged period’ poses to teenage girls is the risk of contracting STDs and HIV/AIDS, and subsequent out of wedlock pregnancy, regardless of the whether the pregnancy was planned or unplanned. Early pregnancy and childbirth by young mothers’ poses health risks for example fistulas to the young mother, and there is an increased risk of her baby being born prematurely or she has a still birth (WHO, 2012). In this research I explore the relationship between culture, traditional practices in relation to contraception and eventual TP. Culture, race, migration status, education, future aspirations are all important when examining why women and more so teenagers use or do not use contraception. To offer clarity scripting theory described above within the context of intersectionality theory offered an appropriate framework to work within. I further drew upon the reproductive theory, pro-natalism ideology and the motherhood theory within the same framework.

3.6 Pro-natalist ideology and motherhood within intersectionality

Women’s maternal role has profound effects on women’s lives on ideology about women, on the reproduction of masculinity and sexual inequality, and on the reproduction of particular forms of labour power … Most sociological theories have either ignored or taken as unproblematic this sphere of social reproduction … (Chodorow, 1978, pp. 11–120).

Motherhood remains and continues to be seen as an essential and important duty of a woman. Pro-natalism referred to as the ‘ideology of compulsory motherhood remains a constraint to women in countries and cultures whereby a woman’s status and achievements are continuously measured or weighted against the number of children she has’ (Reissman, 2000, p. 29). Women who by choice or because of biological and health reasons do not have children risk stigmatisation (Reissman, 2000; Remennick, 2000). How women
experience having children depends on their cultural background, how motherhood and childbearing are seen, understood and perceived in that society (Oakley, 1980). Being unable to bear children is perceived to be one of the most unfortunate things to happen to a woman (Remennick, 2000). With some women doing anything in their ability in order to have a child as this becomes a form of security in their relationship, sons often favoured over daughters (Liamputtong, 2006; Levi, 2010). Oakley (1980, p. 96) says motherhood is a ‘social construction of adult femininity has certain crucial stages, among which becoming a mother is probably the most important … the core to the female tie to the home is not housework but her children. Motherhood then becomes not a challenge and experience but an expectation and a ‘natural’ part of a woman’s life. In traditional society, common in African societies, the girl child practices nurturing a baby from a young age. As children grow and develop, they carry the babies born within the family, often biological siblings or children from members of the extended family. This becomes their orientation and practice towards motherhood. Once these children grow up they want to be mothers themselves because from an early age they have been orientated towards motherhood (Afable-Munsuz, Speizer et al., 2006). Bringing up children becomes a shared enjoyable experience rather than an isolating frustrating task within such a setting (Oakley, 1980).

However, such realities change after migration to countries like Australia, Canada and the Britain. Families are mainly nuclear in nature, paid employment is required for survival, and to be able to achieve and secure good employment literacy and education are required. Further, a girl may growing up in such a setting may have limited opportunity to care for other children as she grows up. Having children and nursing babies within such settings becomes a process that requires orientation lessons, rather than through observing your parents and extended family members do it as is the case in traditional and most developing countries.

Further Africa is a pro-natalist society, supported by a culture that a woman’s status is defined by her childbearing abilities (Ojwang & Maggwa, 1991; Dlamini, Taylor et al., 2009). In pro-natalist societies a woman or a couple choosing to stay childless for the pursuit of success in academia, business or otherwise are perceived to be selfish because they are refusing to continue the bloodline (Remennick, 2000; Oladokun, Arulogun et al.,
This view is reverberated by other researchers about pro-natalist societies, such as Israel, whereby a woman’s identity is defined by her motherhood status, and not by her gender and personal achievements alone (Remennick, 2000). This is in line with traditional gender orientation where by a woman’s femininity is defined by her child bearing and nurturing abilities (Oakley, 1980). Women who have many children are perceived to have more status than women with smaller numbers of children. African culture defines a girl’s life in three main stages; birth, marriage and motherhood. Girls are expected to marry followed by the birth of a child usually within the first two years of marriage (Oladokun, Arulogun et al., 2009). After such a period if the woman is still not pregnant the family begins to raise concerns about the woman’s fertility. Sex is perceived to occur within the institution of marriage and sex is primarily for procreation purposes. The institution of marriage considered the core of the community and society ensures the continuing of the bloodline. The fear of not being able to bear children is ever present for women who exist within societies where pro-natalism ideologies persist as stigmatisation and strangers asking personal questions about the number of children you have or when you plan to have children remain an everyday presence and struggle for women (Reissman, 2000; Remennick, 2000). For women who have experienced other trajectories and adversities in the absence of the right role models and support system, having children soon becomes normal and a priority. This is further strengthen by the challenge women known or unknown who want to have children but are unable to do so experience due to infertility (Oladokun, Arulogun et al., 2009).

Infertility has been defined as the inability of the couple to conceive or have a viable pregnancy after 12 months of regular sexual intercourse (Russell, Bradford et al., 2005). There are several reasons, why infertility occurs, which include, incompatibility of the couple, STDs, pelvic inflammatory disease, cancer, blockage of the fallopian tubes in women and for men, low sperm count (Russell, Bradford et al., 2005). Infertility remains a problem in Sub-Saharan Africa, because of higher rates of STIs, which are often poorly treated (Raine, Gard et al., 2010; WHO, 2012). Women carry a greater burden when infertility occurs as traditional society blames a woman for not being able to procreate, rather than the couple; a concept closely associated with ancient reproductive theories.
Stigma, isolation and ostracising the woman, derogatory comments about her being a ‘man’ are not uncommon. Such attitudes leave the woman with a sense of worthlessness (Remennick, 2000; Liamputtong, 2006). One will therefore think that adoption should be considered an alternative, considering the negative consequence to the individual and the couple as a result of their infertility. In Africa, adopting a child is still an uncommon practice, and stigmatised. The child is often not accepted as a true blood of the family, and there is always the fear that he or she may bring ill luck to the family or contaminate the family’s bloodline (Oladokun, Arulogun et al., 2009), childbirth is preferred. Negative attitudes are directed by community members towards an adopting couple and towards the adopted child. Adopted children are commonly referred to as ‘bastards’ and ‘motherless babies’ in such communities. Due to the high levels of stigma involved with adoption parents who adopt often choose to conceal this from their friends and family, and pass the child as a natural birth (Oladokun, Arulogun et al., 2009). Aside denying the authenticity of adoption and calling the child your own, the communities are concerned about the sincerity of adopting parents. Adopting parents are thought of as having other motives; often negative ones towards the adopted child. This puts pressure on individuals to have biological children. Such pressure is greater for women together with the fear, burden and stigma attached to motherless women.

Teenagers faced with an unplanned pregnancy have to think about the stigma attached to teenage motherhood or towards motherless women without children (Oladokun, Arulogun et al., 2009). More so it seems the context in which TP occurs for example to a married teenager compared to an unmarried teenager remains open and seems to be of little concern rather than the pregnancy in itself. The fear of infertility later in life due to natural causes or as a consequence of infections or abortions often carried out by unskilled persons is ever present. More so continuation of the bloodline is ever present with cultures and societies going to great lengths to ensure this happens. Child bearing is preferred while child fostering is a favoured and accepted alternative.

Girls and women who exist in such setting where motherhood is seen as compulsory, for them, pregnancy becomes the norm. Women in some pro-natalist society against all odds
and pressures, coupled with little social support decide against motherhood (Reissman, 2000). Societies with entrenched gender roles risk imposing gender attitudes, such as compulsory motherhood on the females. Females who are born or who grow up within such pro-natalist environments see themselves firstly as future mothers rather than as individuals who choose to become mothers. For young women who have experienced disadvantages like poverty, poor or no ‘family’ relationships, rejection, violence and other forms of trauma becoming a mother becomes the one thing they perceive they still have some degree of control over (Hanna, 2001). All women’s choices whether pro or against motherhood should be supported without being judgmental. Attempts should be made to understand the context within which females exist and the reasons behind individual decisions. The intersectionality theory provides such an outlet whereby the several layers and levels of existence of refugee teenagers and women can be understood.

3.7 Responding to TP by utilising dimensions of the social model of health within intersectionality theory

The social model of health is concerned with the health of individuals within the social context. These social contexts include the social and physical environment, community, culture, and race. In responding to TP the intersectionality framework, which considers the above factors together with gender and migration status is essential. Germov (2010, pp. 331–332) has described different social dimensions that can be utilised to respond to this; they include social production and distribution of health and illness; the construction of health and illness; and the organisation of the healthcare system. The first dimension, social production and distribution of health and illness recognises the social, living and working environments as contributors to health and illness (Wilkinson & Marmot, 2003). As a result, illness distribution becomes unequal with some members of the society suffering more (Eckermann, Dowd et al., 2007) because of inequity (Baum, 2008). For example, a teenager with limited or no access to healthcare providers, health information and services may not use contraception because of lack of knowledge and access to such services. For females a lack of and/or inequitable distribution of resources may place a teenager at risk of STDs and unwanted pregnancies.
The second dimension of the social health model is the construction of health and illness (Germov, 2010). People’s definition of health is influenced by their belief system, including cultural understanding of health. Culture has been defined as a people’s way of life (Papadopoulos, 2006); because cultures evolve and change, so do people’s health beliefs over time (Germov, 2010). Thus, health becomes situational rather than concrete, and what a person may define as healthy or unhealthy changes as the individual’s situation changes. Good health policies should reflect these changes. Germov (2010) provides an example how homosexuality used to be seen as a psychiatric disorder and how this pathological view of homosexuality has shifted and changed over time. In Australia, homosexuality is perceived as normal, although this is not the case in most countries around the world and Sub-Saharan Africa where all the teenage mothers and women in my research migrated from. However, what brings about such policy shifts are people’s beliefs and values in the society or setting they live in (Germov, 2010). One needs to think if the presentation of TP as a social problem is an economic or a political construction and if this is problematic. Attempts should be made at understanding teenagers’ experiences and if their lives have changed for the better or for the worse since they became mothers and what motherhood means to them.

The third dimension of the social model of health is the organisation of healthcare systems (Germov, 2010, pp. 332). The focus here is at the tertiary level where policies, including funding policies and service utilisation are structured to benefit all its users and practitioners (Baum, 2008). A good healthcare system shares its resources equitably among services providers, and ensures that all members of the society have access (Eckermann, Dowd et al., 2007). An example here is funding and resources, like human resources, directed to different sectors of the healthcare system equitably, rather than focused in one or specific, dominant areas of the healthcare system. Such distribution of resources takes into consideration the diversity within the general population and people’s needs. Policies are also put in place whereby all sectors of the society are involved in the health of the people. This is commonly referred to as intersectoral collaboration (WHO, 2009). Health
becomes the responsibility of everyone and by all sectors of society and not just the responsibility of the healthcare system alone (Baum, 2008).

Contraception use and TP are a part of a more complex existence of refugee teenagers because of the multiple factors and trajectories where they come from and how they live in their new country. They are bound by their connection to culture and the community, with loyalty to culture and their community being an important part of their lives and, which they remain connected to. Hence within the intersectional theory I draw on the social model of health to further shed light on TP among African refugee teenage mothers. The social model of health can be summarised as follows: that an individual’s health is influenced by the environment, opportunities, lifestyle, ethnicity, culture, race, social gradient, and the SDH the above play a significant role in the health of the individual, including sexual health outcomes (WHO, 2009). Humans are social beings and their belief systems, cultures and subcultures all contribute or influence the way they define and see their health (Wilkinson & Marmot, 2003; Lin, Smith et al., 2007; Baum, 2008; Germov, 2010). These aspects are vital and should be considered when dealing with individuals and their health issues, including TP African girls with a refugee background.

3.8 Summary

In summary I have discussed different theories for this research within the intersectionality theoretical framework. Intersectionality is vital when researching a group, such as refugees, teenagers who carry other labels or categories, such as race, gender, other culture, migrants, low literacy and so on. Through the intersectionality theoretical framework the different intersections within which women, teenagers, migrants, people of another race or colour exist are able to be explained and understood. One is able to ‘unpack’ the different categories without labelling or blaming anyone about their life decisions.

Gender cannot be excluded when we deal with issues of TP. The extended traditional African family set up is different to a western nuclear family. An African approach and multiple theoretical approaches offer an acceptable approach to researching Africans.
Scripting theories continue to be relevant in traditional societies where women and men supposingly play different roles when commencing a relationship or are in a sexual relationship. Ancient reproductive theories, while they may be untrue continue to indirectly inform ways of thinking. This is further supported by cultural practices where men are perceived to be superior, and should be in control, while ‘good’ girls and women have to be submissive, listen, follow and depend on their men and their guidance. African teenage girls are orientated towards motherhood early on in their lives. This is further perpetrated by the stigma associated with infertility. Motherhood provides women with status among their peers and the community. The downside is females may not be able to resist male sexual pressure if they are not provided with the appropriate tools. These tools are good support, good education, and economic freedom and independence.

The intersectionality theoretical framework takes into account the different aspects that influence the life of women and migrants. Most importantly, victim blaming is discouraged while support and education to improve live chances are advocated. Hence intersectionality theory provides an appropriate framework for use with women, migrants, refugees and people from different races and cultural backgrounds.
Chapter 4: Study Designs and Methodology

4.1 Introduction and research objectives

From the literature it is evident that a knowledge gap exists regarding TP, contraception, motherhood, culture and sexual health issues among AATs with a refugee background in greater Melbourne. The aims, objectives and research questions for this research were spelled out in chapter one.

In this chapter, I start by describing researching a sensitive topic and a vulnerable group. I then proceed to the research design and research methods; the theoretical frameworks that informed my design; recruitment of participants, including inclusion and exclusion criteria and ethics considerations. Finally, I discuss my position as a researcher who is a migrant, a woman, a mother, is of African background, a university lecturer with a healthcare background. Here I discuss what I call my insider/outsider perspective in this research. I highlight the advantages and disadvantages of being an ‘insider/outsider’ researcher and what this meant exploring a topic that I describe as sensitive.

4.1.1 Researching a sensitive topic

Different researchers have defined ‘sensitive’ with reference to contexts where the research is conducted, the social and political situation/environment and the willingness and ability of the participants to speak freely to the researcher without facing any consequences or the researcher facing consequences (Farquhar & Das, 1999; Brewer, 2003; Lee, 2003; Liamputtong, 2007; Dickson-Swift, James et al., 2008). Bearing this in mind, the definition of a ‘sensitive’ research can be problematic; all qualitative research could be termed ‘sensitive’ (Brewer, 2003). Brewer defines ‘sensitive’ as dependent on political, social, financial or other implications, such as cultural factors, and that ‘sensitive’ research can be a source of problems for either the participants or the researcher (Brewer, 2003). Brewer gives an example of a researcher killed as a result of undertaking research relating to drugs
and the drug trade; thus, such research is ‘sensitive’. This view is echoed by Lee (2003), who says sensitive research does depend not on the research topic alone but expands to take into account the context in which it is conducted. Virginia Dickson-Swift and colleagues (2008) define ‘sensitive’ as encompassing not only the effect of the research on the researcher, the participants and context in which it is carried out; rather, sensitive research involves the total research process from the research design through to the dissemination of findings and implementation of the findings, including the research consequences in practice. By implications or consequences, I mean policy changes that may occur as a result of the research, and can be reflected in culture change at the work place, or change in behaviour towards a social group or ethnic community. Such change can be positive, reduce stereotypes of a social group or community, or perhaps reinforce stereotypes. While I like the inclusive nature of the above definitions, Renzetti (1993) and Liamputtong (2007a) define sensitive research as that which may pose a threat to those involved in the research either as participants or researchers, and this threat can occur at the time of data collection, accessing the research participants and getting the participants to discuss the topic under exploration with the researcher. Participants may see such information as personal, and they may not desire to share this with a stranger (Renzetti & Lee, 1993; Brewer, 2003; Lee, 2003; Liamputtong, 2007a).

‘Sensitive’ research has also been described as research where by the researcher finds it difficult to keep or retain the information collected in their safe keeping and/or the researcher has difficulties (excluding financial) disseminating the research findings (Renzetti & Lee, 1993; Lee, 2003; Liamputtong, 2007a). Renzetti and Lee (1993) identify sexual issues or any experiences that are personal as examples of sensitive issues. These include socially unacceptable behaviours such as drug use, sexual abuse, behaviours such as child prostitution, and other acts often poorly regarded by the wider society. Lee contends that sensitive areas include a) studies, which are concerned with deviance and social control; b) inquiries, which exercise coercion or domination; c) research that intrudes into the private lives or deeply personal experiences of the research participants and d) research that deals with sacred things (Renzetti, 1993, cited in Liamputtong, 2007, p. 3). Liamputtong extends the list of ‘sensitive’ research to include ‘miscarriage, abortion,
exploitation of marginalised people, the young, weak, old, and the sick, sex workers, including issues, such as TP’ (Liamputtong, 2007a).

My research involved speaking to women, teenagers and refugees about their personal sexual experiences, a topic I know, as an African woman, that most people will not share the information freely with a stranger (Liamputtong, 2007a; Hydén, 2008). Some women would not use words like sex, vagina and penis when answering questions during interviews because they felt the information was too personal and there were aspects of their sexual lives they felt they could not share with a person other than their husbands. As one participant put it, ‘Mimmie, we never talk about that [sex], only in the bedroom; we do not even kiss’. This woman would not even use the word ‘sex’, and her body language (turns away smiling) gave me all the signals that this was a personal thing and we moved on to another question. Some women, conversely, were simply excited to talk about something that they had never shared with anyone else except their husbands or their sex partner in the bedroom. For others, depending on if they were mothers or had experienced TP or were key informants (KI), there was a common expression of discomfort using words like vagina, penis, sexual intercourse, condom or anything to do with sexuality; some women would not use any of these words. There was a sense of morality and sacredness about these words.

All the teenagers and young women in this research, including all the participants in the African women’s group, were refugees; all had arrived in Australia under the humanitarian programme. Refugees have experienced difficulties, such as trauma, abuse and loss (Luster, Qin et al., 2008; McDonald, Gifford et al., 2008; Gifford, Correa-Velez et al., 2009). With such a background and the challenges experienced by this group of migrants, they are said to be ‘vulnerable’ (Liamputtong, 2007a; 2010).
4.1.2 Researching a vulnerable group

Vulnerable is synonymous with being at risk of something. Vulnerable people are people who may be at risk of or have experienced hunger, poverty, crime and involvement in illegal activities as a result of their circumstances (Hydén, 2008; Liamputtong, 2010). Vulnerable people may have suffered discrimination, experienced war and other atrocities, because of their gender or age, such as very young or old and weak, their condition or disabilities, or may be stigmatised because of their beliefs, social or sex orientation, race, culture and/or ethnicity (Hydén, 2008; Liamputtong, 2010). I contend that vulnerable people are people who are at risk of being exploited, abused or/taken advantage of by members or individuals in the society in which they live in. In Australia, vulnerable groups may include refugees, people from non-English speaking backgrounds, sex workers, pregnant teenagers, unemployed youth and many others.

The teenagers and women of African background in this research came from communities that are considered minority groups in Melbourne (Cote, Geltman et al., 2004; Cassity & Greg, 2005; Department of Education and Early Childhood Development, 2011); they all arrived in Australia via the refugee and humanitarian programme. This research involved women who come from families and societies where their roles are shaped by their gender, social norms, patriarchal structures and culture, which can be challenging (Dei Wal, 2004; Daly, Willis et al., 2007). From the description above and from the literature, refugees are a vulnerable and disadvantaged group. Refugee teenagers are doubly vulnerable because of their ‘fragmented’ life, coupled with protracted situations, such as being born in a country where they and their parents have little or no status (Dei Wal, 2004; UNHCR, 2005; 2010), living in refugee camps, disrupted schooling (McDonald, Gifford et al., 2008; Gifford, Correa-Velez et al., 2009), not having enough to eat, suffering from trauma and persecution (Pittaway, 2002) and belonging to a group that is a minority group (Liamputtong, 2007; Luster, Qin et al., 2008).

In this study, I had to not only deal with researching a sensitive topic and young women who come from mostly patriarchal societies, but I was researching a group that was young,
and socio-economically and disadvantaged at several tiers (Macintyre & Dennerstein 1995; Liamputtong, 2007; Luster, Qin et al., 2008; Levi, 2010). For example, most of the Sudanese refugees have low levels of education attendance and some have never been to school as a result of the civil war that lasted 40 years in Sudan (Levi, 2010). Some of the teenagers and their siblings were born in refugee camps or a country other than where their parents were born, when their families were waiting for a country to select them. One of the unfortunate things about being a refugee is that they do not choose where they get settled, a country chooses them after stringent criteria have been met (Victorian Foundation for Survivors of Torture, 1998; UNHCR, 2005; Gifford, Correa-Velez et al., 2009). Medical care in refugee camps and in temporal settlement countries is scarce, and where medical care is available, it is often not adequate, comprehensive and/or unaffordable, leaving the refugees and their family vulnerable to disease and exploitation (UNHCR, 2011).

The vulnerability and challenges faced by refugees, especially those from Africa and women in particular, do not necessarily stop after resettlement into a country like Australia (Pittaway & Bartolomei, 2002; Pittaway, 2004; Pittaway & Muli, 2009). After migration to Australia, refugees continue to face disadvantages in the areas of housing, education attainment and employment (Pittaway & Bartolomei, 2002; Department of Immigration and Multicultural Affairs, 2006; Department of Education and Early Childhood Development, 2011). There is new discussion on visible migrants’ status, because it has been recognised that visible migrants are more vulnerable and face more social and structural barriers, including discrimination in gaining employment and appropriate housing, compared to non-visible migrants and the general population (Gutierrez-Jones, 1988; Pittaway & Bartolomei, 2002; Junankar & Mahuteau, 2004; Babacan, 2005).

Visible migrants are those people you can see by examining them physically were not born here or their parents have migrated to Australia in the last decade or two. The visible sign being the skin colour that is often brown, dark or olive, depending on the country or region they migrated from. Other visible signs include wearing religious or ‘cultural clothing’ like the hijab (head scarf commonly worn by the Muslim women from Africa, Asia and the Middle East) and wrappaa (a piece of cloth or two, up to two meters long, worn by African
women around the waist, often with a matching blouse and headwear). Some Pacific and Asian people wear a similar patterned or colourful cloth, which they call a *sarong*; and the *sari* is a long piece of cloth commonly worn by Indian women around their waist with one end thrown over one shoulder. The visible migrants often include Asians, Africans and Middle Eastern people.

The non-visible migrants are those that one cannot tell are migrants by their physical appearance; the only way of knowing their migration status or ethnicity is from their accents, or if they choose to reveal their migration status to you. In Australia, these groups of non-visible migrants will include people of European Celtic background from England, Canada, New Zealand, USA, France, Germany and Scandinavian countries. The skin colour of African migrants range from fair, to olive, to brown or dark skin, depending on their country of birth and/or ethnicity. From my own experience as an African-born woman, and listening to fellow migrants of African descent, it is fair to say that the darker the skin colour, the more challenges and experiences of discrimination, such as gaining housing and employment (African Women, 2008). As a result, some migrants are bleaching themselves with products that contain the chemical hydroquinone, in order to have a ‘fairer’ complexion; hence, they become more ‘beautiful’ and ‘less visible’ and more acceptable. While this is not the focus of this research, it indicates the depths and lengths that some migrants, including refugees, go to in order to render themselves less ‘visible’ and less ‘vulnerable’.

In this research, I considered the refugee teenage mothers and refugee women of African descent as vulnerable (Liamputtong, 2007a). It is well documented that refugees have low levels of education (Victorian Foundation for Survivors of Torture, 2007; Department of Education and Early Childhood Development, 2011); have low levels of English language skills (Borland & Mphande, 2006); continue to face high levels of unemployment (Victorian Foundation for Survivors of Torture and The Horn of Africa Communities Network, 2007; Victorian Foundation for Survivors of Torture, 2009) and are high recipients of welfare payments (Birrel & Jupp, 2000), leaving them vulnerable at multiple levels, (Liamputtong, 2007a), including risk to their health. Low education attainment and
unemployment have been attributed to poor health outcomes (Marmot & Syme, 1976; Wilkinson & Marmot, 2003; Eikemo, Huisman et al., 2008). Girls from socio-economically disadvantaged backgrounds and low education attainment are more vulnerable and at increased risk of pregnancy and early motherhood (Coory, 2000).

As an African woman and researcher, having to research a topic that was ‘sensitive’ with a group that was ‘vulnerable’, was both rewarding and challenging. My status as an African, though not from any of the communities that participants came from, enriched both my research and my research experience. Here I talk about my place as an ‘insider’, and at the same time an ‘outsider’.

4.1.3 Being an insider/outsider

Today it is not uncommon for a researcher to undertake research with people and communities who share the same or similar background, heritage, nationality, race, ethnicity, beliefs or culture as them. Such a researcher would be referred to as an ‘insider’ or ‘internal’ researcher. I am a Cameroonian-African and African-Australian migrant woman, married to an English-Australian husband. I am a mother to three children; I speak four languages, though English and French have been the primary mediums of education, while Ngemba and pidgin was the lingua franca and primary medium of communication in social groups, immediate family and close friends growing up.

The participants in my research were all of African background, were migrants, women, and except for some of my KI, all women had conceived a baby, all but one were mothers or mothers-to-be and they spoke at least two languages or more. These similarities between my participants and I made me consider myself an insider. Further, through my interactions and connection with various African communities in Melbourne, I became accustomed to, valued and respected their belief systems and cultures (Purnell, 2002; Papadopoulos, 2006). I was a woman and mother like them and had concerns like all mothers do; I was empathetic towards their situation (Betancourt, Green et al., 2002; 2003) but did not
question their choices. I accepted personal invitations from participants and will do so in the future if invited to social events; this expanded my African cultural knowledge.

All participants were refugees (except for some Ki), and this is the one main factor that differentiated me from the participants, with the exception of a few Ki. I migrated to Australia as a skilled migrant over a decade ago; I lacked the refugee status that is sometimes awarded to me because of my physical appearance. I considered myself an outsider, not only because I was not a refugee, but I am an academic and I did not experience TP. I did not experienced forced marriage and have not lived in a war zone. I am tertiary educated, and my social networks include people from different backgrounds, walks of life and social classes in society. I did not share the same nationality or ethnicity with any of my participants, nor spoke the same dialect as them, making me an outsider. I am what is described as an insider/outsider based on the previous three paragraphs.

An insider/outsider or ‘external insider’ has been defined as a person who, through their exposure and socialisation, has acquired beliefs, values and cultural aspects of the group they are researching (James Banks, 1998, cited in Liamputtong, 2010, p. 110). Through my interaction in groups, representations at meetings and boards, I am well connected to and feel connected to various African cultures and communities. For example, I was the ‘face’ of the Melbourne West African festival in 2011, representing all the West African countries (such as Cameroon, Nigeria, Ghana, Togo, Niger, Sierra Leone, Guinea, Senegal, Ivory Coast and Liberia); this was an event organised by the immigration museum, with input from members of West African communities in Melbourne (Immigration Museum, 2011).

This insider/outsider status was enough for the participants to accept and trust me as one of their own, and to share intimate stories about their personal lives because I could understand where they were coming from (Liamputtong, 2010). I was seen as a woman, concerned with women’s problems, especially pregnancy among young girls. Young women and teenagers addressed me as ‘Aunty’, a usual way among many Africans to address someone you respect and who is older than you. Other women simply addressed me as ‘sister’, a way of expressing the ‘close’ relationship we shared. Women’s stories
could be shared without fear; they trusted me, but at the same time I was not insider enough to know their immediate family and social networks; there was no risk of their stories being shared with other community members (Dickson-Swift, James et al., 2008; Hydén, 2008).

Confidentiality is a common problem encountered by insider researchers, even when confidentiality forms have been signed. Some participants fear that if they reveal certain aspects of their lives, especially those that are stigmatised like marital rape, domestic violence or incest, this may be revealed to other members of the community; they fear being stigmatised and/or ostracised (Renzetti & Lee, 1993; Brewer, 2003). This is where an ‘outsider’ may have an advantage over an ‘insider’. I was not too close to know the social networks of the participants; they could trust me with their ‘stories’. There was the odd partner and/or man who questioned why I was only interviewing women and not men. It was a valid point, and I would explain the reasons, including the scope of my research. My reasons were accepted, but this may not have occurred if I was not also an insider. Even more challenging was when participants asked questions during the interview about how to solve some of the problems they had. When this occurred, my response was that I would respond at the end of the interview, which I did. An example of a researcher who has experienced this type of insider/outsider effect was the demographer and ethnographer Mridula Bandyopadhyay, when she was undertaking research with women in rural West Bengal India (Bandyopadhyay, 2011).

Bandyopadhyay’s research in Bengal was to establish the causative factors leading to high infant mortality rates (IMR) in this part of India. She was an ethnic Bengal woman who had lived and worked in another more influential part of India most of her life. Though she spoke Bengal, she faced several restrictions when carrying out the research. The challenges ranged from travelling to the research site, accessing the research participants, gaining participants’ trust, getting the participants to speak to the researcher and gaining participants’ consent to tape-record the interviews (Bandyopadhyay, 2011). Bandyopadhyay contends that a researcher in the field has to be part of the research instrument and should be able to adapt to situations they may find themselves in (2011). Willis and colleagues have emphasised the importance of building a favourable relationship
with potential research participants through ‘gatekeepers’ to ease access into a community (Willis, Green et al., 2009, p. 133). I built rapport over many years prior to arriving in the field to collect data (Willis, Green et al., 2009); though data collection had not been the reason to be a volunteer among several African communities groups in Melbourne, it assisted later when I commenced this research. Being an insider/outsider researcher has merits and disadvantages; in my case, there were more merits, though I shall caution insider/outsider researchers to be careful and aware of personal boundaries, because these are not clear-cut (Renzetti & Lee, 1993). The researcher has to determine boundaries subjectively through cues from the participants, like willingness to discuss a given subject in greater detail and their being at ease during interviews and discussion. The insider/outsider researcher could ensure this by being rigorous in their approach, a requirement in qualitative research (Crotty, 1998).

4.2 Methodology, theory and research design

Qualitative research (QR) methods are widely used in the social sciences and QR is applauded as the most appropriate method when exploring people’s life experiences or a phenomena that is difficult to understand (Angen, 2000; Neuman, 2012; Creswell, 2013). According to Avis (2003) as cited in Liamputtong (2009, p. 3), ‘it is important for QR to be situated within a methodological framework’. Methodology is described as a systematic way of gathering credible information (Neuman, 2012). Until recently, qualitative methodology was used more as an exploratory tool and did not receive the same respect compared to research that was carried out using the more traditional positive quantitative approach (Angen, 2000; Marshall & Rossman, 2011). This view is echoed by other researchers who see a QR methodological approach as the most appropriate method to research and understand sensitive issues, especially with vulnerable groups of people (Renzetti & Lee, 1993; Pittaway & Bartolomei, 2002; Denzin & Lincoln, 2005; Pope & Mays, 2006; Bryman, 2008; McDonald, Gifford et al., 2008; Levi, 2010). QR has been widely used by researchers in the field of health and social sciences to explore ‘sensitive’ topics and to research vulnerable groups (Renzetti & Lee, 1993; Farquhar & Das, 1999; Pope & Mays, 2006; Liamputtong, 2007). Liamputtong (2009) emphasise three interrelated
questions when doing a qualitative study. First, there is a need to identify a theoretical framework within which the study is conducted; in this research, I used phenomenology. Second, the research issue must be clearly identified: this study focuses on TP, motherhood and sexual health issues among African-Australian teenage girls who have a refugee background. Third, vital outcomes must be identified as they emerge from the research.

QR design allows the researcher to examine people’s experiences, behaviour and reasons for why they do things the way they do, in their settings and social environments (Polgar & Thomas, 2008; Neuman, 2012; Creswell, 2013). For social scientists and health professionals undertaking research in the field of public health, a qualitative design allows the researcher to seek out information from participants in their own setting and their own context and this is achieved through interviews whereby I explored the attitudes, beliefs, practices and experiences of the participants regarding the phenomena under investigation (Whitehead, 2007).

QR continues to develop and its use is growing in the health sciences and public health. Professionals who work in the field of public health as researchers, do not only go out and gather data, but try to understand the context and setting in which events and illness occur. This is because qualitative methods allow the participants to express the way they understand their health in their own words and their social setting; at the same time QR methods allow the researcher to capture this information from the participants in their own words, as understood by them. Qualitative methods allow for the exploration of small, new and emerging phenomena that is little known, so that other research methods, for example, quantitative research methods, can then be used to investigate the issue with a wider population, depending on the findings from the qualitative study (Neuman, 2012; Creswell, 2013).

Little is known about TP in a social and cultural context among African-Australian refugees in Melbourne. I sought to explore these phenomena and hope that the findings that emerge may be used to inform a larger quantitative study in the future. While there are many convergences, different QR approaches are used to explore and research different
phenomena and experiences (Whitehead, 2007). The methods I employed in this study included in-depth interviewing and focus group methods.

4.2.1 Methodological framework

In order to conduct research into teen pregnancy and early motherhood among AATs with refugee backgrounds, I drew upon both phenomenology and cultural competence frameworks.

4.3 Phenomenology

‘Phenomenology concerns itself with the study of things within human existence’ (Spiegelberg, 1970, p.21). Phenomenology is concerned with the study of human existence and how humans understand and perceive their own behaviours (Spiegelberg, 1970). Phenomenology allows the researcher to uncover those hidden aspects of people’s lives that would not happen during ‘normal’ conversations, or that people will not reveal to strangers or people outside their own social or cultural circles (Spiegelberg, 1970; Liamputtong, 2009). By ‘normal’, I mean socially accepted norms that society approves of (Neuman, 2012), though what can be considered by one social group as normal may not be seen in the same light by members of another group (Hydén, 2008). For example, Margareta Hydén’s narrative writings on sensitive research discusses her first encounter with a pregnant drug addict prostitute called Maria, who Hydén met during her early years as a social worker. Hydén provides an account of how Maria was more comfortable and preferred talking to Hydén about her sex life and sexual know-how than she would discuss television shows or topics that Hydén perceived as ‘normal’ in Hydén’s world (Hydén, 2008). On the contrary, Maria appeared embarrassed when Hydén tried to change the topic from sexual experiences and know-how to topics like her childhood stories (Hydén, 2008). Thus, the concept of normal depends on who with, where and when you are interacting. TP, early and out of wedlock pregnancy continues to have that element of ‘not normal’ and stigma attached to it, with unmarried women finding it very difficult facing their families and communities with such pregnancies (Wiebe, Najafi et al., 2011). For this research, I refer to early
pregnancy and TP as one of those not so normal situations and phenomenology is used as both a theory and method to explore it.

I considered phenomenology as the method of choice for this topic and research for several reasons: a) to reach a group of people that are considered a vulnerable group (young women, who are migrants and refugees); b) discussing a personal and sensitive topic, sexual experiences, contraception decision making, pregnancy and motherhood (Farquhar & Das, 1999; Brewer, 2003; Lee, 2003; Liamputtong, 2007b; Dickson-Swift, James et al., 2008; Hydén, 2008) and c) because of the stigma attached to teenage/early out of wedlock pregnancy, beliefs about contraception and TP by some believers, social groups and community attitudes to women with a TP (Lemoh, Biggs et al., 2008; McMichael & Gifford, 2009; Sueyoshi & Ohtsuka, 2010; Wiebe, Najafi et al., 2011).

Phenomenology allowed AATs who had experienced TP to tell me their experiences in their own words and in the way they understood what was happening in their lives at the time (Neuman, 1994; Liamputtong, 2007). Phenomenology allowed the interviewees to express and narrate their experiences of TP (Liamputtong, 2009) and how TP shaped or influenced their lives and the lives of other significant people around them. Significant people are people that the participants identified as playing a role in their lives, before, during and after the pregnancy. Significant individuals were often mentioned in the discussions or during interviews. In this light the significant people included parents, aunties, uncles, cousins, siblings, friends, lovers, boyfriends and school teachers. To achieve the desired outcomes in a phenomenological study, the researcher had to be committed while drawing upon the following philosophical points underpinning phenomenological research (Whitehead, 2007; Jackson & Borbasi, 2008). These include:

- Reflection about human existence in the world. To achieve this, I had to acknowledge that different people have different ways of life, and that what may seem strange in one culture may be the norm in another culture. Such reflective practice was achieved in this research by the application of a phenomenology and the use of cultural competence.
• Personal reflection about one’s own experiences and personal understanding of the phenomena. In this research, I had to continuously reflect on people I knew who had experienced TP. I reviewed the literature on sexual health, adolescent health, African culture and TP to broaden my knowledge of the topic. This allowed me to reflect and remain objective as much as I could with the data that I collected.

• Reflective thinking, which surpasses ‘proving facts’ and trying to see and understand the meaning of the phenomena under study, especially through the eyes of the ‘other’. Unlike personal reflection, reflective thinking as a research tool allowed me to be able to read and make meaning of what the participants were saying to me and develop code words that were later grouped to form themes. Through this reflective practice I was able to present this information in a systematic fashion, but as told by the participants.

• Understanding phenomenology as a method and framework and how it informed/and was used during the research process. I have discussed this in detail in this section.

While this process can be seen as complex, confusing and confounding, it ensures the trustworthiness of the research data and findings (Whitehead, 2007; Jackson & Borbasi, 2008).

For this research, information was gathered through in-depth interviews and a focus group discussion was held with KI. A second focus group discussion was conducted with mothers and KI from one of the African communities represented in this research. Phenomenology allowed the KI to discuss their experiences working with or supporting African refugee teenagers from their own perspectives, in the way they understood (Liamputtong, 2009). During the focus group, a phenomenological approach provided the opportunity for mothers to describe their understandings of contraception, traditional methods of contraception and to provide insights on raising children and teenagers in Australia. Using phenomenology enabled mothers to talk freely about their own experiences of early motherhood; four of the six women had married by age 16 and where mothers themselves by 17. These mothers were comfortable in this setting; mothers shared a similar heritage, and felt supported by fellow women in the group, allowing participants to share their
‘stories’ in a supported environment (Farquhar & Das, 1999; Cresswell, 2013). I discuss how the focus groups were conducted in-depth later in this chapter. Due to the diverse nature of this research, phenomenology alone was not deemed sufficient to conduct this research (Cresswell, 2013). My participants were from diverse cultures and backgrounds, thus a cultural competency framework was drawn upon.

4.4 Cultural competence

Cultural competence has been defined as a continues process whereby the care provider during the provision of care works within a cultural context that involves the individual, their family and community to provide care that is acceptable to the client (Campinha-Bacote, 2007). The cultural competence approach draws on the principal that people from different backgrounds have different belief systems and world views, but this diversity should be accepted, valued and honoured (Leininger & McFarland, 2002). To value diversity does not only mean accepting the presence of a group that is in simple terms paying lip service; rather, someone who is culturally competent or culturally aware immerses themselves within the ‘other’ group and sees themselves as a part of the group (Toofany, 2006).

Culture is learnt through lived experiences and interactions with people from a particular social group. Culture is complex and not monolithic, and increasingly healthcare providers and researchers are not only dealing with the culture of the client or participant, but with their own hyphenated culture (Yan, 2005). By hyphenated culture, I mean someone who has more than one heritage, and this happens when parents come from two different ethnic groups or races. For example, Canadian-Australian, Chinese-Australian, Sudanese-Australia and the list goes on. However, culture goes beyond race and ethnicity (Yan, 2005). Yan describes culture as an ‘entity, which encompasses food, clothes, beliefs, ways of coping, norms, customs religion, expectations, language’ (p. 75); I add ways of doing things, expressing oneself and associating.
According to Betancourt et al. (2003, p. 297) ‘cultural competence does not focus only on the cultural aspect, but requires that the practitioner should understand the social and cultural influences like health believes and behaviours’ and how these factors interact at different levels. Papadopoulos (2006) agrees that cultural competence is a continuous process and should be applied at all stages by all individuals and should start from a personal level. Conversely, Leininger and colleagues (2002) say that cultural competency is underpinned by the supposition that people from different cultural backgrounds have different beliefs, values, cultures and world views other than their own, and that healthcare practitioners need to respect and acknowledge these different views when working and interacting with people from a background or culture that is different from their own. Toofany (2006) argues that cultural competence is about being responsive to the other person’s culture, and when someone can function competently in a cross-cultural situation, then they are culturally competent.

To achieve this level of cultural competency, a practitioner or researcher has to be culturally aware, and cultural awareness is a process itself (Betancourt, Green et al., 2003; Yan, 2005). Yan has suggested six ways social workers have reported enabled them to achieve cultural awareness and cultural process leading to cultural competence in their practice (Betancourt, Green et al., 2003). Yan interviewed 30 social workers of various ages, genders, cultures and races who provided services directly to clients from multicultural backgrounds in British Columbia, Canada. Yan’s main aim was to discover how the clients managed to achieve cultural awareness thus cultural competence during service provision to their diverse and multicultural clients (Yan, 2005). The findings showed that the social workers during their practice reported to:

a. detach themselves from their cultures by not confronting rejection from clients from the majority culture (the majority culture is ‘white’ Euro-Celtic)
b. separate themselves from their own cultures, especially if they were from a minority group; the tendency was to adopt the majority ‘white’ culture at work
c. take a different cultural role when at work, which was more professional, and this was achieved by ‘switching hats’, swaying away from their own culture towards a
more professional aspects of their role, which was influenced by their education and professional guidelines, modelled on a white Euro-Celtic culture
d. present themselves in a more professional manner to the clients, expressed and achieved by their ability to solve the client’s problem
e. hold the assumptions of the majority ‘white’ identity, because coming from a minority group, the social workers risk being seen as weak like their clients, they had to achieve this by having the ‘powered’ identity
f. use ‘retrospection’ to reflect on their practice (Yan, 2005, pp. 76–77). Yan gives an example of a Chilean-Canadian social worker who reported having to reprimand a daughter during her practice for threatening to abandon her sick mother in the hospital. To this social worker, this was an unacceptable thing for a daughter to do to a parent. Here, the social worker’s own culture and belief slid into her professional practice. The worker was unable to bring the cultural awareness determined in a to e above.

This last case indicates that despite all the efforts, one’s own culture can unintentionally slip in and influence professional practice. Toofany (2006) emphasises that nurses, for example, cannot provide culturally competent care to their clients if they are not aware of their own culture. Therefore, as a care provider and as a researcher, one has to be culturally aware of one’s own culture first during the whole research process as cultural awareness and competency are a continuum (Toofany, 2006). This includes self-reflection on our own attitudes towards different people and groups, being culturally aware and gaining and developing cultural knowledge and skills and then applying them during the design, data collection, analysis and dissemination phases of the research project (Leininger & McFarland, 2002; Purnell, 2002; Papadopoulos, 2006).

As a researcher, I acknowledge my own culture and beliefs; I understand that it is not possible to separate oneself from one’s culture, but I remained aware of how my own culture and beliefs were influenced by my social, professional and educational background (Betancourt, Green et al., 2003). I was aware during the research process that the ‘others’ (here the others are the participants) may have different beliefs and values, for example, about their health seeking behaviour, contraception uptake and use, and saw TP and early
motherhood through a lens different to mine (Yan, 2005). Being aware of this difference and being sensitive to participants’ culture enabled me to interact and gather information in an unbiased manner (Yan, 2005; Campinha-Bacote, 2007).

To be culturally aware means acknowledging and respecting the cultural values, belief systems and interpretations of things such as time from the participants’ perspective. For example, making an appointment could be difficult if the participant had to call me to confirm. I later understood from some of the participants that it was because they had no credit to call me. On several occasions, the interviews had to start much later than scheduled, and the participants did not seem to take any notice of the late starting time, though I may have been waiting for over half an hour to an hour for them to finish their home duties before we commenced. These waiting times were not wasted, because if I was at the home, the members of the household would discuss other social aspects of their lives and were often interested in my professional life and cultural background. On other occasions, interviews had to be rescheduled because the participant had forgotten. Interruptions to provide the needs of the baby was a ‘normal’ and accepted component during the interview process. As a researcher, I focused on understanding the concept of time among my participants, rather than thinking they were always late. Through cultural awareness, I understood that living in Australia did not change their perspective of time. Some of my participants interpreted the time based on the movements of the sun and the moon rather than clocks. Morning could be any time from sunrise to noon; afternoon could be anytime from noon to dusk, and after that it was evening, which gradually progressed to night, when darkness fell. My cultural awareness about this concept of time by my participants, gained from my own cultural background enabled me to allow myself enough time for interviews and for focus groups with my participants of African background. However, it should be acknowledged that while there are similarities in behaviours from people of similar background, there are intra-cultural differences within these groups (Toofany, 2006).

Developing trust with participants was an integral part of the research, considering the topic was in itself sensitive. Personal sexual issues can be seen as a personal private matter not to
be discussed with outsiders (Lee, 2003; Lee & Farrell, 2006; Liamputtong, 2007a). Thus, I had to build trust and rapport with teenagers and women in the focus group for them to be able to comfortably discuss what is considered personal and private aspects of their lives with me. Further, some participants may feel ‘research overloaded’ and ‘exploitation’. By research overloaded, I mean participants could feel that that researchers come in and undertake research with them, ask them questions, take the information from them (data), use the data to develop theories and then advance their careers, and the participant/or their community do not have a direct benefit from the research, nor are informed of the research outcomes or findings (Liamputtong, 2007a). Such feelings of exploitation and ‘research overload’, which may result in feelings of distrust towards researchers by participants, may be due to the history of colonisation and past research experiences by the dominant cultures into the minority and vulnerable groups (Liamputtong, 2007a).

A good example of such distrust of researchers by participants comes from the demographer and anthropologist Mridula Bandyopadhyay (Daly, Willis et al., 2007). Bandyopadhyay discusses the challenges she faced undertaking research in a rural part of India. She later found out after building rapport with the locals that their distrust of health professionals and researchers was as a result of part forced sterilisation of community members by the Indian government; members of this community were suspicious of anyone who came in to ask them questions (Daly, Willis et al., 2007). Another example of distrust of researchers by members of a cultural group is African-Americans (Freimuth, Quinn et al., 2001). Liamputtong (2007a, pp. 33–36) provides a good historical account of research malpractices by health researchers on vulnerable minority groups, including African-Americans. The research findings from such research, which was conducted without consent by unethical health researchers and anthropologists, often supported the ideology that whites were more intelligent and superior compared to the black race, and that black people were an inferior race (Heintzelman, 1996). It was not only such ‘false theories’ (Liamputtong, 2007a) that were damaging to the black American persons, leading to their distrust of research, and researchers; it was direct forms of unethical research practices on blacks, such as the Tuskegee syphilis study (Liamputtong, 2007a). The Tuskegee syphilis research project saw 399 African-American black men infected with
syphilis while another 201 were used as a control group. The participants in the Tuskegee research never gave consent nor did they know or understand the costs to their health and wellbeing as a consequence of participating in the Tuskegee research project (Heintzelman, 1996). Unfortunately, for some of the participants, the outcome from that research project was fatal; it is believed that up to 28 men died from syphilis because of lack of treatment (Jones, 1993; Heintzelman, 1996; Freimuth, Quinn et al., 2001, in Liamputtong, 2007, pp. 33–34).

While it would not be possible to conduct such unethical research as Tuskegee or carry out forced sterilisations in a country such as Australia, people from minorities groups and refugees specifically have had negative past experiences with authorities and governments, including healthcare providers in their countries of origin and refugee camps (Pittaway & Bartolomei, 2002; Govender & Penn-Kekana, 2007). As a result of such experiences prior to migration and other experiences of discrimination in Australia (Pittaway, 1991; Junankar & Mahuteau, 2004), there remains reluctance from some African community members to participate in research or talk to anyone from ‘outside’. By outside, I mean someone who is not a member of their familiar circles or social groups.

I dealt with this by letting the participant know honestly that they may not benefit directly from my research, but the information I gather may help other young people from their communities in the future or inform policies and programmes directed at sexual and reproductive health issues with African refugees in Melbourne and Australia. I told focus group participants that I would contact them or at least some of them with the research findings and, for the teenagers, I gave them my contact details to contact me in the future if they required information about the research outcomes and told them that I would contact them, subject to them having the same contact details.

Trust is a critical part of research when working with people and their culture, especially if the culture is different from that of the researcher. If the researcher wants to produce a piece of work that is not only objective but provides meanings and explanations, for example, why people from different groups do things and behave in the way they do, the
researcher has to interact with the people, at the same time bracketing their own ideas from the research process in order to avoid contaminating the data (Creswell, 1998). I did this by setting aside my own prejudices and preconceived ideas about TP and what I thought about some of the cultural groups that participants came from. This bracketing was applied throughout the research process, and I have written and reported on what has emerged from the data.

Sexual health matters, as stated, can be viewed as personal and some people may not like to share such personal experiences with others, especially people they do not know. To access the teenagers and other participants, I had to gain their trust. Trust was gained through people who had spoken to me, or who knew about the research and were confident that it was harmless to the participants and that teenagers speaking to me could only enrich and contribute to knowledge in this area. Trust was especially important in gaining access to teenagers who had experienced TP. Some of the teenagers and women did not understand the concept of research, while others, because of past experiences, some of which were negative, did not want to speak about such a ‘personal’ issue. Other participants, such as women in the focus group discussion, had their own expectations, such as the provider providing an immediate solution and support to members of the African community regarding TP. To establish trust, I had to build a rapport with AATs through third parties. These third parties were from the African community or were SP who knew the researcher or potential participants, and/or had heard about the researcher and/or the research I was doing.

While I did not immerse myself completely, like an anthropologist or ethnographer, with the different groups represented in this research—for example, living with the participants on a day-to-day basis in their traditional settings—there was frequent interaction between members of the African community and me at both formal and informal settings. Such interactions at various levels provided the researcher with enough interaction and further strengthened the trust between the participants and the researcher. Involvement by a researcher in the field has been widely used in sociology and anthropology (Neuman, 2012). This interaction and involvement enabled me to understand and gain insight into the
lives of young people with refugee backgrounds and the issues that exist within their various communities in a manner that would not have been possible in the absence of the interactions. In order to build a trusting relationship, I had to, for example, meet with teenagers at various settings of their choice several times, and in some cases up to three. It was only after such encounters that the young women in particular then felt confident to speak and share their experiences of TP.

Data was only collected after the participants felt comfortable to speak to the researcher or when previous participants known to potential participants encouraged them to do so, following their trust in the researcher. My interactions with the various African communities in Victoria and interstate made it possible for me to be able to achieve and collect data effectively and efficiently.

4.4.1 QR methods

There are two QR methods adopted in this study: in-depth interviewing and focus group methods.

4.5 In-depth interviewing method

In-depth interviews have been described as a form of knowledge construction by two individuals who have a shared interest about a particular theme (Kvale & Brinkmann, 2009; Liamputtong, 2009; Neuman, 2012; Creswell, 2013). In-depth interviews normally take the form of a conversation rather than a cross-examination and the questions are less structured (Roberts & Taylor, 2002; Neuman, 2012; Creswell, 2013). This less structured nature allows the interviewee to ‘tell their story in the deepest and richest way possible during the interview process’ (Roberts & Taylor, 2002, p. 388). Liamputtong (2009) contends that for the interview to be good, the researcher has to be a good listener and the interviewee does most of the talking. This conversation between the interviewer and the research participant has the sole aim of ‘eliciting information from the participants’ (Polgar & Thomas, 2008, p. 107). During this conversation, feelings are expressed as well as information being
gathered. In-depth interviews have been described by various researchers as focused, unstructured and open ended (Liampittong, 2009; Neuman, 2012; Creswell, 2013).

The open ended nature and the use of open ended questions are advocated for during in-depth interviews (Polgar & Thomas, 2008; Neuman, 2012). The use of semi-structured questions minimises rigidity (Denzin & Lincoln, 2005). The researcher can use prompts as appropriate to direct the conversation or to gain greater insight into the phenomena under investigation (Liampittong, 2009; Creswell, 2013). Unstructured interviews are further advantageous because the information is gathered and interpreted in the interviewee’s own words and as they understand it; thus, in-depth interviews aim to elucidate meanings and interpretations of the phenomena as understood by the interviewee (Denzin & Lincoln, 2005; Liampittong, 2009; Creswell, 2013). However, the downside of this in-depth interview, like other face-to-face interviews, is that it can be time consuming, there is a risk of bias (Denzin & Lincoln, 2005; Polgar & Thomas, 2008) and it can be expensive to conduct (Kvale & Brinkmann, 2009; Neuman, 2012), although Neuman (2012) notes that face-to-face interviews have the highest response rate. The time suggested for in-depth interviews is between one (Liampittong, 2009; Creswell, 2013) and two hours (Creswell, 2013).

Creswell (2013) suggests that for an in-depth interview to be successful, the researcher has to determine participants who can best answer the question and the type of interview should be determined at the research design stage. In-depth interviews have gained a place in QR as an interview method and they continue to be widely used by researchers to gather information, which may then be used to understand a phenomena that little is known about or to generate new information (Kvale & Brinkmann, 2009; Liamputtong, 2009; Neuman, 2012; Creswell, 2013).
4.6 Focus group method

According to Bryman (2008, p. 474) “The focus group method is a form of group interview in which there are several participants in addition to the facilitator or moderator”. Focus group methods, although new in health research, have been in use for a long time in marketing research (Bryman, 2008; Liamputtong, 2009; Marshall & Rossman, 2011). Focus groups allow the researcher to ‘examine the ways in which people in conjunction with one another construe the general topics in which the researcher is interested in’ (Bryman, 2008, p. 475). Members of the focus group can be familiar with one another or not, although the participants have a shared interest in the topic being explored. Having members of a focus group who are unfamiliar with each other prior to the focus can be advantageous as it increases diversity of ideas and experiences about the topic under exploration (Creswell, 2013). One of the theories underpinning the focus group as a method is that people’s ‘ideas do no develop in a vacuum’ and that these ideas and beliefs are socially constructed through people’s understanding of the world (Marshall & Rossman, 2011, p. 148).

Focus groups are advantageous in QR in that a focus group allows the researcher to collect a significant amount of data in a relatively short period from a variety of sources (Creswell, 1994; Crotty, 1998; Marshall & Rossman, 2011; Creswell, 2013). Focus groups can be a quick way of getting data, but the researcher has to be skilled and rules have to be put in place at the beginning of the focus group discussion. The number of participants recommended to take part at any one time in a focus group remains a contentious issue, with numbers ranging from seven to 10 (Marshall & Rossman, 2011), six to 10 (Liamputtong, 2009) and four to 12 (Neuman, 2012). The researcher should aim at having a number that is manageable and not too small for the ideas to be too thin, especially if the participants are not very familiar with the topic.

Focus groups have been described as socially orientated, hence provide a supportive environment whereby people who may otherwise not discuss a particular issue share their
experiences or knowledge from hearing others do same (Crotty, 1998; Denzin & Lincoln, 2005; Kvale & Brinkmann, 2009; Neuman, 2011; Creswell, 2013;). While focus groups used to be face-to-face, on-line focus groups are gaining popularity as there is no travel time involved for both the researcher and the participants, and it is more cost effective (Bryman, 2008; Creswell, 2013). More so, focus group can be useful in validating information already gathered from other sources, such as interviews (Liamputtong, 2009; Marshall & Rossman, 2011). Focus groups are a suggested method of gathering information from marginalised and vulnerable groups and on sensitive topics, and focus groups can be used alone or in combination with other methods (Liamputtong, 2009). Focus groups have been used in the past for gathering information on sensitive issues, such as HIV/AIDS and sexual behaviours (Drummond, Mizan et al., 2011; Marshall & Rossman, 2011).

Focus groups, although sounding simple, require skilful planning and management for it to be effective. Creswell (2013) suggests that the researcher should choose participants carefully, with consideration given to those who can express themselves, are not shy and are willing to interact with other members of the group. The place where the focus group is to be conducted should be chosen carefully, with easy access for participants, enough lighting and comfort. The rules of the focus group should be emphasised at the start, with emphasis given to confidentiality and not speaking over others (Creswell, 2013).

The moderator, who is usually the researcher, should decide on a note taker or else the discussions are audio recorded with the consent of participants. During the focus groups, all members and particularly shy participants should be encouraged to speak and share their opinions. The moderator should use prompts to focus participants on the topic being explored. These help in managing and maintaining the time allocated (Marshall & Rossman, 2011; Neuman, 2012; Creswell, 2013). It is suggested that for focus groups to be effective and for participants to remain focused, they should run for about two hours, although these may vary depending on the context and the type of participants (Liamputtong, 2009; Creswell, 2013).
4.7 Sampling

The sampling framework that informed the research sample and overall methodology for this research was drawn from the Hudelson’s (1996) qualitative health programme guide and a systematic review paper of qualitative methods titled ‘A Hierarchy of Evidence for Assessing Qualitative Health Research’ (Daly, Willis et al., 2007). The authors and co-authors in both papers advocate for a triangulation of methods and sampling. Triangulation here means using a variety of diverse sources of information. I included participants from different ethnic and cultural groups, different walks of life and life experiences, different age groups and from different settings. Using a diverse group of participants increases the credibility of the research (Hudelson, 1996; Daly, Willis et al., 2007). Multiple methods includes using, for example, interviews and focus groups while multiple types of informants include, for example, KI, mothers who attend clinics and mothers who stay at home (Hudelson, 1996). I describe the research sample in detail under the sub-heading Research Samples and Data Collection Techniques.

The prospect to be chosen or selected as a participant in a qualitative study is unknown to the participant and the researcher, compared to quantitative studies where this can be calculated based on the general population or the cohort of interest (Neuman, 2012). Sampling in QR draws on different forms of techniques depending on the research design and the issue under investigation. Sampling techniques in QR include: convenient, purposive, snowballing and theoretical sampling (Morse & Field, 1995; Pope & Mays, 2006; Liamputtong 2009; Whitehead, 2007; Neuman, 2012;). The above forms of sampling have their strengths and limitations. For example, one advantage of a convenient sample is that it is easy to gain access to the participants in one setting, such as young mothers attending a young mothers group, or visiting one multicultural centre to interview members or staff respectively. The disadvantage of convenience sampling is that other potential participants whose information may enrich the data may be left out, or the group may be homogenous, and their views and experiences may not be representative of that of members of the wider community (Neuman, 2011). Bearing this in mind, including the scope of the research, and aiming to ensure that the data collected was diverse and representative of
different views from a diverse group of informants, I drew upon a purposive sampling and snowball sampling technique. The KI were purposefully selected through formal and informal networks because of their knowledge and personal interest in the topic under study, and other participants were recruited by snowballing (Polgar & Thomas, 2008).

4.7.1 Purposive Sampling

Purposeful sample selection allowed the researcher to interview KI who knew and understood the subject matter and had an understanding of the phenomena under investigation (Morse & Field, 1995; Pope & Mays, 2006; Whitehead, 2007; Liamputtong, 2009; Neuman, 2012; Creswell, 2013). In other words, information-rich cases that have the knowledge to provide the researcher with the answers or information they are sorting. Purposive sampling is useful when collecting information using in-depth interviews or when trying to understand people’s experiences regarding a particular issue. Purposive sampling was useful in recruiting AATs, African women and mothers, SP and KI who had insight into the phenomena being explored. The teenagers had information about their experience of TP, while SP and KI had the experience of working with AATs, African families and the broader community.

4.7.2 Snowballing

Snowball sampling occurs when the researcher uses previous participants to recruit other participants. This method is particularly useful when researching hard-to-reach groups, marginalised communities and issues that are sensitive and may be stigmatised within the community (Whitehead, 2007; Liamputtong 2007, 2009; Neuman, 2011). Some members of the African community have negative attitudes towards teenagers who get pregnant while still at school or living with their parents and family. While snowballing is a good method to reach a sample that may otherwise be hard-to-reach, one has to be careful that participants are not coerced and ensure that diversity of participants is maintained during the research process.
4.8 Accessing a vulnerable group, researching a sensitive topic

I realised that sexuality is a very personal matter and the issue of TP is sensitive and remains stigmatised within some communities and social groups (Whitehead, 2007). I was dealing with a vulnerable group. This is where my status as an insider/outsider researcher was most useful. I had built rapport and trust over the years through my volunteer work teaching women and supporting their families. Though I had not been involved with people from all the countries and backgrounds represented in this research, I had had enough interaction with other African people through social gatherings and events; my name was sometimes recognised by people from various communities within the African community networks when I introduced myself, though mostly related to my work as an academic. This does not mean I faced no challenges by simply being an insider/outsider or known. I had to go through the process of recruiting as explained below and accessing a difficult to reach group, pregnant teenagers or women who had experienced TP. It was not a problem identifying KI or organising focus groups as a result of my previous work and support within the community.

However, I overcame a barrier recruiting past and present teenage mothers by speaking to third parties who knew or had heard about the research topic and were able to contact potential participants that are teenagers who had experienced TP. I also took the view that people with similar experiences and views tend to interact with each other. That is, young mothers or girls who have had TP may have a friend, or know someone who has had the same or a similar experience. Approaching young people through their friends, people they respected and felt were truly empathetic to them, their families and their situation, were somehow part of their social groups, were trusted and teenagers and young women felt at ease with was an effective access strategy. Sending and giving out pamphlets and plain English language statements to ordinary community members or trying to recruit otherwise was fruitless. Accessing a vulnerable person through their own trusted social networks and making oneself ‘visible’ in a community that shares cultural or simply race or nationality could be an effective way to reach a group that may otherwise be difficult to access (Liamputpong, 2007a). The researcher must be careful not to simply attend the gatherings
and interact simply for the sake of getting information. For example, my relationship with the African communities started many years before I thought to undertake a PhD. However, I maintained rigour during the whole research process and data collection, as detailed below.

4.9 Recruitment

To be part of the research sample, the potential participants had to meet a number of criteria. To be interviewed as an AATs group, the participant had to be of African descent, had migrated to Australia under the Australian humanitarian scheme, or came and was sponsored by someone who had migrated under the humanitarian scheme and they had to have experienced TP or early motherhood. To be considered a KI for interviews or focus group discussions, the potential participant had to be directly involved with or provided services to migrants of African descent, and specifically refugees. Finally, to be part of the mother’s focus group, the participants had to be of African descent, had migrated to Australia under the humanitarian scheme or were themselves mothers to teenage or pre-teenage children. This inclusion criterion was informed by my research topic, TP and motherhood among African-Australian girls with a refugee background in greater Melbourne. Thus, the overall sample had to be knowledgeable about the topic being explored, interested and could provide the information that I was seeking (Whitehead, 2007). The phenomenological framework used in this research also informed the decision to recruit the teenagers who had experienced TP; information-rich informants, that is, SP who were providing services to women, girls and their families and to the wider refugee community; and women who themselves had arrived in Australia as refugees and who came from the communities of interest where the issue of TP was being explored (Whitehead, 2007; Liamputtong, 2009). Due to the scope of this research, men were excluded. This is discussed under limitations.

Multiple techniques were used to recruit participants for the in-depth interviews and focus groups (Daly, Willis et al., 2007). Initially invitations were sent out to potential participants through formal (church notice board) and informal (friends and community members)
networks. Potential participants were then required to contact the researcher and set up an interview time that was convenient to the interviewee and the interviewer. Both methods were not successful in recruiting teenagers and women who had experienced TP into the research. I then employed another technique, snowballing. I used this for the group one focus group.

Snowballing involved using members of a particular social group who knew and related to each other. Some of the previous participants, KI, SP and AATs, identified potential participants who met the selection criteria. Other people who heard about the research through the formal and informal networks and who were interested in the research contacted the researcher and informed her of potential information-rich informants. The researcher then proceeded to have the informant contact her, and the researcher provided the potential participants with a plain English language statement of the research.

My supervisors and my contact details, together with a plain English language statement about the research, were provided to the participant to forward to their networks and others that they felt would be interested to participate in the research. I had anticipated that AATs would contact me after being informed of the research through formal and informal networks for interviews; this did not occur. I proceeded to call the initial contact person, requested they speak to the AATs and demand the AATs consent for me to be given their phone numbers and to be able to contact them. It was at this point that the researcher then spoke to the interested AATs on the phone, and organised a place and time for the interview that best suited the participant and researcher. Some people declined at this point to participate. The researcher went on to inform them to contact her if they did change their mind. This did not occur. One of the reason AATs did not contact the researcher was because they did not have credit in their phones; this was interesting because none of them had a fixed home phone.
4.10 Research samples and data collection technique

4.10.1 Sample in-depth interviews with AATs

The interviews included AATs who had experienced the outcome TP. The cohort for this study was defined by age, social status and pregnancy experience. The ages of the AATs interview participants ranged from 17 to 30 years; age at first pregnancy was between the 15 and 19 years; they came to Australia as refugees or one of their parents came to Australia under the humanitarian programme. All participants had conceived, were pregnant or had a child at the time of the interviews.

4.10.2 Sample in-depth interviews with KI

KI interviews were conducted with SP. The SP worked in diverse roles in different organisations. Their roles included: registered nurse, community bicultural workers, school principal, medical general practitioner, parish priest and a religious organiser. The entire KI were providing services of some sort to AATs and refugees in the communities of interest for this research. KI were purposefully selected because they had insight and knowledge of the subject matter (Pope & Mays, 2006; Marvasti, 2004). Further, KI were interested in the phenomena being researched. Having a personal interest in the topic seemed to have been a catalyst and motivation for participants to be involved (Cresswell, 2013).

4.10.3 Focus groups sample

Two focus groups were conducted for this research. One focus group consisted of SP who were at the same time KI who provided services to African refugees in Melbourne. The second focus group consisted of African mothers and women with a refugee background, who had insight into TP and motherhood within the African community in Melbourne, and also because of some of the women’s personal experiences of TP.
4.10.3.1 Focus group one: SP/KI

In the first focus group, the participants were KI from different backgrounds, various walks of life and had different levels and a variety of skills. All participants in this group were currently providing a service to AATs or members of the African communities, including the communities that AATs came from that are represented in this research. In total, six KI participated in this focus group. See the table six (appendix) for detailed information about focus group participants. All participants in this group were Christians and had been recruited into the focus group through one of the Christian churches. This focus group took place in the dining room of a church.

4.10.3.2 Focus group two: African women/KI

The second focus group consisted of six women originally from South Sudan, though some had lived in Northern Sudan. All the women had migrated to Australia within the last decade as refugees with their families. All six participants were aged between 28 and 48 years of age. Each woman had at least four children, and a maximum of seven children, one woman was a grandmother. Two of the women were widows and two of the participants in this group were Muslim. The two Muslim women both had tertiary qualifications from Sudan; one was a secondary school teacher previously in North Sudan, while the other worked as a nurse prior to migration. Unfortunately, both women had been unsuccessful in having their qualifications recognised in Australia and could not work in their professions. With the exception of the two Muslim women, all the other women had married and had their first child before their 17th birthday. Three of the women had never attended school prior to coming to Australia, and one of the women had left school early to get married. One of the women had two daughters who had experienced TP and a son who had fathered a child to a teenager when he was a teenager himself. This focus group took place at the residence of one of the participants who had been instrumental in organising the focus group. All the women had a personal interest in the topic and some were leaders within their community.
The heterogeneity within and between the two focus groups, helped the researcher to gather ‘rich’ data, thus ensuring appropriateness and adequacy (Morse & Field, 1995). Sample triangulation was ensured through the heterogeneity and diversity of the samples (Daly, Willis et al., 2007). Such diversity increases rigour and credibility in research (Daly, Willis et al., 2007; Cresswell, 2013).

4.11 Research venues

Locations for this data collection included the homes of the participants where interviews were conducted, the language and literacy centre where some of the girls were attending school and the work places of some of the participants. Interview and focus group locations were selected based on privacy, security and convenience for the participants in particular. The decision about interview locations was decided by the potential participants, but the researcher had to double check this with the participant to ensure privacy and safety prior to the scheduled interview day.

4.12 Data sources

4.12.1 Interviews

I had envisaged that in-depth face-to-face interviews would be conducted with about 20 AATs living in greater Melbourne using semi-structured questionnaires. This number was based largely on saturation theory (Liamputtong, 2009). Saturation occurs when little new information can be obtained. I chose greater Melbourne because most African migrants in Australia have settled in Melbourne (ABS, 2004). Within Melbourne there are large clusters of African migrants in Dandenong, Footscray, Maribyrnong, St Albans, Sunshine, Braybrook, Seddon, Werribee and Melton (ABS, 2004). It was further envisaged that interviews would be conducted with five SP. This number was deemed appropriate for a research of this scope (Neuman, 2012).
4.12.1.1 *In-depth interview question guide*

In-depth interviews were conducted using a semi-structured question guide. The question guides were designed by the researcher with guidance from the principal supervisor at the time. The questions were informed by the literature and were based on the WHO illustrative questionnaire interview guide developed by Cleland, Ingham et al. (2001). The WHO illustrative questionnaire interview guide is an instrument designed by the WHO for use by health professional undertaking research with young people. The instrument is to be used as a departure point for investigators who wish to study the sexual and reproductive health of young people Cleland, Ingham et al. (2001). The purpose of the instrument is to document the knowledge, beliefs, behaviours and outcomes in relation to the sexual and reproductive health of young people. Investigator are to adapt the instrument to suite their local needs and the research methodology Cleland, Ingham et al. (2001). I went on to develop the research instrument with the above points in mind, at the same time with guidance from the supervisors.

The research instrument (question guide) was submitted to the Victoria University Human Ethics Committee (VU HREC) together with the consent forms and all the other documents to ensure appropriateness prior to being used with the participants in this research. The questions were revised based on the comments by the VU HREC, after which they approved them for use for this research. Different question guides were to be used for the AATs, KI and the focus groups. This diversity of the research instrument was to ensure appropriateness of the information to the different groups of participants; I had to gather and to ensure that the research questions were answered and the overall aims and objectives were met. Prompts were used during the interview process. I further tested the interview questionnaire guide with one teenager and a SP. This gave me the opportunity to ensure appropriateness of the questionnaires.

It was not possible to test the focus group questions with a group, thus I sorted feedback from the same provider with whom the SP questions had been tested with. No changes
were made to the question guide; instead, prompts were used during interviews to explore issues in-depth.

4.12.1.1 In-depth interview

Interviews were conducted with African-Australian teenagers who had experienced TP, and KI who were also SP. Interviews were also conducted with KI and SP who had knowledge of the subject under investigation. All the girls and women in this research had come in as refugees. Interviews took between 30 minutes to one and a half hours. The average time for interviews was approximately 45 minutes. All in-depth interviews were conducted on a one-on-one basis between the researcher and the interviewee. Participants sometimes had their babies with them and interviews were interrupted at times for the mother to meet the needs of the baby. All interviews took place at the interviewee’s selected venue. The venues included homes, churches, education centres and work places. All interviews were audio recorded, and I took notes during interviews. I did wrote up the notes in more detail usually within 24 hours after the interview. I also wrote down ‘reflections’ following my interviews.

4.12.1.1.2 Focus groups

Two focus groups were conducted for this research. Focus group one consisted of six professionals who were also SP and KI. The focus group took place at a presbytery followed by a light lunch. The lunch of sandwiches was provided by the church minister and the researcher. The time for this focus group meeting was noon, and we thought it would be appropriate to have a lunch just before the focus group as all participants had to return to their various work places at the completion of the focus group. The church minister was very instrumental in helping organise the focus group. This helped ensure diversity of the group members.

The setting for the focus group discussion was a dining room, which doubles as a meeting room. The room was sparsely furnished with a dining table, six chairs, a cupboard
(containing glasses) and a few religious paintings on the walls. It was a quiet room attached to a kitchen. The size of the room was about four metres by six metres square. An extra seat was brought in from another room.

All participants had the opportunity to read the plain English language statement prior to the focus group meeting. I commenced by welcoming them and thanking them for attending. I then proceeded to have each of them to sign the consent forms and confidentiality forms. After this, I gave a quick brief about the objectives of the focus group; the rules of the focus group were also discussed at this stage. All participants were encouraged to speak but to try to speak one at a time. They had to speak facing the recorder so what they said could be captured efficiently. They also had to call out their names every time they had to say something. This was useful during transcription. This occurred most of the time but not all the time. All participants seemed to have taken part in focus groups and research before. This made it easier to run this focus group.

The focus group lasted just over an hour. However, one person had to leave half way through the focus group because of other pre-organised commitments. This participant requested me to contact her by telephone if there were any further issues or questions for her to answer or clarify. The need for this did not arise.

Focus group two took place in the sitting room at the residence of one of the female participants. All the women in attendance had been given information about the research prior to attending by an acquaintance of the researcher. The room where the focus group was held was well furnished and had a big plasma television. Heavy cream coloured curtains lined about a third of the room and three sofas were available and could sit up to ten people; a central coffee table and three corner stools also featured in this room. It was a very impressive room in the house. The television was in Arabic (cable), and we all agreed to turn off the television prior to the focus group commencing to avoid distractions.

I commenced by welcoming the women, briefing them about the research and explaining the rules of the focus group to them. All women were encouraged not to speak over each
other during the discussions and to call out their names every time they were to say something. We went on to sign the confidentiality agreements and the consent forms. All the women had signed some form of a contract or something to do with confidentiality in the past. It was easy to explain and to be understood why I required their consent prior to commencing the discussion. The women knew they could withdraw their consent at any time without any consequences.

Some participants were more vocal than others, thus I had to keep encouraging the ‘quiet’ participants to contribute. Prompts were used throughout the discussion process. I also used this focus group discussion to check some of the information I had heard from previous in-depth interviews. This usually happened through prompts when a similar issue came up during the discussion. All the women were interested in the topic and contributed to their best abilities. One thing that stood out was that when women got excited, they would speak in Arabic or Dinka among themselves, then I would have to stop them and ask them to say it in English, or sometimes they would realised I did not speak Arabic or Dinka and would quickly regress to English. The rationale given by women to me was that they were used to speaking in those languages to each other and so without thinking would just slip back naturally into their mother tongue. All women spoke English.

The focus group commenced an hour late but this did not pose any problems to the researcher; I had expected an even longer wait. Overall, the focus group discussion was a success. All interviews and focus group discussions were audio taped and transcribed verbatim, notes taken and reflections written later on.

**4.13 Data coding and data analysis**

Data were analysed using thematic analysis. In QR, data analysis commences at data collection as opposed to quantitative data analysis when the analytic phase commences at the completion of the data collection (Pope & Mays, 2006). I also used NVivo, which is a computer software developed to be used by qualitative researchers. NVivo was used in conjunction with manual data analysis.
4.13.1 Data coding and coding framework

Coding commenced as soon as data transcription had started. Audio recorded interviews were transcribed verbatim. Coding, sorting and organising data remains an integral part of thematic analysis (Pope & Mays, 2006). The researcher listened to all interviews at least four times. I read the transcripts over and over to familiarise myself with the information and for understanding (Polgar & Thomas, 2008). In order to make sense of the data, I searched systematically for re-occurring words, some of which later became code words. Open coding was followed by axial coding, which is more specific and rigorous. The researcher coded and recoded the data as the system developed (Neuman, 2011; Pope & Mays, 2006). Re-occurring code words were then grouped together as their meanings emerged to form themes. The data were then further grouped into themes until all themes have been accounted for throughout the data (Pope & Mays, 2006; Liamputtong, 2009). Information that the researcher did not deem useful was not coded. The researcher made sense of the data through interpretation and ‘sifting’ through the data systematically (Pope & Mays, 2006; Polgar & Thomas, 2008).

4.13.2 Computer-assisted data analysis

NVivo software was used in conjunction with manual coding during the data analysis process. Large and complex data sets can be difficult to manage manually. Using computer software requires time, resources and may use modernist assumptions (Liamputtong, 2009). Nonetheless, computer-assisted data analysis allows: flexible use of electronic codes, clear links between selected segments of texts and larger transcripts, easy search methods and the ability to use statistical counts for key words and codes (Liamputtong, 2009; Neuman 2012). I imported transcripts into NVivo and coded the data using an initial coding framework. The coding framework was revised during the analysis process, as new themes emerged and issues were clarified.
4.14 How much data is enough and how much data was enough for my research?

The question about the amount of data that can be considered enough or complete for a qualitative study has been answered by Neuman (2012) as ‘it depends’. After being in the field for a certain period of time and collecting data from various sources, at some point the researcher may reach saturation point where they are hearing the same information and no new information is emerging (Morse & Field, 1995). However, the concept of saturation has been used by researchers to justify small and thin samples (Charmaz, 2005). For this research, I did not depend on saturation alone; I used saturation in conjunction with other criteria. Charmaz (2005) advocates for the following criteria to be used rather than saturation alone: credibility, originality, resonance and usefulness.

**Credibility.** Data is deemed credible when the researcher is familiar with the topic and the research setting and has sufficient information to merit claims made in the research; there is sufficient information that a reader can make independent assessments, which then leads the reader to agree with the research findings. I interviewed 16 women who had experienced TP and solicited more information through interviews with SP who worked and supported African teenagers, their families and other migrant families. I further conducted a focus group with African mothers and four out of the six participants had themselves experienced TP and early marriage. The second focus group, which consisted of SP, had two participants of African backgrounds who had inside knowledge about TP and African culture.

**Originality** offers new categories, new insights and the research attempts to challenge, add to and/or refine current ideas, concepts and practices. This piece of research is original in nature; I collected all the data through in-depth interviews and focus groups and the findings will bring new insights, ideas and knowledge about TP, African culture and motherhood among African-Australians in Melbourne. Credibility and originality will increase resonance and usefulness (Charmaz, 2005).
Resonance here refers to the researcher being able to depict in-depth what has been studied. The researcher is able to make links and show relationships between the individuals and categories studied while making sense of the data after interpretation, at the same time providing insight into the lives and the world of those studied. This I demonstrate in my data analysis chapters and the discussion chapter. Finally, the findings should be useful to the participants, their communities and others, including researchers and clinicians. The analysis should provide information for further research in the discipline, provide hidden social justice implications and contribute to knowledge. The findings from this research could be used to inform policy makers and healthcare practitioners about the issue of TP among African-Australians, and further suggest ways to support teenagers in a culturally acceptable manner.

Diversity in a research sample and methods strengthens the quality of the research and is good evidence for practice (Daly, Willis et al., 2007). I collected data from people of diverse backgrounds who had lived in different settings within and outside of Africa. Some of the countries they came from or had lived in were Ethiopia, Liberia, Libya, Egypt, Sudan, Guinea, Burundi and Kenya. The participants’ ages ranged from 17 years to 74 years; they were of male and female genders, and of Christian (various denominations) and Muslim backgrounds. Participants came from different walks of life, including teachers, nurses, doctors, bicultural workers, community workers and hospitality workers, and others were unemployed. Such diversity provides more credibility, making it possible for the data and research finding to be triangulated (Cresswell, 2013). Triangulation brings in different voices, people from different backgrounds, ages and walks of life (Denzin & Lincoln, 2005).

4.15 Rigour and trustworthiness

Rigour was maintained before and during the interview process through the application of ethical principles. Rigour in research commences at the design stage. For example, the instruments designed and tested with a SP prior to being used. The data were collected using focus group discussions and in-depth interviews. Focus group discussions were
conducted with KI who were SP, and women of African background who were refugees. The background of the SP was diverse; SP were of African, Anglo-Australian and English backgrounds and some had come to Australia as refugees. The in-depth structured interviews were conducted with some SP and AATs. The sample and participants in both focus groups and in-depth interviews included people from different cultural and ethnic backgrounds, Christians and Muslims, male and females and their ages ranged from 17 to 74 years at the time of interviews (Daly, Willis et al., 2007; Neuman, 2012). Using mixed methods and diverse samples ensured that the information that I gathered was rich and represented the views of a diverse group of people. As previously discussed in this chapter.

Participants knew and were reminded at the commencement of interviews and focus group discussions that it was not compulsory to participate. A participant could opt out at any time during the interview process if they wished, without incurring any repercussions. Participants were also given the choice to not answer a question they felt uncomfortable with. While none of the participants terminated any of the interviews, some participants did not answer questions in relation to their sexual experiences that they felt uncomfortable with. This sometimes occurred when the participant felt it was too intimate to describe, and in some cases when they felt it was not a very good experience. Other participants found discussing the same issues with the researcher quite beneficial as she was not judgmental about their behaviour but instead tried to understand why they made certain decisions.

The data were transcribed verbatim, and all transcribed data were made available to my supervisors during the data collection stage. I listened to the digital recordings several times and cross checked all the information with the transcribed data. I have read the transcribed data several times. While reading my transcribed data and when listening to my digital recordings, I wrote down key words, some of which later became code words. I used open and axial coding in conjunction with a deductive theoretical approach (Annells & Whitehead, 2007; Bryman, 2008; Neuman, 2012). Themes were developed based on the research aims and research questions and new emerging themes were identified and are reported in the results and discussion chapters of this thesis (Annells & Whitehead, 2007). Drawing on the cultural competence framework and my own African heritage, I ensured
respect for the participants, acknowledging their cultural capital and background was maintained at all times. This remained an integral part of this research process. This cultural competence framework was used in conjunction with the phenomenology.

Phenomenology as a QR method is designed to elaborate on a phenomenon and open an avenue where participants experiences and phenomena can be explored, which may otherwise would have gone unnoticed or overlooked (Whitehead, 2007). Whitehead suggests that instead of making assumptions, meanings are revealed when phenomenology is used while at the same time providing rich descriptions that help the researcher to make sense and understand the phenomena. The issue being researched was that of contraception, management of fertility, TP, motherhood and culture. The AATs were able to describe and narrate their experiences of TP and motherhood, including their life leading up to the time they became pregnant. SP provided insights of their experiences interacting, working and supporting refugees and young people of African background in Melbourne. The mothers had rich insights into the experience of being a refugee, a parent, or relative of an African teenager, some of whom had experienced TP. Mothers had insight about African culture, pregnancy and motherhood.

A phenomenological approached was deemed most suitable to solicit the information I required. Most importantly, the phenomenological approach allowed the participants to tell me their stories and experiences as they understood it and for me to be able to capture, write and make meaning of their behaviours, choices, decisions and experiences as intended by them.

A cultural competence framework that informed this research enabled me to interact in a culturally appropriate manner with the participants at a trusting level, while maintaining an acceptable distance at the same time. My own cultural knowledge and heritage was an added advantage. I have discussed this in detail in the insider/outsider section above. As an African woman, I was knowledgeable enough about the different cultural groups and how to interact with them in a respectful manner without compromising my position as a researcher. For example, I did understand that women might be late for appointments for
periods of up to one hour or more because of family responsibilities. Most of the women have large families of four or more children, when compared to the average Australian family with one or two children. For the English and Australian background participants, I was able to understand their cultural perspective based on my own background as an educator and a healthcare provider, and my exposure and interaction with Anglo-English Australians at work and within my own family context from my husband and in-laws. In addition to this, I could relate and communicate information with all participants at a professional and cultural level and context easily. The outcomes from this in-depth discussion are reported in the results and discussion chapters of this thesis. As stated earlier, rigour and validity for this research was maintained through the use of diverse research approaches and frameworks, specifically cultural competency and phenomenology.

4.16 Ethics considerations and confidentiality

The VU HREC provided ethics for this research: Ethics Application—HRETH 09/77. The memos for this grant, including other information about the questionnaire and participants demographics, are in the appendix section of this thesis. Consent was obtained from all participants. All participants were provided with a consent form and a plain English language statement explaining the details and significance of the research. Participants were informed that they could withdraw their consent at any time during the interview. Participants had a right to decline to answer any questions and also to ask the researcher not to use any information they had provided.

All participants had to sign a confidentiality document stating they would not discuss what was said in the interview or in the focus group at the completion of the interview or focus group. Privacy was very important, considering the topic is very sensitive and personal. Confidentiality and consent forms had to be signed by all the participants at the start of the interview. All participants have been given pseudonyms to ensure and maintain confidentiality of participants. No information that could identify a participant is included in this research.
4.17 Summary

In this chapter, I discussed the theoretical framework for this research. I discussed my position as an insider/outsider researcher, and the theoretical frameworks underpinning my research. I went on to elaborate and discuss how the sample was selected and how the participants were recruited. The exclusion criteria were also discussed. The section that followed covered the development of the research instrument, and its use in the research. In the last section, I discussed data collection and data analysis. In that section, I provided information about the credibility and trustworthiness of my research and the rationale for ceasing data collection. In the next four chapters, I analyse the data I collected.
Chapter 5: Gender, Culture and Fertility Regulation

5.1 Introduction

This is the first chapter of my research analysis. The chapter focuses on the gender roles and reproductive experiences of AATs living in Australia. I start by situating the girl in the traditional African setting where there are expected roles for men and women. I then describe how gender roles are created in the family and the community. I detail the type of behaviour expected from females and expectations about marriage. This chapter provides an account of the challenges faced by African parents and AATs in transferring cultural and social capital into the Australian setting. By cultural and social capital, I refer to the belief, values and networks that these migrants bring with them. I discuss the institution of marriage in the traditional sense, the role of marriage and the place of the woman within the institution of marriage. What marriage means to the girl and her family, the expectations of the girls, family and community before and after marriage, what she can and cannot do within this institution and procreation are also discussed. The last section describes fertility regulation, out of wedlock pregnancy prevention and management of unwanted pregnancies within traditional settings.

5.2 Gender, culture and marriage

5.2.1 Orientation towards obedience and marriage in countries of birth

Girls in traditional society are raised to be submissive and obedient to their parents, brothers, extended family members and the broader community. Girls have to be seen, not heard and girls listen to what they are told and follow instructions without questioning. The girls are orientated towards unquestionable obedience and submissiveness.

Yeah. You have to listen to the man, everything he says you have to say yes.

(Daniella, AAT)
Independence and asking questions are not encouraged, and dependence on the males is nurtured and fostered. The expectation from parents, the family and the community is that the girls will take such behaviours and apply them later on in future partnerships and relationships. This regulation and orientation towards submissiveness apply to what the girl can do, who she can interact with and to are clothes.

In my country you have to respect the men and you have to listen to whatever he says. For example, like if he said, ‘I do not want you to go out, I do not want you to wear shorts, or that woman is bad I do not want you to handout with her.’ If you respect him and you love him and want to stay with him, you have to listen.

(Ayuba, AAT)

There are feelings among AATs and women that these current attitudes do not allow women’s freedom. AATs and African women refer to ‘the good girl’: she is very quiet and obedient. A good girl is expected to bring the qualities of submissiveness to her relationships and a good girl is expected to raise the profile of the men in their lives without questioning. Rules are enforced and gender roles are clearly defined. Good girls and women play a supportive, subordinate role to their partners. The woman’s roles are domestic based and her duties include, cooking, cleaning, housekeeping bearing children. Elisa, a health professional of African background, described the ‘good’ African girl’s conduct and women’s roles within the traditional paradigm as follows:

A good girl in the African sense, [in country] is someone who is first and foremost obedient. You have to listen to your mother, you have to listen to you father, you have to listen to anyone who is older than you. They’re wiser and they know more and so you must listen to them … our community is also very role orientated, whereby the men play a specific role and the women also play a specific role. The girls want to be like their mothers and the boys want to be like their fathers. There can be that misconception of domination, whereby the young women, ‘You stay home, you cook and you be a good girl,’ and for the boys, ‘I will come, provide and do all of that.’

(Elisa, KI/SP/RN)
A good girl should behave in a manner that is acceptable to the family so as not to bring shame to them and the community. She is not only selfless and obedient, but works hard and is a good homemaker. She goes to school if the family wants her to, and does not attend social functions or engages in behaviours that are usually perceived as normal among teenagers.

The good girl always she has to go to school and then all the time goes to her house and stay at home. Don’t go to the club and don’t go to a lot of parties and respect yourself. No hanging out with men. That is to respect yourself; you don’t need to be hanging out with men.

(Honorine, KI/AAT)

Such gender roles and societal expectations are imposed on girls and women because girls are seen as commodities and property, rather than people with equal rights deserving of equal status like their brothers and male relatives. Family members and the community members feel a sense of responsibility to direct and make decisions for their daughters, irrespective of what the teenage person actually wants. Nikki, a SP of Anglo-Australian background with extensive and significant interaction with African-Australians migrants and refugee girls and women, observed that:

Girls in a [country] community are seen as assets and they are sold for cows and are valued according to the price they will get for cows, and that if they have these kinds of relationships and have babies outside the relationship that the parents plan for them, then that devalues them … They’re coming from a very male dominated culture where they have always had the right to say what happened and the women just did it.

(Nikki, KI/SP)

This culture and belief that girls are family property are echoed by Jacob, a health SP of African background. Jacob discusses how families use girls as income in the form of dowries, leading to the poor treatment of girls. More so, once the dowry is paid to the family, the girl then becomes the man’s property and he may treat her as he wishes, often because she may not be able to return to her parents because they may not be able to repay the dowry they received for her.
I think people are failing to realise that the game has changed and the rules how they are applied in [country] do not apply any longer, or are not going to be applicable in a lot of cases. So the idea that the man will be with this girl until they get married is no longer going to work and that is the same with marriage. I argue with the [country] people that in [country] you may pay many cows to have a wife and she is yours forever, but you pay the same amount of cows in this country (Australia) and she is not yours forever. Not necessarily. So the rules have to change and people have to recognise this.

(Jacob, KI/SP/RN)

Gender roles and expectations are engrained in girls from a very young age within many African communities. While there are differences, there are many similarities too. For example, female circumcision, commonly referred to as FGM in the west, is practiced across many countries and cultures in Africa. Adorning bodies with tribal marks and wearing specific type of ‘jewellery’ are other common practices. Within this culture, the girl is orientated towards home duties and her future role of wife, mother and homemaker. Chelsea, an AAT, described herself, her character and the roles she had to play while in the refugee camp in Africa prior to migrating to Australia five years ago.

I used to help Mum a lot. I used to help. I was just in the house, working, ensuring to cook, cleaning and then get ready for school. I decided for myself, I don’t want boyfriend. I used to hate men; I didn’t like men at all. Even to stand next to them, no. I used to say to myself, ‘I want to have sex when I’m married. I want to be a virgin and have a husband.’ You know what I mean?

(Chelsea, AAT)

Chelsea arrived in Australia from Africa when she was 14 years old. All she had known and had been orientated to do was complete obedience, and to reserve herself for her future husband. All this changed after Chelsea arrived in Australia and she is now a mother to a daughter and not married. She had a boyfriend who promised her that he would marry her. She trusted him but this never eventuated. In the course of restricting girls, the culture inadvertently limits teenage girls’ ability to respond to males when interaction does occur. Unfortunately, these restrictive behaviours imposed on the females are not applied to the boys in a like manner. Josephine sees this as double standards:
It is different for the girls. For example, if the girl takes a step everyone is going to talk about her, but if he takes two or three steps, no one cares. Why? Because he is a boy and she is a girl.

(Josephine, AAT)

It is not only the freedom of movement that males have over their female counterparts; boys are less restricted and are not punished when they do engage in premarital sex. In addition to this freedom, concurrent sexual partnerships are condoned for boys by the community. A female who decides to have sex freely or chooses to have serial sexual partners is considered of low morals by her family and community, because it is seen as an abhorrent act, and such a girl only brings shame and disrespect to her family. Bikutsi describes the attitudes of parents towards sons and male behaviour:

The boys are free, are okay. The boys can play, can play with my son, with another girl and sleep, it’s okay. But my daughter can’t. Someone else can’t sleep with my daughter. So for us the boys can have five women but the girls can’t have many boys and men.

(Bikutsi, KI/AAT)

Restrictive dress codes are further applied to females, not males. Pants and shorts or what are deemed not covering enough re not allowed. This is because your character and person is closely associated with your outward appearance in traditional society. Decency is fostered and nurtured in girls.

The way people dress and the way you are perceived—perception is a big thing. So wearing short skirts or skimpy clothes is not allowed. You must be respectable and look decent at all times.

(Elisa, KI/SP/RN)

And the clothes, you have to cover your boobs and cover even all your legs. And you don’t need to tell the old people [elders and parents], ‘I don’t care.’ They don’t want that in the culture back home [Africa].

(Honorine, KI/AAT)
Some teenagers choose to follow the western dress style. A school principal’s observations about these choices is noted below. In all, the school principal was not pleased with the manner in which the girls presented themselves.

Education about how young African girls present themselves, they tend to present themselves in a very highly sexualised way. For example, when we had a day in school, and all the students had to dress informally, the African girls wore very tight and revealing clothes, many exposure.

(Elizabeth, KI/SP, school principal)

5.2.2 Virginity

Religion plays a significant role in the day-to-day lives of many African people. Religion has been described as a way to control girls and to prevent them from engaging in premarital sex and also to prevent TP. Religion and traditional African society advocates for virginity before marriage, abstinence from sexual relations outside of marriage and chastity. This section focuses on religion and religious influences in the lives of AATs and how society treats them if they maintain these traditional values or move away from them.

Family and friends celebrate the virginity of the girl after marriage.

Because it’s a cultural and religious experience. Even settlement issues affect how they perceive things like contraception ... The difference is a few Muslim communities regard that as a prohibition—like they shouldn’t be using it—and then some find it quite empowering.

(Chantal, KI/SP/RN)

Because I believe in Muslim [Islam]. I’m a Muslim. It’s not good. And then one of the problems is if you’re a virgin and get married your family gets reward. Your husband and family come to a big party and everyone talks about you. ‘Hey, she is a virgin.’ When she gets married … its very funny [laughs].

(Chelsea, AAT)

Having blood stains on the sheets after the consummation of the marriage and a girl’s virginity is not information constrained to the husband alone; the external family celebrate
when there is blood after the marriage has been consummated. The blood is evidence of the proper upbringing of their daughter.

Because when you marry the man, the man need to see blood, because they need to know that no one done [sex] for you.

(Akot, KI/WFG)

The parents too [need to see blood after the first sexual intercourse].

(Christina, KI/WFG)

While the view that the girls need to be virgins at marriage is supported by many AATs and women, there are neither checks nor expectations on boys to remain virgins until marriage. The boys are free because they’re boys. They do whatever they want.

(Carmen, AAT)

Other boys’ kid, kid here, kid here … they know but they don’t care what they are doing.

(Fiona, KI/SP)

Within a society and culture where many girls and women are made to view themselves as the lesser class and are made to believe that women need a male partner to support them through life, it can sometimes make it almost impossible for females to negotiate safe sex, and so reduce their risk of unwanted pregnancies. Jacob, a SP of African background, talked about the difficulties they have trying to get young African men attending their services to use condoms. Basic normal daily activities, such as asking a new male sexual partner to go for a check up or use condoms to prevent pregnancy or protect yourself against STDs, is almost an impossibility for some girls and women within the African community.

Because you can’t trust other people. If you tell them, ‘Can we go and check you?’, they say ‘No, if you don’t want me then I’ll leave you.’ That’s what they say and then the girls they can’t believe he’s going to leave you so, no, they’re going to trust what the man say.

(Fiona, KI/SP)
5.2.3 Marriage and procreation

Marriage in traditional African society is primarily a union between two families; this precedes the relationship between the parties to be married (personal communication by Sudanese elders, 2007). This is similar to other African cultures, where families play a significant role in negotiating marriage partners and the payments of dowry and bride price (Manda & Meyer, 2005). The parents play a significant role in selecting the spouse and a lot of attention is given to each of their family’s background. The man is expected to ask for the girls hand in marriage through her parents and grandparents, but often this is done through the father, the uncles and other males in the family.

For the most part, our parents play a huge part in who our spouses are, so you coming home with boyfriends is essentially not good. They would like to control the situation and do most of the introduction because it involves uniting families. Our parents want to know who the person is, where their family is from, how good is that family, and all that stuff.

(Elisa, KI/SP/RN)

Someone comes to your door, knocks your door and tell you I am here to ask you that they want to marry your daughter. Then you tell them ‘Okay, give me the time,’ and then you check the background, this is a good man.

(Akot, KI/WFG)

Girls get married at an early age to ensure they can bear children and do not risk any problems of age-related infertility. Marriage is primarily for procreation and the use of contraception is unwarranted.

In [country] you would just have to marry when you are like 14 or 15. There’s no need to get these things [contraceptives].

(Francisca, AAT)

Early marriage allows the woman to start procreating early and to be able to have many children. Due to the desire to ensure virginity at marriage, early marriage is encouraged as this is thought to reduce the risk of girls engaging in premarital sex.
Because in Africa a lady has to be a virgin to get married and when you’re married you can have kids as much as you want, but here you can’t. Nearly 50 per cent of them aren’t married and are having kids. A lot of people think they can protect themselves by taking pills but sometimes it’s not true. People forget to take the pills and still get pregnant.

(Alimatou, AAT)

When AATs become pregnant out of wedlock, their ability to marry is highly diminished. Marriage and childbearing remain an important aspect of the African woman’s life. Pregnancy diminishes the family’s ability to make ‘appropriate’ decisions on the spouse. As revealed by one AAT, ‘When you are pregnant, there is nothing much the family can do, because the baby is there and they will let you go.’ This can bring significant challenges and consequences unto the teenager and her family.

Our community is also very role orientated whereby the men play a specific role and the women also play a specific role. The girls want to be like their mothers and the boys want to be like their fathers. There can be that misconception of domination, whereby the young women, ‘You stay home, you cook and you be a good girl,’ and for the boys, ‘I will come, provide and do all of that.’

(Elisa, KI/SP/RN)

Females are perceived to be weaker than men and require a man for guidance and protection always. These attitudes and behaviours are nurtured and supported by a culture whereby there are distinct roles assigned to the males and females gender, but also teaches that women always need a man to ensure inclusiveness.

Because they try to show you that you are different and you are weak.

(Honorine, KI/AAT)

Girls from many African cultures are from an early age orientated to be like their mothers, submissive and obedient, while the boys are orientated to be like their fathers, strong and independent. Procreation becomes an ultimate desire for all girls. Traditional measures are put in place to ‘protect’ females and regulate when and how they procreate. In the next section, I discuss traditional fertility regulation.
5.3 Regulating fertility traditionally and perspectives on western methods of contraception

In traditional settings, fertility is regulated using different approaches other than western methods of contraception. Sex in many cultures remains primarily for procreation than for pleasure, although people still have sex for pleasure and this view continues to change. In western societies, it is recognised that sex is for pleasure, then procreation, and this can be evidenced by high birth rates in Africa and low birth rates in western countries (WHO, 2012), although the people in both settings do have sex. Thus, in these two very different settings appropriate measures are in place to ensure that the primary aim of sex can be achieved; sex is for procreation and enjoyment primarily and respectively.

In western societies, the oral contraceptive pill, condoms and other modern methods of contraception ensure women can enjoy sex and have as many relationships they may want to before and within marriage, without becoming pregnant if they do not want to. The use of contraception is accepted, encouraged and is seen as the norm, even among teenagers in western society.

Most African migrants in Australia are influenced by their cultures, religions and traditions. Traditional beliefs and values do not encourage nor accept that teenage girls use contraceptives or engage in premarital sex. More so, parents do not want to be seen as encouraging their daughters to use contraception, as this is interpreted as supporting and encouraging them to engage in premarital sex; behaviour perceived to be un-African. Teenagers engaging in sexual acts are accepted and acknowledged, but the context in which this occurs is important. Traditional societies have processes and systems in place to ensure that the context in which sex occurs is culturally acceptable, while at the same time fostering procreation. In traditional societies, pregnancy has been prevented for generations using traditional methods and strategies, such as abstinence, and out of wedlock pregnancies through strategies like early marriages, arranged marriages and FGM. In the following sections, I present traditional methods discussed by participants to regulate fertility and valued by traditionally orientated African-Australians.
5.3.1 Virginity maintenance

Virginity is highly valued and encouraged in traditional African societies. Girls are prevented from engaging in any sexual activity, especially sexual intercourse, until marriage. The teenagers are indoctrinated with the belief that sex before marriage is wrong, and is not a righteous act.

In my culture this [premarital sex] is wrong. Every girl knows if you do sex before marriage it is wrong, every girl knows, so when you grow you know you do not do it.

(Christina, KI/WFG)

Having sex before marriage is forbidden, so having a baby out of wedlock is extreme … I know a few cultures where they find abstinence being the most effective way, and that is the most effective way of being protected, in fact.

(Chantal, KI/SP/RN, Muslim)

5.3.2 Religion

Religious teachings are one of the main instruments used by parents to teach their daughters about sex. From an early age they are taught that sex before marriage is wrong in the eyes of God. Using religious teachings, girls are indoctrinated to stay pure until marriage.

In Islam, when you have to stop pregnancy, you have to tell her about God; you tell her that if you do that God will be angry with you, use religion.

(Christina, KI/WFG, Muslim)

Due to the close connection between religion and culture, both are used to enforce the parent’s and religious teachings.

Culture first and religion; In Islam and Muslim when you are pregnant before you are married haram (sin).

(Laura, KI/WFG, Muslim)
Children will normally respect and listen to their parents. Thus, these religious teachings and laws from parents are acknowledged and accepted by AATs, even if they end up moving away from them. AATs accept that all girls should refrain from premarital sex in order to remain pure in God’s eyes. They believe that those who break these laws will be punished by God here on earth, or in their afterlife. This is a punishment AATs do not want but do accept and acknowledge.

In the Koran, you have to be married before you have a baby. Even sex, you’re not allowed to do sex with any men until you are married, and if you are, there is a punishment your family have to give you before you die. If they don’t give you the punishment before you die, you’ll still get the punishment from God. So it’s very bad for us. The punishment is this special … it’s like lashes.

(Chelsea, AAT, Muslim)

Religious teachings and traditional beliefs underpin the actions of AATs and their families and using these religious teachings, traditional societies are able to plan and regulate fertility in a manner acceptable to them. This is a view shared by both Christians and Muslims.

Premise that there is no sex before marriage either cultural or religious.

(Jonathan, SP/FG, bicultural worker, Christian)

Modern methods of contraception are considered against biblical and Koranic teachings. Girls are brought up not to believe in modern forms of contraception, while married women already believe that contraception is prohibited and is against their religious beliefs and values.

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.’ It’s more, in their view, a religious matter..

(Chantal, KI/SP/RN, African background)

While religious teachings are important in ensuring virginity because it encourages abstinence, AATs find themselves in a situation they find hard to navigate. Religious
teachings are normally incorporated and enforced using other traditional practices (which I describe below), which is either missing or lacking in the Australian setting.

**5.3.3 Abstinence and early marriage**

Abstinence from sex before marriage is encouraged by both culture and religion. Early marriages are encouraged and nurtured. The young women are informed from a young age that they are not to engage in any form of sexual activity until marriage. This view of abstinence is shared by SP and KI of African background and AATs.

Abstaining from sex until you get married … you are told it’s abstinence, abstinence, abstinence. You’re not supposed to be having sex at all so there’s no option.

(Elisa, KI/SP/RN)

Something they agree with and confirm is that in their countries of birth they would not be having premarital sex.

If I was in [country], I wouldn’t be having sex with a man before I got married.

(Alimatou, AAT)

So the girl, she should abstain until when she gets married to have sex.

(Honorine, AAT/KI)

Age at marriage in Africa and in very traditional orientated and religious settings is low compared to Australia, though differences exist depending on level of education and location, with girls in school and those living in cities with higher socio-economic status less likely to marry early (Dennison & Hadley, 2005). Girls are married as they approach puberty or immediately they reach puberty, before they have the opportunity to engage in sex with someone other than the husband.

In [country] they (teenagers) will surely be married, except if they are in the capital city studying or doing something … for example, my mum she married at 15; that is very young age to get married. But she was not at school.

(Candida, AAT)
Abstinence before marriage is thought to ensure that the girls are at low risk of contracting an STD or any infection that may render them infertile. Early marriage further ensures that child bearing will commence early and the young woman will have a longer fertility period as a married woman bearing many children for her husband.

Because in [country] a lady has to be a virgin to get married and when you’re married you can have as many kids as much as you want … if I was in [country I wouldn’t be having sex with a man before I get married.

(Alimatou, AAT)

Abstinence is perceived to be the proof to the in-laws that the girl has conducted herself appropriately. To ensure that she has not engaged in sex before marriage, the husband and his family has to see ‘proof’ of virginity. After marriage, when her husband and the in-laws, including the external family members see blood after consummation, it is confirmation that the teenager preserved herself for her husband.

Because when you married the man the man need to see blood because they need to know that no one done [sex] for you.

(Awel KI/WFG)

The parents also [want to see blood after the first sexual intercourse].

(Laura KI/WFG)

This is confirmation that the girl’s family raised her appropriately, and she will be able to replicate this same behaviour with her own children later on. It is not uncommon for the bride’s family to be rewarded or paid extra dowry as an incentive because of the virginity status of their daughter.

That’s the same way, because I believe in Muslims. I’m a Muslim. It’s not good. And then one of the problems is if you’re a virgin and get married your family gets reward. Your husband and family come to a big party and everyone talks about you, ‘Hey, [20:43] is a virgin. When she gets married … It’s very funny..

(Chelsea, AAT)
In summary, drawing from the above discussion, I argue that it is not easy to ensure and maintain the virginity of girls in isolation. It is achieved in collaboration with family, the community and other cultural systems in place. Abstinence is not only fostered before marriage, after marriage and childbirth, nursing mothers are encourage to abstain from sex with their husbands.

5.3.4 Abstinence during the post-partum and breastfeeding periods

Abstinence from sex has been used to regulate fertility for married girls and women, to plan the family and to space the children. During the post-partum period women, are forbidden to have sex with their husbands. Women are also prohibited from engaging in sexual intercourse when breastfeeding. Breastfeeding remains an important aspect of the lives of African mothers, and it is unusual for a woman to not breastfeed. The perception is if you have sex while breastfeeding, the breast milk will go stale. ‘Stale’ milk will render the baby sick, and worse, the child may die. Falling pregnant while still breastfeeding brings shame to the woman, her husband and the community. As a result, abstaining from sexual intercourse during the post-partum period and while breastfeeding is encouraged and most women respect and adhere to this practice strictly. The post-partum abstinence period normally lasts between six to 18 months but could be longer depending on the setting and the context. Women are perceived to be able to focus on the baby without the husband’s interference during the post-partum period and while they are breastfeeding.

Normally we don’t have contact with the man. We don’t have sex with a man when you breastfeed, because you don’t have contact with the man when you’re breastfeeding. So with my first son, he was born in 1998 and I stopped breastfeeding in 2000, so he was about two years and I didn’t have contact with the man all this time. And it was still the same with the other children as well.

(Honorine, KI, age 30)

While this may seem unusual, some women are generally pleased about abstinence during this post-partum period; it not only helps them plan and space their children, but keeps the men away and allows time to focus on the baby’s needs.
Then you are breastfeeding and he goes to the other women she’s [breastfeeding mother] happy.

(Madonna, AAT/KI)

Women sometimes manipulate traditional belief systems and practices to plan and space their children as they want. This is particularly the case when women do not receive the support they expect from their husbands. Breastfeeding is then used as an excuse not to have sex. In such circumstances, breastfeeding will be prolonged. Men do not have much control when it comes to weaning the baby, if the mother chooses not to.

When we came—we came in 1999[from country to transit country] and the child, he was about a couple of months and he turned two years and he wanted me to stop breastfeeding so he can get another child. I was telling him the life is hard, we need to swap with each other to run the house and to pay the bills and food, because I didn’t have time to have a child and the problems began from there. I didn’t know to go to the hospital and take the pills and nobody told me about it even so I kept doing everything the way they told me … Not to sleep with the man when you’re breastfeeding, so I was keeping breastfeeding the boy and he was two years old and he was calling me by the name.

(Honorine, KI, age 30)

5.3.5 Polygamy—men having more than one wife

Polygamy here refers to a man having two or more wives. The practice of polygamy allows the man to have sex with another wife during the post-partum period of another wife

Other husband … they get three women, four women, then you are breastfeeding and he goes to the other women.

(Madonna, AAT/KI)

My dad many [wives] … I think eight. My mum was number four.

(Francisca, AAT)

Where a man has one wife only, concurrent sexual partnerships are not uncommon and this practice is condoned by polygamous practicing cultures. The man turns to external sexual
partners, regular or casual for his sexual fulfilment during the wife’s post-partum period and when she is breastfeeding.

Some men they do find themselves a woman, or they go and get married. It’s okay for them to marry another woman.

(Honorine, KI, age 30)

Unfortunately, these external sexual relationships by men are not always ‘sanctioned’ by culture; that is, during post-partum or while his wife is breastfeeding.

Because when the doctor said to my husband, ‘Oh you can use condoms, it’s okay,’ he said, ‘No, she’s my wife so I don’t use condom. Condom is for street girls. So when you don’t like this girl and sometime you want to have sex, then you can have sex with condom.’

(Bikutsi, KI/AAT)

5.3.6 Arranged and forced marriages

Arranged marriages occur when the family makes the decision about whom and when their child marries. Arranged marriages normally take place when the girl reaches puberty or early adolescence and are seen as a means of preventing out of wedlock pregnancies. Parents will normally arrange the marriage of their children.

My dad told me to come home (from Uganda) to visit my grandma, then when I came they decided to give me to this man … we were just like neighbours, but not related. In our culture, it is the elders who decided. In our case, it was his grandmother who decided they were going to marry this lady (me). This was decided together with my father and my future mother-in-law.

(Faustina, KI/AAT)

It’s not only the parents who decide and arrange who the girl marries; external family members can make the decision on behalf of the girl’s parents. Awel, for example, was given to her husband when she was just 15; she had her first child at 16 and at 30 had six children and may have more. Below is what she said about her arranged marriage.

One uncle maybe shows the brother’s son … ‘See this girl, she is a good girl, I like. Maybe you can marry her’ … Like me, for example, when Thomas [her
husband], it is his cousin who sent the photo and said, ‘Look I find the girl,’ because he was looking for a wife. Then Thomas came from Libya and he married me.

(Awel, KI/WFG)

Regardless, the parents remain the key decision makers and have a lot of influence about the person and when their daughter marries.

For the most part, our parents play a huge part in who the spouses are … they would like to control the situation and do most of the introduction because it involves uniting two families.

(Elisa, KI/SP/RN)

The perception is that if the girl is not married by a certain age, usually in their early teenage years, the girl’s risk of engaging in extramarital sex is highly unlikely. An arranged marriage is seen as a way of preventing this from happening. For young girls, arranged marriages usually occur before puberty, or when the parents think the girl is at ‘risk’ of engaging in premarital sex. This view was shared by SP, KI of African background and African women, irrespective of religion.

Even arranged marriage, that’s been a way of controlling a girl [from] having premarital sex as well … Arranged marriage, yes. Absolutely.

(Chantal, KI/SP/RN, Muslim)

In country you marry when you are a teenager before you go to the street (to know street life [implying sex]), so you marry early.

(Christina, KI/WFG)

While arranged marriages are used as a method of preventing TP by parents and adults, teenager girls used the unintended outcome of TP to escape from arranged marriages. I discuss this in more detail under pregnancy intentions.
5.3.7 Fear and intimidation

Fear and intimidation were reportedly used by parents and family members while in Africa to prevent teenage girls from engaging in premarital sex. Such intimidation is used with the boys to keep them away from the girls, as the virginity of the girls at the time of marriage is important, as described earlier. Activities and initiation ceremonies that bring teenage boys and girls together have strict rules. Both sexes are intimidated and threats of death are not uncommon to ensure that the rules are not broken, and any sex does not take place.

I grow up in the village, but in the village we have freedom, like Australia. Like in the wet season, the boys and girls go camping without their parents but nothing (sex) happens because everyone is scared about their life. The girls are scared about their lives and the boys are scared … because when you married the man the man need to see blood [implying you are a virgin] because they need to know that no one done [sex] for you.

(Awel, KI/WFG)

Threats of life and ‘payback’ were commonly used by a girl’s family to deter boys from engaging in sex with their sisters and female relatives. If a boy was seen to want sex from a girl and with no intentions of having her as a wife, he was promptly told the same would be done to his sisters or close female relatives. Sometimes threats about taking his life were made to him and his family. This acted as a deterrent for males.

5.3.8 Watching over the girl

The entire family and community ‘watch over’ the girl in a traditional village setting. In such settings, extended family members live together in one household or close by. If relatives do not live in the same compound or close by, the neighbours and fellow community people will know the young people and their families. Members of the entire community have a responsibility to watch over and discipline the children, especially the girls, irrespective of whose children they are. This makes it difficult for any act, such as having a boyfriend, to go unnoticed or to escape the hearing of parents and relatives. As a result, boys but especially girls are deterred from engaging in romantic relationships for fear their parents will hear about it and the punishment they risk receiving.
In [country], Mum and Aunt and Uncle sometimes live together; if they are not living together they are neighbours; if not, they will not be living very far away, they all live in the same community or neighbourhood. Not like here (in Australia) … In [country] the girls are scared of the neighbours, Uncle, Aunty, and they will not do anything wrong, but here (Australia) they afraid of no one.

(Christina, KI/WFG)

These extended family members and community people do not only watch over the girls, but they constantly remind the girls of their roles and duties for the future, and the consequences of not abiding by what they are told. These consequences include lack of support from the family if she gets into trouble, for example, by becoming pregnant. In most of Africa, there is no social security for teenagers or young people; they depend on their parents and close relatives for financial support. Not adhering to the social norms and listening to parents and relatives places teenagers at high financial and social risk, a risk they will not want to take.

Because both parents, your uncles, all the relatives will put an eye on you and then they will tell you this, or if this happens, we will not be responsible for it unless you listen to us. We [parents] have a plan for your marriage. For example, if the boy says we don’t want you, we will take our daughter and the responsibility.

(Faustina, KI/AAT)

5.3.9 Strict tribal rules and curfews

Tribal rules or methods used traditionally to enforce and ensure that pregnancy is prevented or stopped outside of marriage include curfews and combination of methods like the community and family ‘watching’ over the girl. Curfews are imposed on girls when they reach puberty, so they do not have contact with other teenagers or anybody of the opposite sex. Activities are organised so that females spend most of their time with their mothers and other female relatives, while males do same with their male relatives. Female social activities are usually home bound and in groups, normally take place during the day; as a result, females are kept within certain boundaries.
In [country] you stay with your father and your mother, you don’t go anywhere … I don’t know. Don’t go anywhere. No boyfriend. No sleeping with the boyfriend.

(Madonna, KI/AAT)

When the girls are allowed to go out, there are strict guidelines about where they go and when they return home. There is usually a companion, often a trusted male relative of hers.

Come home by six o’clock for the girls, that’s what has always been happening, good girls come home at six o’clock … no association with boys, unless you are getting married … you must have a chaperone with you. If you are going out with boys that is a huge no-no.

(Elisa, KI/SP/RN)

5.3.10 Beating and hitting

Beating and hitting are used by external male relatives on teenage girls who are suspected of wanting to engage in, or have engaged in, premarital sex. When asked about the family’s response towards a teenage girl who is ‘suspected’ of wanting to, or has engaged in, premarital sex, there was an unanimous response from the women in the focus group about beating the girl up, with Laura saying:

You will hit her; the girl’s father and uncles will hit her, if you see her behaviour is changing.

(Laura, KI/WFG)

This view of beating girls and women in the name of discipline is acknowledged by teenagers as a common practice within their communities to straighten girls and women who do not listen. According to Daniella, when a girl or a woman does not listen to the man or males in her life, she is beaten up.

Of course straight away if they see you’re doing it maybe they beat you or something. That’s what happens … because you don’t listen to them. Yes, you have to listen to the man.

(Daniella, AAT)
Beating is used as a deterrent to other teenagers who may want to engage in ‘risky’ behaviours, such as premarital sex. It is not uncommon for the male suspect to be beaten as well by the teenage girl’s male relatives.

5.3.11 Forced unions to avoid shame and embarrassment

When all the above methods fail and it becomes obvious that the teenager is pregnant or at risk of becoming pregnant, a ‘union’ is organised by the two families for the young people. This is a strategy whereby the boy’s family together with the girl’s family bring the girl to live with the boy’s parents and she is referred to as his wife. The young people involved would normally have no option of refusing the union. While they may have been happy to be boyfriends and girlfriend, they may not necessarily want to be married or not just yet. Such an arrangement allows the girl to live with the boy and his family. This arrangement is in place until the family organises a formal blessing or an actual marriage ceremony for the teenage persons. This practice is thought to be used by African-Australians to deter other teenagers from love relationships.

For those that pregnancy may be suspected, the parents organise a marriage. Sometimes two people are liking each other and their parents might agree. Instead of them having sex behind our backs, why don’t we make it a formal acknowledgement? I don’t know if it’s a marriage but they do some kind of ceremony that they are able to have sex together—that is the religious way. So they can be married and are technically married and that can happen and they can have sex … most of the time there is no no. No option of saying no. There’s much pressure from family. There are big arranged marriage issues.

(Chantal, KI/SP/RN, Muslim)

Such an arrangement is seen in a positive light by its practitioners, because they argue it is for the future good of the girl and her children rather than for the immediate gain. Again, it is perceived that such a union prevents any embarrassment, humiliation or punishment on the part of the girl from her family and community if she is found not to be a virgin or is pregnant out of wedlock. Such unions help to send a message to other young people about what awaits them if they engage in sex outside of marriage or if a girl gets pregnant. Thus, forced unions are seen as a solution to an otherwise social problem.
We have to look and see how to fix this problem … help her to marry the boy or the man.

(Laura, KI/WFG)

While these rules may appear to be tough, the members of the practicing community think they are necessary. This is because it helps ensure discipline among the boys and ensures the males take responsibility for their actions. There is a perception among African community members that, as a result of their inability to maintain traditional ways of life in Australia, more teenage girls are becoming pregnant. This is interpreted as the boys having no regard for the girls’ bodies, but also the boys not having to take financial responsibility for the children. Unemployed persons only pay the minimum child support to the other parent, which is approximately 30 dollars a month per child, and they cannot be forced to pay more support for the children if they state they are not earning any income. It is not uncommon for an African teenage boy or some in their early 20s to have fathered several children to different girls, yet do not have to take responsibility for the children. As Christina, an African woman, said:

The boy may impregnate maybe one girl here [Australia], sometimes maybe three girls, maybe two girls at the same time, maybe four and many times, because he does not look after anyone.

(Christina, KI/WFG)

In Africa, he would have to marry the girls and to do so he would have to work and pay for the dowry. Although it is difficult to perceive the situation of a girl in such a polygamous situation, in traditional settings marriage remains one of the social security options and ensures inclusiveness of the mother and her children. Forced unions within these communities then become a necessity and are perceived to be a lesser of two evils. Short-term unhappiness from the teenager is perceived by the parents to be a better option for her and her children instead of leaving her as a single mother, often with no education qualifications, skills and/or a secured future.

5.3.12 FGM/FC and honour killing
FGM is a traditional practice whereby there is partial or total excision of the labia minora and labia majora; in some cases, this includes the excision of the clitoris in the female genitalia. There are different types of FGM, type I, type II and type III; the name or type of FGM depends on the severity of the procedure, with type I being the least severe and type III being infibulations (Ngum Chi, 2006). In traditional society, FGM is referred to as FC, traditional cutting or simply as circumcision. Here I refer to it as traditional cutting or circumcision. The main reason behind traditional cutting/circumcision is to ensure that the girl remains a virgin until marriage and to render her marriageable. In communities where circumcision is practiced, no man would marry an uncircumcised girl (Ngum Chi, 2006). Circumcision diminishes a girl’s sexual desires, so she preserves herself for the enjoyment of her future husband. As a SP from one of the African communities that practices circumcision stated:

Because if you cut off all their pleasure or sensitive areas in their genitals, then they will be less likely to seek sexual activities from somewhere else. And that’s how it’s being controlled. So now being illegal here, there is a big fear that these girls will be sexually active because they haven’t been circumcised and when they become teenagers they’ll have that feeling and will be more likely to seek sex … it is the norm, it is what everyone does and so it is not a problem for the people who do it. It is only when I came to Australia, heard about FGM and then went home and asked my mother what it was, and she told me even you [me] had it done but it was the simple one … but no one ever talked about it before because it is just seen as normal by everyone and every girl has it done so you can get married.

(Chantal, KI/SP/RN, Muslim)

Fortunately, some of the young men who come from communities that do practice traditional cutting, but were either born in Australia or grew up in Australia, are against the practice of traditional cutting. There is a culture shift whereby the young people want to make sure that their female partner enjoys sex with them rather than being there to serve the male partners sexual needs, worse still, to be a passive participant. These young men do not see the need for circumcision and, for some, why the girl should be a virgin at the time of marriage.

One of my colleagues said when she spoke to—because, again, this is regarding FGM—she said, ‘I’ve seen the transition of the different generation of African
communities.’ When she spoke to an older African man regarding FGM he said, ‘That’s part of our culture. We should do that,’ and was very positive for FGM and then when she spoke to this young African man they’d never heard of FGM and said, ‘What is that? Why on earth would a girl do that or why would someone do that to a girl?’ This is a [country] African boy. Then when the female worker said, ‘Do you know that she will be feeling less pleasure because the clitoris and the sensitive area are all cut off so she won’t feel it?’ He said, ‘Then I want to go with a western woman. I want to sleep with an Australian girl because if I have sex I want her to feel and enjoy it as well with me, because that’s a turn on for me. Instead of being with someone who is just laying down there’ … He said, ‘I don’t know why someone would do FGM or whatever cutting to a girl.’

(Chantal, KI/SP/RN, Muslim)

However, the above view is not shared by some young women. Instead some women, including teenagers, who see a ban on circumcision as an erosion of their cultural identity advocate for traditional cutting/circumcision to be restored. For these women and teenage girls, outlawing circumcision is perceived to be destroying traditional practice, thus eroding their culture. Traditional cutting to some is perceived to be a religious requirement and gives teenagers a sense of identity and purpose. SP and bicultural workers, especially those workers who share the same or a similar African heritage from these FGM practicing communities, shoulder the blame for trying to destroy a cultural practice that in this case was used to control women’s sexual freedom. The SP above, who comes from a community that practices traditional cutting, said:

They blame people like me. They blame that you are just destroying our culture, destroying our practice and you should be ashamed of yourself … Women, there were a lot of newly arrived [country women] who came here by marriage and they had a baby and told the doctors, ‘Okay, can you circumcise me the way I was before?’ And he said, ‘No, we cannot do that. We just do the basic cutting to get the baby out and fix it and that’s it.’ They were quite distressed and said, ‘I don’t know how to sleep with my husband anymore. Even going to the toilet for passing urine is quite distressing.’ The funny thing is the pressure is just in the women themselves. It’s not really the male that is pressuring. Its women pressuring each other. And FGM too; women are pressuring the girls to have FGM. Even though we do it a lot for the men, to enhance his pleasure of having sex with a cut person. At the same time, I understand why the women are enforcing each other to have
FGM, because in the past that’s the only way of having financial stability for the girls.

(Chantal, KI/SP/RN, Muslim)

Teenage girls risk being killed by their male relatives if it is known they have engaged in premarital sex. The girl may be killed as she has brought shame to the family. While honour killings may not be the custom in Australia, it is not an uncommon practice in some parts of the world, including some parts of Africa. However, the punishment is more severe for the females compared to males. This is because premarital sex is a sin and brings shame to a girl and her family and it is easy to detect and accuse females of engaging in premarital sex, especially if she is pregnant.

_Haram_, sometimes they kill you … sometimes they can kill the boy in [country], here [in Australia] nothing, no one can say anything no one can ask him.

(Akot, KI/WFG)

Within the focus group, this was contested among the participants. A Muslim practicing Sudanese woman stated that honour killing was not the case in Islam. However, Chelsea, an AAT Muslim stated that having a boyfriend in her culture and religion is unacceptable, and you cannot tell your parents you have a boyfriend; teenagers who dared, risked their lives. To its practitioners, honour killings are a deterrent aimed at preventing premarital sex and unwanted pregnancies among teenagers.

It’s cultural stuff. In [country] we don’t believe in protection, that much our family doesn’t want to hear that we have a boyfriend in [country]. We can’t tell Mum or Dad that we have boyfriend. Mum is ‘no, you’ll be dead for me.’

(Chelsea, AAT)

### 5.3.13 Abortion

Abortion is used as a contraceptive method by some teenagers and women in Australia. when faced with an unwanted or unplanned pregnancy. However, abortion remains an unpopular method of choice among African teenagers and women because it goes against religious teachings. As one of the SP expressed:
The girls, especially the Muslims girls, cannot be seen to have a child when they are not married; that is why you are not seeing any to interview. So I think they just quietly go and have an abortion. We have facilitated some, because they do not want their families to know they are having sex, not to talk of being pregnant.

(Chantal, KI/SP/RN)

There is an element of shame and stigma directed at pregnant unmarried girls and their families. The girls are perceived to not have conformed to expected traditional norms. Although abortion is highly frowned upon, it seems a better option to having a child out of wedlock. Religiosity seemed to play a role in women’s decisions to terminate a pregnancy. Having an abortion does not come easily for African teenagers. Abortion was not an option for AATs in this research; however, some had been informed by their teachers and health professionals about the option to terminate the pregnancy in cases when they knew about the pregnancy early on. Past events in AATs lives often influenced their decisions not to opt for an abortion. For Chelsea, it was the death of a teenager in a refugee camp after a botched abortion, coupled with the manner in which the teenage girl’s body was treated after her death that influenced Chelsea, a young Muslim girl, not to seek an abortion when she found herself pregnant years later in Australia, although she knew the challenges that lay ahead for her for having a child out of wedlock. Chelsea did understand that having a child out of wedlock was challenging, but the risks that came with abortion were even greater, according to her.

It’s the same consequences. You get pregnant without marriage it’s not good. Abortion is even worse, because you are killing someone, so that is more worse than keeping the baby. Some people prefer to keep the baby than doing abortion. And in the camp, one girl, she was pregnant and she was a Muslim girl and she got pregnant by a Christian boy, and then the Christian boy denied the pregnancy and then she went and drank something to get an abortion and then she die. So that one make many people scared in the camp. Everyone would say, ‘I’m not going to do abortion anymore.’ And then when she die like a Muslim. You do abortion and no one will touch you. They have to get someone to take you away, they can’t even bury you. No one will come next to you. So it was so sad. Her family members crying, ‘There’s no one to bury her… She [Nurse] just asked me, ‘Are you going to keep the baby?’ And I was like, ‘Yes,’ because for me I’m Muslim and we don’t do abortion and everyone’s like, ‘Yeah, abortion,’ because I don’t know if this is my last child or not. I’m going to keep this baby.
Abortions, also referred to as ‘washouts’, were more likely to be used by married women with children who are in ‘monogamous relationships’ with their husbands in Australia to plan their families, rather than unmarried nulliparous teenage girls. There was the fear among women and AATs that abortion could render them infertile, and they would never have children in the future, something they all want to do. Overall, abortion was not viewed favourably by women and the AATs, with none of them reporting having ever had an abortion in the past.

5.4 Summary

Religion and culture are intertwined in the lives of most African people. African girls are prepared from an early age for marriage and motherhood. Traditional gender roles, which advantage males over females, seem to hinder female independence but further disadvantages women in relationships in regards to their sexual health and decision making.

Fertility is regulated using traditional methods and systems, such as breastfeeding, abstinence during post-partum and polygamy. Women manipulate some of these practices in their favour to plan and space their families. TP is controlled using methods such as religion, early marriages and virginity at marriage. Girls who marry as virgins are highly respected and in some instances will attract a reward for their families.

Young African teenage girls are not empowered enough to resist pressure from males and to safely negotiate safe sex with male partners, which I can only attribute to early orientation of respect for male. The males do not necessarily respect the girls, again because of unequal gender roles favouring men. Forced unions are used to protect teenage girls who may have engaged in premarital sex, or are pregnant, from shame and embarrassment within their community. Abortion, while used by some African teenagers, is not a choice for most African teenagers and women with an unwanted pregnancy, with nulliparous African teenagers less likely to have an abortion as evident in this findings.
Young African men from FGM practicing communities are rejecting the practice of FGM; conversely, some young women from these same communities advocate for the practice to continue, as they see it as part of a long standing cultural and religious practice. Fertility regulation, preventing unwanted pregnancy, especially TP, are complex issues among people and cultural groups with high cultural and religious values.
Chapter 6: Contraception Knowledge, Myths and Relationship Experiences

In the last chapter, I discussed gender, gender roles and traditional methods of contraception and fertility regulation following settlement in Australia. This chapter focuses on knowledge of contraception and sexuality. The perceptions, attitudes and myths in regards to contraception by AATs and women SP are discussed. This is followed by an examination of the influence such knowledge and myths have on AATs contraception decision making. In the next sections, the focus is on sexuality, love, sexual coercion and risk taking on the part of AATs. A summary of the chapter is provided at the end.

6.1 AATs knowledge of modern methods of contraception

Most AATs had little knowledge of contraception and sexual health leading up to their pregnancies. Knowledge was particularly low about contraception before pregnancy. During interviews, when asked, ‘Could you tell me what you knew about contraception before you became pregnant?’ AATs responses included:

Hmm, I didn’t know anything I knew nothing.

(Josephine, AAT)

I did not have an idea, that’s why. If I had idea then we just use something.

(Veronica, AAT/KI)

Even for those with several children, their knowledge of contraception was almost non-existent prior to arrival in Australia.

At the time, I didn’t know anything at all … when I came [to Australia] I had my son [fifth child] and he was about nine months and we went to the doctor and the doctor asked me if I’m on the pill and I said I don’t know what that pill means and she explained it to me. I told him I never heard about something like that and she
said, ‘If you don’t do something about yourself you’re going to get yourself pregnant.’

(Honorine, AAT)

For some teenagers they did not only lack the knowledge about contraception; two of the teenage mothers did not know that by having sex a girl could get pregnant.

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, AAT)

Other AATs had heard about contraception after arrival in Australia from friends and the media. However, they did not understand how contraceptives worked and 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, AAT)

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 your self-getting pregnant.

(Kayla, AAT)

For those who learnt about contraceptives after arrival in Australia, they were often unsure if using contraceptives would affect their ability to have children later on in life. This lack of understanding acted as a deterrent for them using contraceptives.

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, AAT)

To some AATs, it was already too late for them to protect themselves since they were pregnant already. Antenatal visits were often the place where AATs heard about
contraception and its use for the first time. When AATs were eventually taught about contraception, they did not quite understand what it was all about and did not take the information seriously. For example, when I asked Ayuba and Chelsea what they knew about contraception and if they could tell me the names of some of the contraceptives they knew, their respective responses were:

What is contraception? I asked my midwife about it when I was pregnant, she told me about it. Later my doctor spoke to me about it … they said that I could use condoms or medicine, the other thing they put inside the body, (demonstrating with her hand that the thing is put in your arm) and I can’t remember the others.
(Ayuba, AAT)

Contraception is just like to prevent pregnancy, is it? It protects from something else and the injection … The family planning? … I didn’t take it serious, you know? I just buy it and put it in the house. I wasn’t seriously taking it. Condoms, I forget the name, implants? Because when I turned 17 or 18, I received a letter from the Women’s Clinic and have appointment with them. I went there, they have one counsellor and she tell me about the pills … Yeah, I forget to take the pill. And then they have one called the morning after pill you know that?
(Chelsea, AAT)

A lack of commitment was expressed about using pills on a daily basis and returning to the doctor every three months for injections depending on the method used by the teenage person. For AATs who were on the pill or other methods of contraception, there seemed to be a lack of understanding of why it was important to get new prescriptions prior to running out of the previous one.

Yes, I used the pills but then (silent) … I had a family doctor that told me about everything. I used to drink pills and then I stopped. I do not know but I kept forgetting that I had to take them every day at the same time. They just finished and I could not be bothered to go back and get more.
(Candida, AAT)

The injection for three months, I don’t know the name. And the pill … I like that about the contraception, because sometimes it can stop me from getting pregnant
and if they give me medicine for the disease and it’s good because there’s something to protect me. I don’t know a lot about that stuff.

(Jessica, AAT)

Teenagers lacked the knowledge about regular availability and accessibility of contraceptives in Australia. Some teenagers did not know that they could always go to their doctor for new prescriptions and that contraceptives were readily available for purchase at pharmacies in Australia.

No medicine [contraception] in [country]. [Country] not like here [in Australia].

(Madonna, AAT/KI)

In summary, AATs had limited knowledge of contraception prior to arrival in Australia. Some knowledge about contraception was gained after arrival, but this knowledge was often lacking and wanting. Lacking in that it was sparse, and wanting because the information was sometimes distorted or incomplete. Teenagers were not confident about their knowledge of contraception, how, when and why they should get new prescriptions and how often they should do so. Further, the use of contraception was directly associated with pregnancy prevention. STDs were hardly ever mentioned.

6.2 AATs’ perception of African parents’ knowledge and attitudes towards contraception use

AATs’ perception about their parent’s knowledge of contraception was that their parents were not knowledgeable enough and were not sure about what they knew about contraception. This meant it was difficult for parents to guide or support AATs in decisions making 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, KI/AAT)
To AATs, parents did not only lack the knowledge but were over influenced by their culture and belief systems when it came to contraceptive advice for themselves and their children. Culture according to AATs was always in the way of the parents’ judgments.

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—about boyfriends and stuff.

(Chelsea, AAT)

AATs thought that parents with negative beliefs about contraception go on to impart such attitudes and beliefs unto their children. Culture was the rationale used by parents to impart these beliefs.

Yeah, I knew I was on it but I did not take it serious … maybe a month or two or three months. I didn’t take it serious, you know? I just buy it and put it in the house. I wasn’t seriously taking it … as I said its cultural stuff the use of protection … Because if you talk to me I’m not interested, but if my mum tells me I think ‘Well, I think I have to listen to Mum.’

(Chelsea, AAT)

Parents have a great influence on the day-to-day lives of their children. As a result this had an effect on the attitudes of AATs towards contraceptive use.

I mean if their parents already said ‘Contraception is not a good thing,’ it’s not in their culture, then they will take that as part of it as well … They already have their culture in their head.

(Chantal, KI/SP/RN)

Not all AATs perceived that parents had negative views about contraception use. Positive influences on the part of some parents towards their teenage daughters’ use of contraception were noted by AATs. Some parents perceived contraceptive use to be good for their daughters. For example, Carmen has had a positive influence on contraceptive use from her mother. Carmen, a teenage mother of two, had implanon inserted and her boyfriend asked her to take the implanon out, which she did out of love and respect for him. But Carmen’s mother was not pleased about this decision when she found out about it. Due
to the support shown towards Carmen by her mother, Carmen made the decision to re-insert her implanon so that she does not become pregnant for the third time as a teenager.

My mum said it was a good thing, so I’m going to get it [implanon] put back in for a little while … they just think having an implant in I’m going to sleep around with other men and not getting pregnant.

(Carmen, AAT)

However, prior to becoming pregnant for the first time, Carmen, who had arrived in Australia at the age of two and had learnt about contraception in school, decided not to use contraception for fear of her parents finding out she was sexually active; something they eventually did when she fell pregnant. Thus, it could be said that the parents’ attitude towards contraception used by their daughters changed once their daughters had experienced TP, and when parents wanted to prevent further pregnancies from the same daughter or others children within their families.

In summary, AATs perceived that parents had little or no knowledge of contraception, and parents’ attitudes to contraception use were negative. Culture is the common reason used by parents to rationalise their decision not to support contraceptive use by their daughters. However, some mothers saw and continue to see contraceptive use as useful for their daughters; but this positive attitude happens after a daughter or a close relative has had an unwanted TP.

Males have a negative view of contraception, and for the men who do accept that their partners use contraception, it remains the woman’s responsibility to ensure she is up to date with her contraceptive. Using contraception is perceived to be a female’s responsibility alone, rather than that of the couple. Interestingly, there is little or no focus on preventing STDs and HIV/AIDS; the focus is on controlling the sex lives of females by the parents, boyfriends and husbands, with contraception use, if any, often directed at preventing pregnancy by AATs.
6.3 SP’s perception of African parents’ knowledge of contraception

SP perceived that parents (mothers) of teenagers and other members of the African community had little or no knowledge of contraception, including preventative health approaches in general. These views regarding African parent’s lack of contraception knowledge were shared by African SP and mainstream service providers, regardless of their gender.

During the focus group discussion with SP, Jonathan, a bicultural male worker of African descent, was quick to say ‘there is no knowledge about contraception … the knowledge is often not there anyway.’ Jacob, a male registered nurse of African descent with extensive knowledge and experience working with African migrants, said the problems about contraceptive uptake and use extended to encompass preventative health in general. The African migrants did not understand the value of prevention; people had the tendency to seek healthcare only when they were seriously sick and a problem was evident. Seeing a health professional like a nurse or doctor was a last resort to seek treatment and restore health, rather than to prevent and maintain health.

Even with parents and the grownups, when they first arrive, we’ve picked up numerous cases of STIs, so that means the use of contraception or condoms across the board is limited.

(Jacob, KI/SP/RN)

Ruben, a medical doctor who has extensive contact with refugees and the African community, supported Jacobs view, saying:

There is a cultural lack of interest in preventative health … there seem to be cultural barriers to getting messages across … there should be a focus on parents as well.

(Ruben, KI/FG/GP)

According to these SP, people normally visited a health facility or a health professional to seek help when they were sick, and often very sick. Thus, contraceptive use, considered preventative health, is not something a person who is well would go to consult a health
professional for. The consequences of such attitudes to healthcare include the unintentional spread of STDs, especially when they are asymptomatic, limited or non-use of barrier contraceptive methods, such as condoms, and unintended pregnancies.

Some of the SP had a different view about contraception use by African women. According to Chantal, a Muslim registered nurse of African descent, some African women, especially of Ethiopian descent, and those with higher education attainment, saw contraception as a liberating and empowering tool for women. The use of contraception according to these women, she said, was to be encouraged.

Some find it quite empowering. I think mostly with Ethiopian women they see it [contraception] as an empowerment.

(Chantal, KI/SP/RN)

This aspect of empowerment and positive views of contraception was not equally shared by men of African background, according to Chantal. To some men, she said, when a woman uses contraceptives, the perception is she can control when she has children, and how many children she wants. Contraceptive use provided the women with the power and ability to manage their fertility and to plan their families. This then led to feelings of loss, regret, lack of control and a sense of worthlessness on the part of the men. During our interview and discussion regarding contraceptive use by African women, Chantal said:

And disempowerment for the male as well … 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. It’s [contraception] more in their view a religious matter.

(Chantal, KI/SP/RN)

Trust is a vital aspect of any relationship. Like some of the mothers above, for some men, if their female partners decided to use contraception it was perceived that, they no longer trusted them and they wanted to be promiscuous. The perception was, the woman was having other sexual partners and did not want to fall pregnant or be found out.
Contraception use is viewed as loss of control by the man … yes it is a trust thing, but it can also be a controlling thing.

(Elisa, KI/SP/RN)

There was a level of distrust, fear and insecurity on the part of the men regarding contraceptive use. It was not only the men who did not trust their women using contraceptives, parents, including women, had the perception that contraception knowledge on the part of teenage daughters equates to early onset of sexual activity and promiscuity. From Elisa’s perspective, using contraceptives meant the teenager was concealing sexual partners and activities from the parents or a partner if they were in a permanent relationship.

Then the perception is, who else are you having sex with? You want to be promiscuous, because you shouldn’t be having contraception if you are just with one partner. Then again, good girls don’t use contraception if they are in a relationship.

(Elisa, KI/SP/RN)

Overall, SP perceived there was little knowledge about contraception use among African women. Healthcare services and the services of the SP were often sought only to restore health rather than to plan and maintain health. Men were often unsupportive of their partners using contraceptives, because there is a perceived sense of loss of authority and control over the wives and daughters. This fear is equally shared by women towards their daughters, as contraceptive knowledge and use is perceived to equate to promiscuity.

6.4 SP perceptions about AATs contraception acceptance and risk taking

6.4.1 Views on AATs contraception

The perception among most of the SP irrespective of gender, religious affiliation, role and ethnicity was that preventative health and contraceptive acceptance and its use was not the norm with most of their clients of African descent. For the small group of AATs and women who accepted contraception, and understood its benefits, their male partners often
opposed its use. Below is Chantal’s’ account of parents’ attitude to contraception use.

Chantal is a healthcare provider of African and Islamic background.

Contraception is not a good thing, it’s not in their culture … 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.’ It’s more, in their view, a religious matter.

(Chantal, KI/SP/RN) of African background)

The above view is supported by Elisa, another healthcare provider of African and Christian background.

As much as we would like to think of ourselves personally as an African, we really aren’t, we just go with the flow of what life brings with it, you know? I have to say they’re very resilient young people to survive here and to do well for some of them but, again, we do fail in that they do get caught up in between. You get parents who have got their cultures entrenched in them and trying to pass that to the young people as well as they’re here learning a different way of life. It’s very difficult for the young people … I think this society allows young people a lot of freedom; freedom to choose, freedom to be. You get young people as old as 10 years having boyfriends and girlfriends, where that is unheard of in the African sense. So by the time they are 14 or 15, some of them have already started engaging in sexual activities and I find in my line of work here that the [Anglo-Australian] parents actually encourage them to then use contraception. They [Australian-Anglo parents] will bring them to the doctors and prescribe the pill, for example, or go out and buy them condoms or whatever. That concept of ‘be safe’—if you are going to do it, then be safe. I’m sure most parents don’t agree with it, but the perception would be if you’re going to do it be safe, whereas for us [Africans] it is—and I’m not saying that they don’t do it [sex] because I know they do it, but they do it under wraps. Their [African] parents don’t know that they are doing it and the community doesn’t know that they’re doing it and so they’re doing it in an unsafe way. I said earlier on about 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, KI/SP/RN, African background)

This view by Jonathan was supported by the GP, who had extensive contact and work with AATs. To him, there were several forces at play from lack of interest in preventative health,
to limited time on the part of SP and cross-cultural issues about sexual health education delivery and uptake.

There seems to be a cultural barrier to getting the messages across; there are issues of clash of culture, erosion of their culture, different issues around sexuality, parental unwillingness to educate their children about sexuality. It’s not a subject that is usually discussed in anyway within the family unit.

(Ruben, KI/SP/GP)

Other SP noted that there was a cultural denial that the AATs had boyfriends, let alone that they had sex out of wedlock. Such denial meant that the parents did not see the need for contraception education or its use by their daughters.

There is the premise that there is no sex without marriage, either cultural or religious.

(Jonathan, KI/SP, bicultural worker of African background)

SP perceived contraception uptake and use to be important in the lives of AATs, but that contraception was not widely used by sexually active AATs. SP understood the cultural and religious challenges AATs faced within their families and communities about contraception use, and having a boyfriend.

6.4.2 SP perceptions of AATs’ risk taking behaviours

SPs supported most of what AATs said about risks above. According to SP, some teenagers revealed they never really thought about STDs and the modes of infection. Barrier methods were closely linked with pregnancy prevention, and not with STD prevention. This view was supported by SP, who said teenagers were often surprised when STDs where discussed in sexual health education sessions. Further, there was the ‘lack of trust’ commonly associated with condoms, and the perceived questioning of the man’s authority. As Chantal said:

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. 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, KI/SP/RN)

Fiona, a SP of African descent, reported that boyfriends often threaten to leave the relationship if AATs insisted on condom use or for them to screen themselves to rule out the presence of any STIs, including HIV/AIDS. This was the case even when AATs were sure the partner was involved in another relationship; their relationship was something AATs did not want to lose.

If you tell them, ‘Can we go and check you?’ [before engaging in sexual intercourse] they say ‘No, if you don’t want me then I’ll leave you.’ That’s what they say and the girls they can’t believe he’s going to leave so no, they’re going to trust what the man say.

(Fiona, KI/SP)

There was confusion about the roles each party had to play when it came to contraception use. According to Chantal, AATs saw condom use as the sole responsibility of the male partner. Men, conversely, saw non-barrier contraception methods like oral contraception pills, injections like depo-provera and implants like implanon as the responsibility of their female partners. Thus, contraception use and prevention of STDs, and unwanted pregnancies, was not seen as the couple’s responsibility but rather an individualistic responsibility. Blaming the other person was the pattern. Partners blamed each other depending on the status of the relationship. An ‘our’ approach to prevention was not the practice, rather it was a ‘your’ responsibility approach.

When it comes to condoms, it’s more like, ‘If he doesn’t want to use it, it’s because of him’ … But the condom is more a male thing and he needs to wear it. If he doesn’t wear it, then that’s his problem. Another example … the husband found out that the woman is pregnant as well and he was displeased with it and said, ‘You should have dealt with these things. Contraception—what do I know about it? You should know these things and protect yourself from getting pregnant.’

(Chantal, KI/SP/RN)
AATs risk taking behaviour was closely linked to the status given to mothers in the community, hence AATs desired motherhood. Girls with children are awarded more respect than women with no children. AATs understand the status and respect their mothers/females had within their families and communities because of motherhood. Childbirth and the number of children one has increase their status in the community; women with more children are given greater status. AATs let themselves get pregnant and also risk infections from STDs to attain motherhood. However, because motherhood is admired and mothers respected, it was a risk some AATs were prepared to take. Elisa a 30-year-old successful, tertiary educated SP of African heritage, used herself as an example to highlight the status a mother has, even when they are young and single. Elisa is not married and has no children. When asked what she thought about TP within the African community and the reason for the perceived high rates of TP among AATs, she said:

Pregnancy is a huge thing for Africans mainly. In fact, I was talking to one of my aunties the other day and of course she was telling me, ‘You’re now 30 and you’re not married …’ and all that sort of stuff and there was one line that she actually said, ‘Who do you think is more respected in the community, a married woman with no children or an unmarried woman with a child?’ It was very interesting because the answer was 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. I went home to [country] and my father was organising a husband for me … (laughing loudly as she said this).

(Elisa, KI/SP/RN)

According to Elisa, the hidden message from the aunty above was get pregnant and have a child, because professional success, though acknowledged, was not seen at the same high level as being a mother, and when you are 30, that is too late to be single and childless. AATs took risks to fit in the traditional mould of good girl and submissive and obedient ‘wife’ when with their boyfriends. Motherhood that raised an AAT’s status among her peers, family and community was preferred over childlessness in the longer term, and the risks as discussed above were considered short-term only.
Most AATs and parents in the groups did not know about specific STDs, except for the awareness of HIV/AIDS. Such awareness can be likened to the fact that most of the participants in this research came from or had lived in countries in Africa where the HIV/AIDS epidemic had taken a toll on the lives of friends, family and the wider community. HIV/AIDS remained a focal point of sexual health education while participants were in Africa and in refugee camps. All permanent migrants and refugees get tested for HIV/AIDS before being approved for a visa for travel to Australia. HIV/AIDS was seen as terminal and there was the stigma factor attached, whereas the view towards other STDs like chlamydia was, if you get an infection, you could get treatment for it and would be cured completely.

Because of the AIDS epidemic that we have in Africa, you definitely get that education. But when we come here there’s no such thing. It’s not an epidemic here and so people are not really worried about it. There are other things to be worried about, which is chlamydia and all that stuff, but then again, 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, KI/SP/RN)

There was the false perception among participants that there was no HIV/AIDS in Australia and that the risk of contracting HIV was very low.

They don’t use condoms … that goes back to my notion that people are not scared of STDs 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, KI/SP/RN)

It is true that the prevalence of HIV/AIDS is significantly lower in Australia compared to Africa. However, the incidence rate among heterosexual couples and migrants continues to increase as migrants who are now permanent residents or Australian citizens visit their home countries, travel overseas and return to Australia unscreened. SP further stated that that risk taking was not limited to AATs only, but expanded to include even adult African
parents who arrived in Australia with asymptomatic STDs. A healthcare provider of African descent stated:

The other reason why I’m saying that is that even with the parents and grownups when they first arrive we’ve picked up numerous cases of STIs, so that means the use of contraception or condoms across the board is limited.

(Jacob, KI/SP/RN)

SP noted that the lack of preventative health knowledge in members of the community coupled with the ability of men to have multiple concurrent sexual partners, which is perceived as ‘normal’ behaviour and condoned by members of the community, exposes women to and increases the risks of contracting STDs.

There is a cultural lack of interest in preventative health. There seem to be cultural barriers in getting these messages across.

(Ruben, KI/SP/FG/GP)

This perception about the lack of preventative health resulting in unintentional risk taking was supported by other SP. Attending a health service for a health check, including taking measures to protect oneself against the risk of infection and STDs or unwanted pregnancies did not come easily to AATs and the broader community. This could be attributed to other pressing needs, such as accommodation and education during and post-settlement, further underpinned by a culture where discussing your sexual health needs is not traditionally accepted as something to be shared with third parties, except when you are in need of medical care.

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. In a lot of cases that has happened, especially with newly arrived African communities. If they don’t start exploring their sexuality and are not getting tested and don’t know how to stay safe, all that can have a big effect their health.

(Chantal, KI/SP/RN)
AATs lacked knowledge and awareness about STDs. There was some awareness about HIV/AIDS, but not much attention was paid to this after arrival in Australia. Risks were taken by AATs to maintain or continue relationships with boyfriends and sexual partners even when this exposed them to risks of infection and unwanted pregnancies. Males saw it in their favour to threaten leaving a female and move on to the next relationship if she insisted he used a barrier method while they had sex. Motherhood is admired and AATs risk STDs to get pregnant. SP perceive that and acknowledge that AATs and adult African parents have a low awareness and knowledge about STDs and are reluctant to seek preventative health. Culture and belief systems that do not promote preventative health practices and discussions of about sexuality may be inadvertently putting AATs at risk of STDs and unwanted pregnancies.

6.5 Women’s (mothers’) attitudes towards daughters and AATs’ contraception use

Women had a negative view of contraception use by AATs overall. While I did not seek women’s knowledge of contraceptive methods for this research as it was beyond its scope, women’s attitudes towards contraceptive use by their daughters and other teenage girls was solicited. Using contraceptives was perceived by parents to be immoral. Girls thought to know about contraceptives and to be seen using contraceptives was ‘bad’ and ‘promiscuous’. Women believed that adolescent and teenage girls should not be educated nor informed about contraception.

If your daughter knows [about contraception] she can make a lot of boyfriends, you must tell her it [contraception and sex] is bad and you must tell her you will be sick … if you tell her that [about contraception use] then they will do it [sex] anytime.

(Akot, KI/WFG)

Discussions about contraception and sex were considered by women and parents with traditional beliefs to be a taboo topic; parents were to wait until the girls married or were about to before sex could be mentioned. Parents wanted to maintain ignorance about sex
and contraceptive use on the part of their daughters until such a time. During the focus group with mothers, women unanimously agreed that it was not proper to speak about contraception and sex to pre-teenage girls or girls in their early teens. If a parent decided to discuss sex with their children before such time, sex had to be shown in a negative light. The parents had the responsibility to make the children scared of sex and to dissuade children from sex as much as they could.

I do not speak to my daughters who are 13 and 14 … you have to wait until the girls are married … we do not speak to the children about sex openly … we do not speak about sex … you have to scare them about sex, scare her.

(Laura, KI/WFG)

It was not only contraception and sex that parents were not to discuss with the children; anything to do with sexuality is considered culturally unacceptable to pre-teenage girls and teenagers. For example, in the focus group discussion with women, there was unanimous agreement about not discussing sex and sexual expression. One of the participants went on to say that even discussing kissing is regarded as culturally inappropriate, let alone sex and contraception. When you do speak about a sexual topic, it has to be behind closed doors.

With us even kiss too hard; the father and mum they do not do anything in front of the children … For example, my husband and I were going to Melbourne one day and they wrote something on the billboard, he asked me to read and I pretended that I could not. This is because it was about sex; I knew how to read it but I said no [can’t read]. We discuss sex matters with our husbands but only inside our bedroom … it is difficult for us to say. I cannot … this is not culturally acceptable.

(Awel, KI/WFG)

Sex is regarded as sacred and not to be discussed with children, and daughters in particular. Matters of sex, including contraception, are topics reserved for adults and should stay in the bedroom between husbands and wives. Discussions about sex and contraception use should be portrayed in the same a negative ‘culture’ light.
6.6 AATs’ attitudes and myths about contraception

In this section, I discuss AATs’ decisions to use or not to use contraceptives. I further discuss AATs’ thoughts regarding contraceptives and the perceived biological effects of contraceptives on their bodies. I provide information about myths surrounding contraceptives in general, with specific references to condoms.

6.6.1 AATs’ attitudes towards contraceptive use

AATs resist the use of contraception. AATs do not think of contraception use as an important aspect of their lives, nor do they accept or understand the long-term benefit of contraception use to them. Such an attitude is underpinned by their culture, where contraceptive use is not supported.

I don’t put it in my mind … because in [country] we don’t use anything.

(Daniella, AAT)

Because in my country young people they get pregnant and also even if you’re married you can’t because it’s not like much in our country to use those things. I don’t think so, I wouldn’t be using it … Also it is too expensive. Maybe rich people only use it, not poor people. Even the husband, maybe he will say no. Even some people here in Australia, the husband says no.

(Bikutsi, AAT)

AATs are less likely to use contraception even when they have been identified as having unprotected sex and are at risk of an unwanted pregnancy. There was little acceptance of contraception use because of the fear contraception may render them infertile.

Because when I turned 16 or 17 I received a letter from the Women’s Clinic and had an appointment with them. I went there, they have one counsellor and she tell me about the pills and then I didn’t like … I was like, ‘No, no, I don’t want to take any.’ And then they gave me the prescription and I went and buy it but not take it too serious.

(Chelsea, AAT)
Chelsea reportedly fell pregnant not long after. Like Chelsea, some AATs who had heard about contraception decided against using it. AATs feared their parents would discover that they were using contraception, an indication that they were sexually active. They feared the consequences they might have to face from their families and community.

I did [know] but I thought if I took contraception my parents would find out about it and then they would know I’m having sex and all this; I was scared.

(Carmen, AAT)

There were AATs who, regardless of parental and cultural influences about contraceptive use, went on to use it; but they failed to follow the advice and instructions from their doctors about effective and continuous use of contraceptives. Continuous contraception use did not seem to be understood by AATs or maybe was not viewed as important.

It finished and I forgot. I didn’t know.

(Stephanie, AAT)

Yes, I used the pills but then (silent) … I had a family doctor that told me about everything. I used to drink pills and then I stopped. I do not know but I kept forgetting that I had to take them every day at the same time. They just finished and I could not be bothered to go back and get more.

(Candida, AAT)

There was the false impression that if you were on the pill, you could not get pregnant. This is only true if you take the pill as prescribed and follow instructions as required when you happen to miss a pill, something AATs were less likely to do. According to Alima:

A lot of people think they can protect themselves by taking pills but sometimes it’s not true. People forget to take the pills and still get pregnant.

(Alimatou, AAT)

AATs had negative attitudes towards contraception use. Those AATs who decided against all odds to use contraceptives, specifically pills, lacked the skills and knowledge for efficient use.
6.6.2 Myths and misinformation about contraception use in general

Myths and misinformation influenced AATs’ decisions towards the use of contraceptives. By myths, I mean information that is untrue but that people believe. Myths are usually passed down from one generation to the next, often by people trusted and respected by the individual and the community. The perceived bio-dynamics of the negative effects of contraceptives inside the body influenced AATs’ decisions against contraceptive use. The most common myth was that contraception causes infertility and that when one uses contraception they will never be able to conceive a baby.

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, AAT)

Or maybe they will stop you to not get pregnant again. They think like that way.

(Bikutsi, AAT)

For other AATs it was the thought of putting on weight and having irregular cycles, coupled with the myth of infertility, that discouraged their use of contraceptives.

People used to scare me and say if you take pills, you will not give birth in the future … some people said you get fat from them … Not really, but what can I do, the doctor said with the pill, but later if you decide that you want to have kids later it could be hard or impossible. So I left the pills. With the implant, I used the implant, she is sure 100 per cent and I could just take it off and get pregnant. But that your periods could be irregular, you could gain weight.

(Candida, AAT)

Healthcare SP confirmed that from their own experience working with AATs, and also because of their own African heritage, contraception was believed to cause infertility. For a culture where nativity is paramount, it was not surprising that AATs would rather not use contraceptives for fear it may render them ‘barren’.
I’ve found some women were saying that they might be barren afterwards if they’re taking the pill or using contraception. Pregnancy is a huge thing for Africans mainly.

(Elisa, KI/SP/RN)

There was the disease causing factor associated with contraception use by AATs. AATs believed that contraceptives caused ‘growth’ in the stomach and cancer, blocking their womb, and they would never be able to conceive. Cancer is a considered incurable, despite all the treatment options available and the increasing scientific knowledge about cancers. Some African community people are afraid of pronouncing the word cancer for fear of getting the disease, or even letting people know they have cancer when they do. This is because of the stigma and fear in the community associated with having cancer. As a result, AATs develop a fear of the disease, even though none of the above myths are true, nor are they based on a scientific research. Therefore, AATs avoided the use of contraceptives for fear they may develop cancer following their use. This myth of contraceptives causing growths and cancers was associated with different types of contraceptives. For example, Stephanie and Josephine said:

Because I think sometimes from the injection you can get cancer from it.

(Stephanie, AAT)

I did not like the pills, and I preferred just going according to my cycle, because even though the pill is good, if you take it too much it will make a ‘growth’ in your stomach, so I go according to my cycle. Maybe it may stop you from having children later, that is why I think and everything you take always have side effect, every medication has side effect.

(Josephine, AAT)

Some AATs despite all the odds decided to use contraception, but they had to stop using contraceptives or take ‘breaks’ because lengthy contraception use was thought to render AATs infertile and could delay them having a child when they wanted. AATs did not understand that almost all contraceptive methods are easily reversible, and that when you stop using contraception you can fall pregnant within a short period, sometimes within a
month depending on the method of contraception. The myth and misinformation was that you had to wait in some cases for up to seven years before your body was ready and you would be able to conceive.

No, she [friend] just tell me … because she [friend] went to Melbourne and they put it in for seven years not to have a baby. For me, I was so scared, I thought, ‘No, I can’t do that for seven years. And then they have to put it in your vagina? No. I can’t do that. And then I didn’t do it.’

(Chelsea, AAT)

Another myth was that you could not become pregnant if you only had sex once or sparingly and there was no need to use contraception before engaging in sexual intercourse for the first time or with casual partners.

People still think if you sleep with a person just once then they’re not going to get pregnant. You still come across that.

(Elsa, KI/SP/RN)

Finally, there were boyfriends’ and parents’ attitudes towards contraception use by teenage girls. Parents believed that girls knowing about contraception or using contraception would have them engage in sexual relations with many sexual partners and they would have many boyfriends. Boyfriends saw contraception use as something that their female sexual partners would use so they could cheat on them without being found out.

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 … The mother think if they tell you about it, you’ll just go off and do it.

(Carmen, AAT)

The above myths and misconceptions about contraceptives, reinforced by beliefs and a culture orientated towards marriage and child bearing, together with engrained negative attitudes towards contraceptive use, dissuaded AATs from using contraception. The lack of knowledge on the part of AATs and the perceived loss of control over AATs’ sexual lives by their parents and males only made matters worse for AATs, and further reinforced negative myths and misinformation about contraceptives. These myths and misinformation
dissuaded AATs from contraceptive uptake and use. Condoms, which are considered an effective barrier contraceptive method because, if used effectively, they protect both parties from STDs and infections like HIV/AIDS and from unwanted pregnancies, was the least liked and used method by AATs and their partners. Due to the importance of condoms in reducing the transmission of HIV/AIDS and other STDs, the next section highlights AATs’ attitudes and myths about condoms.

6.7 Attitudes towards condom use and myths about condoms

Condoms were disliked by AATs and their partners. Myths and misinformation existed in regards to condoms. Below I provide the participants’ views and myths on condoms, including the perception of SP about AATs, African parents and condoms use.

6.7.1 AATs’ attitudes and myths about condoms

Condoms were perceived to reduce sensation and sexual pleasure. AATs feared there were too many risks associated with condoms. Condoms were thought to be dangerous because they would get ‘stuck’ in your stomach.

I don’t know. Because sometimes it looks like it [condom] might go into my stomach or get stuck there. I don’t know … one of my friends was talking about it and that’s why I’m worried because they tell me, ‘Don’t think about using condoms.’

(Jessica, AAT)

This fear of condoms was common, and AATs decided not to use condoms even when they were sure that their boyfriend had other concurrent sexual partners. For example, Ayuba avoided using condoms even after she suspected that her boyfriend was sexually involved with other women. This decision was based on another teenager’s experience with condoms when they lived in the refugee camp. Ayuba said:

No, I did not want him to and he did not want to either … I thought it (condoms) is not safe, I thought it could get stuck in my body. Because when I was like eight, there was this girl who used a condom with her boyfriend and she almost died. In
my country in Africa, she had a condom stuck and go inside her (pointing between her legs) … I still think it is not safe, oh no (shakes her head from side to side).

(Ayuba, AAT)

Asking your partner to use condoms was perceived as showing a lack of love and trust. It was is seen as being uncommitted to them and to the relationship. The male partners often reacted negatively and accused the women of not trusting them enough and said they wanted to leave the relationship. AATs did not want to risk ‘losing’ their boyfriend by asking him to use condoms.

He used to tell me sometimes, ‘I love you. I don’t have to use contraception on you.’ I don’t know, when they say it like that, ‘I love you. I want to marry you. You use contraception on street girl not the person that you love.’ That’s what he used to tell me, so I don’t know if that’s true or not.

(Chelsea, AAT)

Bikutsi said that after having two miscarriages, though still a teenager, her doctor advised her against another pregnancy in the short term. She and her ‘husband’ (they lived together and her family accepted their relationship) were counselled against further unprotected intercourse and told to use condoms in the short term. Below is Bikutsi’s ‘husband’s’ reaction to the doctor asking him to use condoms when they have intercourse; Bikutsi laughed out loud when she narrated this story.

Because when the doctor said to my husband, ‘Oh you can use condoms, it’s okay,’ he said, ‘No, she’s my wife so I don’t use condom. Condom is for street girls. So when you don’t like this girl and sometime you want to have sex, then you can have sex with condom.’

(Bikutsi, KI/AAT)

Using condoms with a regular partner or someone considered a lover was perceived to be derogatory and disrespectful on the woman’s part. Condom use was associated with ‘shame’. The perception was males use condoms with casual partners, not with long-term partners; condoms were to be used with someone you did not care about or loved. Condoms
were used with girls notorious for having serial boyfriends. However, the same could not be said for the males.

After living in Australia long enough to understand the freedom in controlling and managing their sexual lives, AATs had to bypass their male partners, who were seen to be the barrier towards condom use. There were times when some of the male partners accepted using condoms with their frequent female sexual partner at her request. Such situations were rare, but did arise when AATs became suspicious that the man had another concurrent sexual partner. However, there was no subsequent use later on, thus no regular condom use. Jessica had suspected that her boyfriend had other girlfriends through her friends, and she insisted on using condoms with him during their next sexual encounter.

One day we tried. We never used that for two years but three months ago I’m not sure what made me think about using the condoms, and then we used a condom and then I asked him why he accepted because I think he met another person. After that we didn’t use it again.

(Jessica, AAT)

Despite the general negative attitudes towards condoms, there were some AATs who portrayed condom use in a positive light, even when they did not use condoms themselves. According to Madonna:

To use medicine [contraception] and use the condoms? Yeah, it’s a good thing. To not have another baby.

(Madonna, AAT)

In this research, condom use, like other methods of contraception, was associated with and focused on pregnancy prevention by AATs and their partners rather than with STDs and HIV/AIDS. This is despite the fact that the burden of disease as a result of HIV/AIDS and STDs is significant and may be greater compared to becoming pregnant as a teenager or being a teenage mother.
6.7.2 Women’s (parents’) attitudes towards condoms

For mothers and African women, asking their daughters or AATs to use condoms or any other form of contraception was unacceptable. Such advice was considered poor parenting and uncultured. Women in the focus group unanimously condemned advising their daughters to use contraceptives, and said that if they found out that their daughter carried a condom in her bag ‘just in case’ she had to use it, they would be very sad for her. Such a girl was considered promiscuous, unruly and lost.

Not good, I don’t know maybe she has condom, not good, and if she has condom I will be very, very sad about her … Use the culture and advise those not to be engage in sex. If she has condom she may do 100 men … it is not good.

(Christina, KI/WFG)

Girls who carried condoms with them were perceived by women to be at risk of HIV/AIDS and other STDs. The perception was girls using contraception, such as condoms, were more likely to experiment sexually and to have many sexual partners.

Not good because for her, she may become sick, like AIDS.

(Laura KI/WFG)

Women and mothers had a low regard for condoms and girls who had a tendency to use condoms or carry condoms with them. Such girls were perceived to be of low standards and having poor manners. Women from the focus group suggested and agreed that sexual health education for their daughters would be accepted if they knew and trusted the person. However, they said they would not do it themselves as it was culturally unacceptable.

6.7.3 SP perceptions about AATs’ and women’s (parents’) attitudes towards condoms

The perception of SP on how AATs and parents viewed condoms was insightful. Health SP had exposure with a range of teenagers from different backgrounds. To SP, African teenagers, especially the boys, were very focused on their sexual pleasure when in a sexual
relationship with a fellow AAT. Condoms were perceived to reduce sexual pleasure and to encourage promiscuity of the females.

Most of the boys had these preconceived notions that having sex with a condom is not fulfilling. So they do not want to do that—they don’t want to use the condoms, so most of them would pressure the girls not to use condoms.

(Elisa, KI/SP/RN)

Conversely, females were more likely to try to understand how contraception works or give some forms of contraception a try. However, when it came to condom use, AATs and other females saw it as a male responsibility, although there seemed to be an association of low morals on the part of females when it comes to condom use, as explained earlier. This may be one of the many reasons why condoms were not popular among AATs. Apart from this, condom use was disliked by both sexes. Like other forms of contraception, was not seen as a couple’s responsibility, but rather an individual and gendered approach was taken, depending on the method.

When I do a lot of sessions with young girls, they make it look like condom is not their problem, it’s the man’s responsibility. So a lot of times it’s like, ‘Okay, I want to know about the pill, the implant, and the different types of contraception,’ but when it comes to condom it’s more like, ‘If he doesn’t want to use it, it’s because of him’ … But the condom is more a male thing and he needs to wear it. If he doesn’t wear it then that’s his problem.

(Chantal, KI/SP/RN)

Such individualistic and gendered approaches towards condom use gave rise to power imbalances within the relationships, with the females often exposing themselves to risks of infection in order to keep their boyfriend. In line with AATs’ earlier attitudes towards condom use with their regular partners, Chantal, a SP of African background, noted that some of her AAT clients, despite knowing that their regular partner cheated with another woman, were unable to effectively negotiate and enforce condom use with him, because ‘losing’ him to another woman was something AATs did not want to risk.

One of the clients I had, after I’d done the session she realised how many infections there are and got quite worried. She came after the session and she actually lived with this guy for two years and she has two kids with him and she’s
100 per cent sure that he cheated, but then she asked once to wear a condom and he said, ‘You’re suspecting me of cheating. If I wear condom then I’m not going to be with you anymore, but if I don’t wear condom then it means you trust me that I don’t cheat’ … Trust and preference I think as well. The guy’s sexual pleasure.

(Chantal, KI/SP/RN)

Condoms are not a contraceptive method of choice for AATs and their partners. AATs’ parents dislike their daughters and AATs in general using or having condoms in their keeping. SP views confirm the AATs’ attitudes towards condoms and the challenges AATs face trying to negotiate condom use with their regular sexual partners. Gender imbalances exist within relationships between AATs and their boyfriends, and the boyfriends threaten to leave the relationship if AATs insist they use a barrier contraceptive method such as condoms.

6.8 Relationship experiences of AATs and risk taking
6.8.1 Love and sexuality

Love in this context is the expression of affection and the manner in which this affection is demonstrated by a male or female towards the other person in a relationship. The reported sexual orientation of all AATs and African women in this study was heterosexual, and there was limited reference to homosexuality. The thought of homosexuality in the few instances it was mentioned was met with surprise and a prompt notation that homosexuality was not African and those who practice it should be shunned. No individuals in this research reported ever being in a homosexual relationship or having a friend or someone close to them who was homosexual. It is possible that because of the culture, religious beliefs and homophobia directed at homosexuals by members of the community, together with African government policies where homosexuality is outlawed, homosexuals may be too scared to ‘come out’. Apart from South Africa, the practice of homosexuality remains a crime in most African countries.
Chantal, a SP, mentioned that in all her practice she:

Had only heard of one girl of African heritage who reportedly thought she may be lesbian. The girls’ parents had to be counselled that their daughter was a lesbian, but they still did not accept their daughter’s sexual orientation. The parents reportedly informed the SP that homosexuality was not part of their culture [African] and she was shunned.

(Chantal, KI/SP/RN)

Chantal added that ‘fear existed among community members, the perception was, if one homosexual popped out, others may do the same, creating a significant problem in the community.’ There is a sense of shame and stigma associated with the practice of homosexuality in societies where tradition, culture and religion are so intertwined.

A boyfriend or baby’s father expression of love to AATs was broad and situational. Love was directly associated with sexual enactment, an experience that many of the AATs said they would rather not remember because of the associated pain. Honorine says she does not know what love is because she was given to someone at 15 as a wife. She left the relationship, but it left her not wanting to have anything to do with men. Below is Honorine’s experience of love as sad and painful:

I was just always nervous with the man because it was the first time I had contact with the man and the next day or a couple of days later I smelt a man smell and the little boys, I hid from them. I see them around I am nervous when I see the man around … yes, it was painful and I still remember that today, that’s the only thing I never forget … So I do not know what love is.

(Honorine, AAT/KI)

Honorine’s experiences of love were similar to that of the other AATs’ experiences and description of love. Feelings of love were expressed in relation to support received by AATs from the boyfriends or the fathers of the children, rather than merely romantic feelings. For example, Daniella described love between her and an (ex-)boyfriend:

Because the relationship was good, he came to our house. Sometimes he visited me. If there’s anything I wanted, I’d call him and he’d do it for me. Sometimes I’d leave the baby with him and go with my friends or to my auntie’s house or
something like that. When the baby is sick, he helps me because he has a car … And when he comes home, he’ll bring food and stuff and sometimes he gives me money for the baby or nappies.

(Daniella, AAT, mother of one and pregnant)

African culture does not encourage public expression of feelings of love, such as kissing publicly or other forms of romantic display, like couples cuddling in public. The manner in which affection is expressed and appropriate behaviour is influenced by culture.

African heritage has a big influence on the decisions they make regarding sexual life.

(Chantal, KI/SP/RN)

While not publicly expressing feelings of love is suppressed and easily enforced in Africa, AATs in Australia are exposed to a culture where love is expressed outwardly and in public. However, they seem not to be able or did not want to express such feelings. This I can only attribute to a culture where females are not encouraged to express their views, including the way the feel about their partners and their relationships. Though there were isolated situations where AATs felt they could express their romantic feelings for someone they loved, the love they described was directly tied to commitment and having a baby. The sexual partners often responded differently to this, leaving AATs heartbroken. As Kayla, expecting a baby from another boyfriend living interstate, said:

I wasn’t willing to be pregnant in this relationship, but I had a first relationship and I didn’t quite understand my ex … I was really committed to that relationship he was cheating on me and I was very committed to the point where I would go to his family house, I would go and help out, I would go and try to make them like me and like my personality and I wanted them to make me feel like I’m part of their family.

(Kayla, AAT)

Love as expressed by AATs was complex and directly related to sex and child bearing. Veronica said she had no romantic feelings for the father of her baby, but had responded to his continuous demands of sex rather than her romantic feelings for him.
He used to come to my house every day to see me. He kept asking me for sex, and asking me to sleep with him. I did, then I did not see my period, then I realised I was pregnant for someone that I did not love.

(Veronica, AAT)

There were some AATs who experienced another form of love, as Ayuba said:

He came to Sydney to visit his friend. His friend was my best friend’s brother, then they started telling me he likes me (blushes and turns her face), yep and then we went out … I just met him for one month, then came to live with him and was pregnant in one month.

(Ayuba, AAT)

I didn’t ask him. He used to tell me sometimes, ‘I love you’ … I don’t know, when they say it like that, ‘I love you. I want to marry you’ … that’s what he used to tell me, so I don’t know if that’s true or not.

(Chelsea, AAT)

The above quotations demonstrate what AATs described as love and how they understood and experienced it. Particular cultural expectations of certain patterns of behaviours expected from females towards male sexual advances makes it difficult for AATs to differentiate between sex demands and genuine expressions of love. AATs, as a result of cultural imposition, are in positions of weakness compared to males. AATs going out of their way to feel included by a boyfriend and his family as part of their family, even when they are aware of the presence of other concurrent partners, is concerning. AATs inadvertently open themselves to coercion and sexual abuse in such a process.

6.8.2 Sexual coercion and sexual abuse

Most of the girls had experienced sexual coercion and abuse. They were all less sexually experienced than their male sexual partners but had been raised to be submissive. The girls did not know how to withhold or say no to the boys’ sexual advances or to simply withstand the pressure from the boys.
He need to tell me that we need to have sex, and he kept telling me and asking me, so I just said yes (lowers her head in regret).

(Veronica, AAT)

Sexual and physical abuse were a common occurrence and, to some AATs, endemic within the community. Irrespective of the type of relationships, arranged or by choice, there was some form of sexual abuse. Jessica left a refugee camp and came to Australia on a spouse visa to marry a refugee, as arranged by the spouse and her family. According to Jessica, she did not love this man and wanted to marry someone else; below are some of her experiences during the three weeks they spent together. The abuse she experienced ranged from sexual to physical and emotional abuse.

If you, don’t love the man, then you refuse to have sex, sometimes he can force you … yes … he can beat you up or he can sleep with you by force even if you don’t want him to … If a man has a wife, he’s also beating them, is what I think. Yes, with [country] men I think that happens all the time. Yes, I stayed with him (arranged marriage) for three weeks and after that I told him, ‘I can’t stay with you because I don’t love you.’ He beat me every day because I didn’t love him. [He beat me] all the time. The first week I came, I lived with his sister and then the second week I stayed with him, and that week we started fighting every day when he came back from work. Some days if we didn’t fight he just swearing at me because I didn’t want to sleep with him. He’d pull my hair and … everything.

(Jessica, AAT)

Honorine’s experience, while similar to Jessica’s, had some differences. Honorine had to stay with the husband her family had arranged from her mid-teens until her late 20s. Honorine left after she moved to Australia via Egypt, after giving birth to five children. This relationship left her emotionally fragile and, from her story and experiences of sexual abuse, she does not know what love is; all she knows is sexual and physical abuse.

Because I was a virgin at that time and I don’t want to get married and they forced me … I don’t know why. I didn’t know at that time why and why this is happening to me. Yes. It was painful. And I still remember today, that’s the only thing I never forget about that marriage. I went to the hospital and from the hospital I went back to my house because I was really, really going crazy … I got married. I was just always nervous with the man because it was the first time I was in contact with the man, and the next day, or a couple of days later, I smelt a
man smell and the little boys, I hid from them. I see them around and always nervous when I see the man around.

(Honorine, KI/AAT)

Kayla had experienced rape from the tender age of about three years. Kayla still had the emotional scars left by her immediate relatives and neighbours.

I don’t know how to put it; I’ve always been sexually abused since I was little by my cousins and people who live around while my mum’s not home. People would force me and I would get raped every time mum is not there, and my cousin would do a lot of things to me while there’s no one there. Because I used to be very shy and used to be very scared of saying anything to anyone I would hide it away from Mum.

(Kayla, AAT)

Abuse was perpetrated not only when the women/girls did not want to have sex. For example, Honorine gives an account of her wanting to use contraceptives:

I went to the doctor and the doctor gave me the pills and I had to show him the prescription, and I showed him and he cut it and put it in the bin. So I told him, ‘Okay, you’ve got it. You’re never going to cut the doctor away from me. I’ll go to the doctor tomorrow and I’ll get the same one and I’ll go to the pharmacy as well and buy it because whatever you do it’s not going to stop me, whatever I want to do, because you have to sit down and we have to discuss this.’ And he just said, ‘I don’t want anything,’ and then it was a big argument and turned into the fighting and the next day when I went to the hospital and I got another one and I bought it and I showed him, and then it was a big problem … Yes and he stopped himself to have sex with me because he said a funny thing. He said, ‘Take your pill. That will be your man and you can have sex with that pill.’ And then he moved out from the room and he went to the children’s room and he slept there for about three years, because the baby he was two years and after three years we had sex again. So he stopped himself for three years..

(Honorine, AAT)

Coercing the girl to have sex or coercing her to get pregnant ‘intentionally’ is a manner in which male partners demonstrate their virility and maturity. AATs submitted to pressures; I could only attribute this to AATs’ perceived lower position within the family structure,
resulting in low self-esteem. Other AATs resisted pressure to have sex, leading to the boyfriends accusing them of having another partner. Living in a community where socialisation is orientated towards having a partner, and marriage and childbearing are seen paramount for females, AATs succumbed to such pressures despite understanding the risks and the consequences. Below is Jessica’s experience of when she said no to 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, AAT)

Jessica’s boyfriend did not keep the promise to look after Jessica and the baby. This ‘proof’ of fertility was not isolated to the men. Some AATs, because of past traumatising experiences, wanted proof of their own fertility and to show ex-partners that they could bear children. After being raped multiple times by relatives and neighbours, coupled with living with a step-father who never accepted her like his own child, all Kayla wanted was a child and a family of her own. With such a desire for motherhood, Jessica, Kayla and other AATs may have become more vulnerable to risky relationships. It could be argued that the boyfriends may not have been ready to be fathers to the same level expressed by some females.

That’s why in my second relationship I said, ‘I just want to get pregnant. I don’t care from whom, but I just want to have a baby.’

(Kayla, AAT)

Despite all odds, there were AATs who felt safe to say no to sexual demands from males or who felt they could freely express their desire to have sex and would not be at risk of abuse.
He used to tell me and then I’d accept it. He doesn’t do nothing [if I said no], just leave me.

(Chelsea, AAT)

The position and social hierarchy of AATs within the family unit and the community, coupled with cultural expectations of men proving their fertility as evidence that they have reached manhood, exposes AATs to coercion and abuse in sexual relationships. Risk taking on the part of AATs and their partners was another commonality in this research.

6.8.3 Sexual risk taking

Sexual risk taking was common, as highlighted in attitudes towards condom use and myths. AATs’ limited knowledge and awareness of STDs and the lesser desire to use condoms further exposed them to infection and pregnancy risks. Not getting pregnant was the primary objective of sexually active teenagers, who had little use for barrier contraceptive methods.

They’re just thinking about not getting pregnant, not getting pregnant, but they’re not thinking about disease.

(Carmen, AAT)

It never crossed my mind if I got AIDS because I guess … (silence) and I tell my boyfriend that if next time I get any disease, I will know it was you having another girlfriend.

(Jessica, AAT)

The perceptions are that males can have several sexual partners or wives and females have to accept this. Having several wives or concurrent sexual partners was perceived to be good, because women get relieved of sexual responsibilities and other duties when they were pregnant or had a baby. There was no regard for the risks and consequences to one’s health and life because of concurrent sexual partnerships.
Other husband maybe they … you get three women, four women … yeah another woman [when she is] breastfeeding, he go to another woman..

(Madonna KI/AAT)

AATs did not understand the risks of STDs and the effects they may have on health. Negative cultural beliefs and lack of awareness about the cost effectiveness of barrier methods, such as condoms, is widely spread among AATs. While females disliked their partners having other girlfriends and concurrent sexual partners, being termed ‘wives to be’ or being referred to as a wife brought a sense of false security. This meant the couple were less likely to practice safe sex, placing both parties at risk of STD and unwanted pregnancy.

6.9 Summary

AATs’ knowledge of contraception was present but sparse and rife with myths and misconceptions. Contraception use was mainly directed at pregnancy prevention, with little or no thought given to STDs. There was some awareness about HIV/AIDS, and this can be attributed to the mass media campaigns in Africa about the epidemic there. In Australia, there seemed to be a false belief that there is no HIV and, if there is, the risk is low. While this is true to an extent, it does not reduce the devastations that HIV brings to the individual and their family upon diagnosis. SP had a low opinion on AATs’ and women of African descent’s contraception knowledge and use. AATs’ perception is that their parents have little or no knowledge of contraception. Some SP reported that there exist a proportion of African women who see contraception as an empowerment tool for women.

Homosexuality is stigmatised by most African people. Love was commonly referred to as the first experience of having sex, and this brought up painful memories in AATs. Culture, religion and gender shape what happens in sexual relationships. Sexual abuse and coercion was a common experience among AATs, which I attribute to cultural factors and beliefs that enhance gender inequality. Partners were less likely to support AATs and their child during pregnancy and after the birth of the child.
Chapter 7: Pregnancy and Motherhood

7.1 Introduction

This section focuses on the pregnancy experience and motherhood. I discuss the reaction of AATs and their sexual partners/boyfriends, family members and the community to news of pregnancy. I describe the supporting roles played by parents, sexual partners, boyfriends, siblings, extended family members and the community, including SP, during and after pregnancy. I give an account of AATs’ expectations of motherhood and discuss AATs’ actual experiences, the joys and the challenges of being a teenage mother and how motherhood influences AATs’ lives. AATs’ relationships with siblings, the baby’s father, parents, friends and the wider community after the birth of the baby is also discussed. A brief summary concludes the chapter.

7.2 Pregnancy

Pregnancy and motherhood remain and continue to be an integral part of the life of African girls and women. If a woman decides not to have children, this is viewed as un-African and considered a foreign ideology. For young women, this mindset to have babies is instilled from a tender age, and to AATs, having a baby at some stage in their life remains paramount. The timing of the pregnancy is what can be problematic, rather that the act of being pregnant in itself. Thus, news of pregnancy is receives mixed reactions from teenagers, their sexual partners and boyfriends’ family and the community.

The age at first pregnancy for AATs who participated in this research ranged from 13 to 19 years. Table (Table number) shows the age of AATs at the time of first pregnancy. There were a couple of girls who had at least two children or were expecting a second child by their 17th birthday.
7.2.1 Rationales for pregnancy
7.2.1.1 Pregnancy ‘intended or accidental’

Some teenagers allowed themselves to become pregnant intentionally, though most of the pregnancies were unintentional. However, for some AATs, pregnancy provided freedom from family pressures, financial freedom and independence. Pregnancy provided someone and something you could love unconditionally, and who loved you unconditionally; pregnancy helped prove your fertility and served as an escape route from arranged marriages. For others, not much thought was given to being pregnant as a teenager. If it happened, they shrugged their shoulders and went along with it.

It’s an accident, but if you have the baby, even if it’s an accident or you plan it, it would be just the same.

(Francisca, AAT)

No it just happen, but when I told him he said it was okay [Shrugs her shoulders] … It is fine … because I want it [smiles] … I don’t know … I think because I wanted a baby.

(Ayuba, AAT)

7.2.1.2 Pregnancy used for securing the relationship and as a sign of attaining maturity

A woman’s fertility and child bearing ability remains an important part of African culture and stems from a culture and society whereby women with children are given more respect and voice than woman without children. Such thinking puts unnecessary pressure on teenage girls to prove their fertility and bear children when they do not quite understand the responsibilities that come with it.

Pregnancy is a huge thing for Africans mainly … So most of the young people would rather know that they are going to have children and you’d not use contraception because there’s that notion of ‘It might make me barren.’

(Elisa, KI/SP/RN)
I wasn’t willing to be pregnant but I had a first relationship [at age 15] and I was really committed to that relationship, but I didn’t understand my ex … Because my first relationship, actually, I was in love with that boy and I thought if I got pregnant our life would be better. But I wasn’t sure if the problem was from him or me because in his relationship before he started going out with me was going for four years, and then we went out for two years and even sometimes he would tell me ‘I’d like to have a baby from you.’ So we were trying to have a baby. It just didn’t work and he always made me feel like it’s my fault, like I don’t get pregnant. I don’t know why he was doing that. That’s why, in my second relationship I said, ‘I just want to get pregnant. I don’t care from who, but I just want to have a baby.’ I couldn’t believe myself because I went to the point of just giving up and saying I would never [be pregnant] because people have been playing with and abusing me sexually. Maybe it affected me and I would not have babies.

(Kayla, AAT)

Pregnancy was used to save the relationship and to show the male partner they were committed to him. Girls succumbed to pressure because they were brought up to listen to and respect the man in their lives. For other teenagers, pregnancy served as a way of escaping from pressures within the family unit. Pressures came from extended family members and step-parents that AATs had migrated with. Becoming pregnant meant you could leave home to live on your own with the support of the government social services, get a house of your own through the Department of Human Services and be free.

We observed a huge number of incidences of TP. How do I attribute that? What causes that? We don’t know. What I could gather was that I think for the girls it was their passport to freedom in a sense. Because then they would be independent of their families, rent their own house, stay there and be free.

(Jacob, KI/SP/RN)

Because I was living with my step-father and he was treating me very bad at home, so I said it’s better to just get married [go and live with a male partner]. Yeah, I feel like he doesn’t like me in the house and maybe I’m causing the problems or something. And also he treats his children good but me not good.

(Bikutsi, AAT)
Social security payments from Centrelink served as a motivation for teenagers to get pregnant.

Centrelink is a big problem, and then they give her freedom, that is why a lot more girls here get pregnant, because Centrelink give her freedom for the money. I heard from one girl, they were saying they want to be single mum, because with her baby they will have more money. She went out of home, not staying with her mum. She is now pregnant. Why? Because of the money. If you marry someone with no money, how are you going to feed the child if there is no money? How will you pay for the milk for baby? Here [in Australia] you can do anything, freedom.

(Akot, KI/WFG)

Because usually before in our country we don’t do all these things while you are a girl, but now to come into Australia, it’s just a land that you can do whatever you wants. So if the girls want to, they have a right and they want to have everything for them and do whatever they want.

(Francisca, AAT)

Teenagers do not only have one pregnancy; there is the perception that having more children increases your Centrelink benefits. Thus, AATs sought to have more children to increase their social security payments.

Yes. I see a lot of girls doing that to get the payment, having kids. It’s for the boys too, because the boys say, ‘If you have a child I don’t need to look after the child because Centrelink pay for the child, and you will get money to look after the kids. I don’t need to be there … One of the girls gave birth in December and the other one in January, and I gave birth in March. The difference between the babies and mine is two months.

(Alimatou, AAT)

For others, CentreLink payments meant the boys who fathered the children did not have to take any responsibility. The perception was the government in Australia pays the mother, so you do not need to protect yourself or use contraception. This view about the influence Centrelink payments may have on AAT had been reported by SP and some African community members.
In Africa, when the girl brings the baby, you can be sad but you can be happy when the baby is born, and maybe you can take to her to another man. But here no other man. Bring the baby today and leave it with me (mother) in the house and give me the money from Centrelink and say, ‘Take this, Mum’ and goes back and look for another baby.

(Patricia, KI/WFG)

Teenage pregnancies in certain African communities … I can confidently say that most of them are getting pregnant to get the $5,000 from the government. There’s no discipline, there’s no father figures, there’s no mother figures and you’re in a society where you’re confused and you have no idea where you fit in or who you fit in with. So if they want to get out of home and do it as quickly as possible, for them they think, ‘$5,000 is a good start,’ not knowing that it’s a difficult road ahead. We have had to deal with a lot of young people who fell pregnant specifically between 2005 to 2006 when the money kept going up.

(Elisa, KI/SP/RN)

A significant number of teenagers in this research migrated to Australia with extended family members, step-parents and friends. Living with people they do not know and have not lived with posed challenges, not only for the teenagers but for those people too. Some AATs felt no one loved them or cared about their needs. Getting pregnant meant they had someone they could love and who could love them back unconditionally.

I think that sometimes they allow themselves to become pregnant because they don’t feel that they are in situations where they are loved particularly, and that by having that child they have someone they can love unconditionally and they have someone that will love them unconditionally. A lot of the girls have come here without families, so that’s a different category of girls who have come as unaccompanied minors or brought by someone who wasn’t their parents and part of their extended families. Those relationships break down and they then feel isolated and have no close family here with them, and they need and want someone that will love them. That puts them in a vulnerable position in terms of young men because anyone who seems to be giving them love and care, they will just flock to without really assessing what is going on properly.

(Nikki, KI/SP)
Pregnancy was thought to help the teenager’s family accept the boyfriend if the family did not approve of the relationship and vice versa. Once the family found out the girl was pregnant, they would allow the couple to live together or would not disapprove of the relationship.

I thought that if I was pregnant and have a baby together with him, Mum will not be able to do anything about it and we will be together because of the baby.

(Candida, AAT)

Pregnancy is the easy way out [of an arranged marriage] in [country] … yeah, yeah, because when some people they say okay, if they do not like you they say we can have a baby, get the girl to be pregnant and then later on, the family, they cannot do anything because they can say I like my husband. Then later they can marry, because if the husband is good, husband is good (with emphasis). Like if he is 21 or something, they can let them marry if it is a good family, they can let them marry later.

(Awel, KI/WFG)

One of the rationales provided by teenagers and in this example, Kayla, for wanting to get pregnant with her previous boyfriend, though it did not happen, was because she was in love with him. Kayla went on to so say that pregnancy was a common practice and strategy used by teenagers to secure a relationship with someone they wanted.

Actually, I was in love with that boy and I thought if I got pregnant our life would be better … And some, because they love their boyfriend so much and they don’t want to lose, they they’ll try to tie them up with babies.

(Kayla, AAT)

Once the girl is pregnant, the rules around dowry and marriage are relaxed. Pregnancy reduces the burden of paying an excessive dowry to the girl’s family, which the boys would not normally be able to afford. Pregnancy served as an escape route out of a wedding ceremony, which is expensive. However, impregnating a girl they were not ‘married’ to did mean the boy had to pay a fine as determined by the girl’s family and relatives for ‘his crime’.
We planned to have a baby so that we could live together, because for my culture reasons, he didn’t have that much money to come and marry me. So we planned to have a baby and live together. In a lot of ways … He’d normally say, ‘No, there’s no need for using a condom because if you become pregnant then you become pregnant.’ That’s what my boyfriend said, ‘I will look after you and the kids,’ but then he never did after that … In my culture, if a girl gets pregnant it’s really easy for the parents just to 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, AAT)

7.2.1.3 Pregnancy: an escape route from arranged marriages, a path to freedom and happiness

In African culture, girls are seen as a commodity to be traded and the man’s family has to pay a dowry or bride price to the parents and relatives of the girls. Traditionally arranged marriages are used to prevent out of wedlock pregnancy, irrespective of age. Once the girl is pregnant, this limits the parents’ negotiating power and even their ability to make a decision about the teenage girls’ future, in contrast to them deciding who and when she marries to fulfil the families financial obligations and duties.

The easiest thing to say is that girls in [country] community are seen as assets and that they are sold for cows and are valued according to the price that they will get for cows. If they have these kinds of relationships and have babies outside the relationship that the parents plan for them, then that devalues them so they then have to go into a new negotiation, whereas the parents would have hoped for something different and they will then either reject them or have some kind of new negotiation given the circumstances that they are in.

(Nikki, KI/SP)

My dad told me to come home (from Uganda) to visit my grandma, then when I came they decided to give me to this man. So I asked him why. He told me that I have two brothers in year 12, he could not afford to pay their fees, so if they married me off, that will mean they will use the dowry to pay for my brothers fees.

(Faustina, KI/AAT)
Some of the mothers admitted that regardless of all the challenges and stigma they faced being teenage mothers, the baby brought happiness and the joy they had hoped for. Teenage mothers felt they had someone they could love, but who made them happy too. For some teenagers, pregnancy and motherhood was good for them as they finally felt relieved they were loved, and had something and someone to live for.

When I came to Australia, my aunty asked me to abort the child and I said no, because that was my first pregnancy and I didn’t know what was going to do. It might have been my only child and I said I couldn’t abort the child … [having a baby] it didn’t affect me because I’m happy all of the time. If I’m at home with her, then we have fun together and it’s good.

(Stephanie, AAT)

Marriage between man and woman remains an important institution in traditional society. The majority of girls and women in African traditional societies are uneducated and have little employability skills. Therefore, marriage remains the only avenue available to her and her children that can provide her with a certain level of ‘social security’. Marrying someone is perceived as being lucky, and greater status is given to married women.

If you are lucky, you can marry when you are younger. My cousin is still [considered] a girl now and we are only two months apart, and she is behaving as if she is mad and is considered a girl.

(Awel, KI/WFG, 30-year-old mother of six children)

Arranged marriages can be planned when the girl is born or when she is growing up and before pregnancy. Arranged marriages can also be made quickly when the girl falls pregnant. In Africa, parents have a lot of say in who girls marry, whether pregnant or not. While out of wedlock pregnancy is not condoned, if the teenager is pregnant, the parents are sad but they know they can ‘fix the problem’. She is given to another husband if her family does not approve of the partner.
When the girl is pregnant, brings the baby, I think it is a big, big, big problem in Australia. In Africa, when the girl brings the baby, you can be sad but you can be happy when the baby is born and maybe you can take her to another man. But in here no another man.

(Patricia, KI/WFG)

The girl is not given to just any one. The family looks for someone that can care for the mother and baby. The family looks at the long-term welfare rather than the immediate welfare and happiness of the mother.

Because in my country, the daughter, if she is pregnant outside, maybe you take it. This man, I do not want it, you take it to another man (other women agree to this) and he has cows and he has anything, you take him to someone rich, you take him from the someone that has made him pregnant, who may or may not have anything. In our culture, no, (very firm) you take the daughter and you give to another man.

(Amina, KI/WFG)

In [country] the different family like your son make a girl pregnant and you have a good family, you can say, ‘I will pay it and I will pay.’ You can ask the family how many cows do you want and you can marry her. If he is refusing you, (mother) can say why you make her pregnant? You force him.

(Christina, KI/WFG)

In Australia, it is not always possible or easy for the pregnant teenager’s family to enforce their culture on the boy. That is, making him take responsibility by paying a dowry for the girl to the family, marrying her and taking care of the mother and child.

In Africa, I see a lot of young girls who have kids and the man looks after them and takes the responsibility, and then they know what they are going through and they’re not going to end up being single.

(Alimatou, AAT)

Regardless of the reasons given for the pregnancy, some SP reported that pregnancy could change some of the girls’ lives for the better.
When they become pregnant and have a child they can often be totally transformed in their personalities (in a good way).

(Nikki, KI/SP)

The community perceptions have contributed to the increase in the number of pregnancies among African teenagers, coupled with the inability of parents to control their children, because of the ‘freedom’ given to children in Australian and its individualistic approach to child upbringing, rather than the traditional African communal approach.

7.2.1.4 Traditional expectation of bearing many children

Traditional society and culture dictates that the girls marry young so that they can bring forth many children during their lifetime. Teenagers are under pressure within their family units and communities to have children by a certain age, and many children, so the children can grow up before the mother gets old and weak. If the mother starts having children later, such as in their mid-20s, the belief is that she may not be able to bear many children for her husband. Such a woman (in her late teens or 20s) would have to marry an old man, who has had other children with previous wives.

A girl should have [baby at] 16 and 18. The babies come and grow up like the mum. The mum not old. You get the baby turn before 25 [years] … The baby go down, the mum she’s old … Like here [Australia], 25 and 24 is good here. Like [country] 16 and 18—she not married by then she has to marry an old man … Yeah, she is old. She’s old. The men want 16 and 18.

(Madonna, AAT)

Such attitudes towards early marriage and child bearing may be due to high IMRs in countries of origin compared to Australia, and may further explain why teenagers get themselves pregnant; the teenagers and their families have not quite adjusted to living life in Australia.
And probably they haven’t made that adjustment to living here; they haven’t worked out that you don’t need to have 10 kids because six are going to die and all those things that happen in Africa. So I think that’s the way that their cultural heritage affects their attitude.

(Nikki KI/SP)

7.2.1.5 Parental inability to control children and consequences

Parents blamed the increasing number of TP among teenagers on a lack of parental control over their children. A common regret on the part of parents, SP and, surprisingly, teenagers, was the inability to ‘discipline’ the children in Australia. In Australia, the families cannot enforce traditional style discipline. This coupled with social security payments and government agency intervention means the boys and men responsible for the pregnancies can take no responsibilities. The consequence of this is that one boy can impregnate several girls and knows that there would be no consequences to him; he does not have to provide for the children and their mothers, Centrelink does.

In [country], the boy may impregnate maybe one girl, here sometimes maybe three girls, maybe two girls at the same time, maybe four and many times, because he does not look after anyone.

(Christina, KI/WFG)

One of my friend’s, her boyfriend has I think four kids … They can have three, four or five. They know [about the children], but they don’t care what they’re doing. Other boys, kid here, kid here, kid here … So these people, they don’t care. So they have kids but they don’t know how to take care of those. They say here you have to be your own so you can do wherever you want to. So that’s why 18 girls and 16, 13, they run from home and say, ‘This is Australia. We don’t care anymore. It’s not like Africa.’

(Fiona, KI)

Aside from the above factors, parents spoke of their fear of the Australian child protection laws that may affect them if they disciplined their children.
I never speak to my girls because the rule in Australia can punish me, when I speak to my girls or when I punish them, maybe she can call police … and I do not like it … the big, big, big problem in Australia is the rule. I do not like it.

(Patricia, KI/WFG)

7.3 Reaction to news of pregnancy
7.3.1 Parents’ and guardians’ reaction

Parents and guardians were generally angry and very upset to know their teenage daughter or niece was pregnant. AATs reported their parents and guardians feelings ranged from being shocked and very disappointed to throwing the teenage girl out of house.

She was just so disappointed in me. She just never thought I would be the person to do that to her—to get pregnant. She thought I would finish my school and do something better than having babies at this age. She was not happy with me because we had our uncle coming to stay. He came and he stayed with us because he was homeless for a little while and I had to give them my room—him and his wife—and I was sharing the same room with Mum and she would be crying every night and she would not want to talk to me if I asked her something.

(Kayla, AAT)

Well the first time was a big shock for them and I think my mum was pretty down that she didn’t raise me right or wasn’t looking after me okay. But at the end of the day, any mother would want their children to have a family and have their own kids.

(Alimatou, AAT)

AATs found it very difficult to tell their family about the pregnancy. Teenagers were very afraid to tell their parents about their pregnancy status early on. Most parents had to discover for themselves that their child was expecting a baby of their own.

They just knew because my stomach was getting big and I was getting bigger. And then my dad just asked me one day and I said, ‘Yeah.’ They got angry about it.

(Carmen, AAT)
I could not speak to my mother just like that. She would just yell and scream. I was scared. Talking to her about sex is very hard, could not do that.

(Candida, AAT)

Unfortunately for most of the AATs, once the parents or the external family members found out about the pregnancy, the common reaction was to throw the girls out of home. Teenagers went and lived with friends and extended family members during this time and only returned home months later or just before the baby’s birth.

After I got pregnant, Mum decided to let me out of the house, but now I’m back home again. I was three months when I left the house and by the time I came back I was five months pregnant. For a little while some family didn’t want to accept it [the pregnancy].

(Kayla, AAT)

So I kept the baby and moved to my aunt’s house because my mum kicked me out. She was very angry, she kicked me out and I only came back home when I was about to give birth.

(Candida, AAT)

Due to the difficulty on the part of the parents accepting the pregnancy, AATs resorted to using an intermediary to break the news about the pregnancies to their parents. The intermediaries were often female, and were trusted friends and aunts.

In my [country], in my [country], it is very difficult … The daughter pregnant it is very hard. Like my daughter when she was pregnant, she went and told her aunty, not me.

(Amina, KI/WFG)

Once the revealing stage was over, some parents soon realised nothing could be done and the best they could do was accept the situation. This surprised some of the teenage girls, especially those that were not sent out of home.

My mum, first she was angry but then she got over it the next day. She didn’t do anything about it. I was shocked.

(Carmen, AAT)
My mum was upset because of my schooling and stuff and then I talked to my mum and we had a fight for some time. I think I was almost five or six months and she was angry still. But since I have the baby she’s nice to me now.

(Chelsea, AAT)

AATs finding out they were pregnant was difficult in itself, and even more difficult for their parents. AATs acknowledged that their parents and guardian were right to be displeased about the pregnancy situation, but the teenagers were displeased by the way some of them were treated.

She had a right to be angry, but not at the level she was. She took my clothes and threw them outside. I took them and went to the park, and was there for about two hours by myself. I was four months pregnant [spoke softly with her head bowed], after that I got a call from my aunty who spoke to me and then came and picked me up. I don’t know who told her about what had happened.

(Candida, AAT)

Becoming pregnant was positive news to teenagers who had intentionally let themselves pregnant. Finding out they were going to be mothers soon brought a sense of joy and relief. The teenagers could finally prove they were fertile and dreams of becoming a mother were fulfilled.

7.3.2 Siblings’ and extended family members’ reaction

Siblings and extended family members were disappointed with the teenager when they learnt she was pregnant. There was a perception from teenagers that they had let their siblings down by becoming pregnant out of wedlock. The brothers and males in the family are supposed to ‘protect’ their sisters, and the sister becoming pregnant is seen as the brothers failing in their duties. The community perception of the brothers then is that they are weak.

My family was very upset why I had a baby when I was not yet married. My older brother was very disappointed. Because he did not know I could do anything like that; that is have sex, let alone become pregnant while not married (speaks with a
lot of regret). I never used to play with a boy. Even when I came here when a boy asks my name I will just ‘crack them shit’, but all that changed.

(Candida, AAT)

They think that the brothers didn’t talk to their sisters. [That] the brothers are stupid, they don’t do it … Because we think different, our people think different.

(Francisca, AAT)

Kayla is the eldest of six children and the only girl. She felt she had let down her siblings.

For a little while, yeah … For a little while some family didn’t want to accept it … My brothers were examining me like an example because they never had an older brother to look up for, they always had me and I always tried to be a better example. The reason why I didn’t continue my schooling back in Egypt is because of my brothers … They were very disappointed seeing the example has been … They’ll always examine me like, ‘If I know how to read this you have to read it as well.’ And I tried. Until I was up to 16 or 17 years old I never wore a dress or a gown or I never put a skirt on, I never did my hair. I was just like a tomboy, just trying to be an example for them.

(Kayla, AAT)

The reaction from Francisca’s guardians who had brought her to Australia was somewhat different. They accepted that she was now old enough to start her own family, though they were not necessarily happy about the pregnancy.

They don’t mind at all … because it’s good to have another family. This is my family.

(Francisca, AAT)

A history of conflict existed between this AAT and her guardians; the teenager had migrated with her uncle and his wife and their children whom she used to care for when they lived in Khartoum-Sudan. This sense of relief from her guardians, who were at the same time members of the extended family, was intended to send the message to her that ‘It serves you right, because you did not listen to us’. Francisca revealed that the guardians no longer speak to her.
7.3.3 Sexual partners’ reaction

The reaction from the male partners when informed about pregnancy status was mixed but more positive. The men/boys were happy about the news of the pregnancy, because impregnating a girl did not only ‘prove’ manhood but also maturity. Other boyfriends simply accepted the fact that the girl was pregnant, and it really did not mean anything to them. When I asked Ayuba if she and her boyfriend had planned her pregnancy and what his reaction was when he learnt of the pregnancy, her response was:

No, it just happened, but when I told him about it he said it was okay [shrugs her shoulders], its fine … [smiles, she was carrying and cuddling the baby during the interview. The baby’s father had greeted me when I arrived but disappeared with his friend into the room next door; and neither of them left the room for the hour and a half I was there.]

(Ayuba, AAT)

I told my friend [who was his sister] and she told him that she is pregnant for you. He was excited, Emmmm … [this woman was thinking and reflecting about the whole excitement about the pregnancy. The boy was a teenager, at school and was living with his parents at the time].

(Josephine, AAT)

For Jessica, while she felt unprepared for motherhood, her boyfriend felt the exact opposite. When he was informed about the pregnancy, his response was as follows:

He was happy and he said, ‘That’s what I want and I’m 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’ … he didn’t.

(Jessica, AAT)

Unfortunately, this did not necessarily mean that the men/boys felt they had to take the responsibility of caring for the child and the mother. While most of the males were excited about the pregnancy, some of them refused to admit that they had impregnated the girl, and
the girls had to go through lengthy court processes of using DNA to prove that he had actually fathered the child. Unfortunately, for some of the teenage girls, the males were right in contesting the pregnancies, because some the DNA results did prove that the person said to be the father was not.

7.3.4 Friends’ reaction

Friends were often supportive of the pregnant teenager, and trusted friends were informed very early about the pregnancy.

It’s too hard to tell … I was one month, was it one month or three week? Three weeks, to my friend, then I told my mum.

(Chelsea, AAT)

Some friends remained friends with the teenager throughout the pregnancy and provided as much support as they could, but some friends distanced themselves.

Some [friends] are very close like this one who is here now, she visits daily even before I had the baby, she encourages me. The others are now very distant from me. I think because I was pregnant.

(Veronica, AAT)

Some AATs were new in the country and did not have anyone they could call a friend or trust enough to confide in.

Yeah, in Perth, where I got pregnant, they [friends] didn’t know about it, I had it [pregnancy] and then I moved. Nobody knows because I haven’t told them, because I haven’t got any friends that connect with me, like really best friend. I can’t just talk to all the girls that sit with me and I don’t know really well and haven’t met them.

(Francisca, AAT)
7.3.5 Community reaction

The community reaction towards teenagers was negative, leaving them with feelings of shame and embarrassment. The negative view of the teenager by the community left their parents disappointed too.

I was embarrassed; I was embarrassed with everyone [in the community]. My mother was angry with me, because I could not go to school. She felt bad, because I am pregnant in street [unmarried] and it is a big problem in the community.

(Veronica, AAT)

Such feelings of shame and embarrassment were not confined to the girl alone but affected her family as a whole. This is because of the community perception that the parents had not brought her up in a respectable manner.

The community frowns at you and your family is looked upon differently [as a result of the TP within the family].

(Jonathan, KI/FSP)

Such negative views of the family by the community can be explained as the community members continue to foster gender roles for males and females. They harbour the idea that girls are to be given to the man that the family has chosen, kept indoors and supervised by their families at all times. The females have to stay virgins until they marry the man the family decides for her. As this SP of African by background puts it:

I think people are failing to realise that the game has changed and the rules how they are applied in [country] do not apply any longer, or are not going to be applicable in a lot of cases. So the idea that the man will be with this girl until they get married is no longer going to work and that is the same with marriage. I argue with the Sudanese that in [country] you may have however many cows to have a wife and she is yours forever, but you pay the same amount of cows in this country and she is not yours forever. Not necessarily. So the rules have to change and people have to recognise this. Now these teenagers who become pregnant in this country are not playing by any of the rules as they are applied in [country]. So I think they should be changing their mindset.

(Jacob, KI/SP/RN)
The reaction towards the pregnant teenager was overall disappointing from family, friends and the community. Luckily, there were the odd friends who stood by her. Regardless of the reaction towards the pregnancy and the reason for becoming pregnant, the mother to be needs support during pregnancy.

7.4 Support towards AATs in relationships

Support during the pregnancy came from various sources, which included family, siblings, friends and some members of the community. SP provided support ranging from emotional to educational information about social security and financial services. In this section, I discuss the various support systems and networks available to teenagers during pregnancy.

7.4.1 Overall parental support towards AATs in sexual relationships

The support that AATs received from parents when they are in a relationship was conditional. By conditional, I mean it depends on how the relationship came into existence. Parents were less likely to support their daughter if she complained about a male partner, especially in relation to not wanting to have sex with him. This was common place if the male partner was a husband or a man the family had given the girl to or acknowledged the relationship by receiving a dowry from him and his family. If he complained to the parents she did not want to engage in sexual intercourse with him, he was encouraged to force himself unto her.

No, they’re [parents] not going to do anything. No, if he’s your boyfriend then you can tell your parents, but if it’s your husband you can’t tell them. Sometimes your father gives you an arranged marriage and if you refuse to sleep with him then when the man comes, he tells your parents and he just does it by force. They’re [parents] not going to care. But if he’s your boyfriend it’s different.

(Jessica, AAT)

Mothers were somehow more sympathetic than fathers, but the mothers could not express this support openly in the presence or hearing of their own husbands. A mother could not
be seen to go against the word of the girl’s father, even if the mother sympathised with the daughter’s situation, for fear of vengeance towards her by the husbands.

They [parents] would say you’re wrong and you should listen to your husband … Yeah, just accept when husband hits you in front of them—if they’re seeing the effect in front of them that is the time they can talk. They can say, ‘You’re wrong. Don’t do this.’ But if something happened behind it and they didn’t see it, they’ll always say the husband is right.

(Honorine, AAT)

If the mother openly showed support for the daughter, she would be punished promptly by the father. This is because the parents [fathers] arrange the marriages, and men are allowed to ‘discipline’ their wives if they feel the women are not obedient. Women have to listen to men, but men are not expected to listen to women except if they wish to.

My dad told my mum, ‘Look, you need to tell your daughter to marry this other guy.’ Then he fought with my mum every day and then I said, ‘Okay, I’m going to marry him’ … Yes, with [country] men I think that [beating] happens all the time. If a man has a wife, he’s also beating them.

(Jessica, AAT)

You have to talk to him first [before making any decision], if he says no it means no and if he says yes then okay. Because I respect him I have to agree … In my country you have to respect men and you have to listen to whatever he says. For example, like if he said, ‘I do not want you to go out, I do not want you to wear shorts, or that woman is bad I do not want you to hang out with her,’ if you respect him, and you love him and want to stay with him, you have to listen … other men they do not listen to you [wife] to whatever she says.

(Ayuba, AAT)

Such abusive behaviours towards women are underpinned by ‘traditional’ thinking, whereby men are perceived to be more knowledgeable, men have rights over women but women have no rights, women are fragile and are the property of the man and his family.

So whatever, you have your right, don’t tell this in front of the woman, she has right, you have to tell the man behind her. So whatever the man does wrong they’re not going to tell the man at the front of the woman, ‘You are wrong,’ so
they have to call him and tell him around the corner or somewhere else. So they don’t want a woman to have right.

(Honorine, KI/AAT)

The way we view women, they are mothers, they’re fragile and to a certain extent they need to be looked after and all that, but they also need to respect our husbands and fathers and be obedient.

(Elisa, KI/SP/RN)

7.4.2 Parental support towards AATs as a result of TP

The teenagers who had their biological parents (or a parent) living with them received the most support during the pregnancy. Thus, the amount of support a teenager received depended on who she was living with at the time of pregnancy, regardless of their immediate reaction on receiving the news of the pregnancy. The mothers provided most of the physical and emotional support during the pregnancy. By physical, I mean cleaning and cooking, and emotional, I mean providing with love and ensuring they are happy and comfortable. Mothers, unfortunately, were sometimes blamed for their daughter’s pregnancy.

Because when they are young, they get pregnant and then they come back to their parents when the boyfriend cannot look after them, and the dad blame the mother that ‘You did not take care of your daughter well, you did not advise her.’

(Faustina, KI/AAT)

Fathers and stepfathers were seldom mentioned when it came to support during pregnancy, regardless of if they lived with the teenager or not at the time of pregnancy. The support that mothers provided ranged from caring for the girl at home, ensuring she had enough rest and ate well to taking her to medical and antenatal appointments.
My mother, she has been thinking about it and now she’s become a big supporter of me and the baby. She comes to some appointments … She will take care of me and she will give me advice … She gives me advice on how to look after myself and at home she doesn’t make me work too hard and she always makes sure I get enough rest for myself and I eat good.

(Kayla, AAT)

Every mum, like if my daughter get baby, first time not good, this is my baby I have to help her, though you are not happy, after you forget. But what can you do, I kill my daughter? No, but you are very sad I have to take the baby and look after the baby.

(Laura, KI/WFG)

7.4.3 Support from the baby’s father

The level of support and involvement by the person who impregnated the girls during and after the pregnancy was wanting. Most of the fathers at some stage during the pregnancy were living in another state or were in another country. For the boyfriends who lived in Australia, and in some cases with the girls, they saw their role mainly as that of a ‘provider’ or to sparingly support the mother to carry out her duties. Table 7 shows the place of residence of the father during all or most of the pregnancy period. According to Carmen, the father of her first child:

Went to Sydney and then he got himself in trouble and went to jail … He was going to Sydney for his sister’s wedding and he got into trouble … so I just moved out from him because he’s a trouble maker … [I was] three months pregnant … [She] haven’t seen him..

(Carmen, AAT)

This young woman spoke with a lot of regret in her voice; however, she got pregnant within a year of having her first child at age 17. Fortunately, she received more support from the second boyfriend and his family. When asked about the level of support and state of her current relationship she stated:
Yes, it’s serious … because we live together and my family knows about him and his family also knows about me, so they’re friends and they get along.

(Carmen, AAT)

She did not mention how involved he was in supporting her care for the children, considering she is a teenager and a mother to two children. Stephanie had left the refugee camp in the transit country where she was living without realising she was pregnant. She decided to keep her pregnancy rather than abort the baby as suggested by her aunt after they arrived in Australia. Unfortunately, she has had to go through the whole pregnancy by herself with no support from the father:

Where he lives in Africa, there is no telephone line.

(Stephanie, AAT)

Some teenagers knew that they would have no support from the father, but decided to keep the pregnancy. This meant going against the advice and wishes of their close friends.

Some of them are telling me why get pregnant again when your boyfriend is not even with you and you should just abort the baby. I tell them that sometimes it is not good to abort the baby. It’s not fair. I can’t abort this baby when I have Rosy her. It’s like I don’t like the baby.

(Jessica, AAT)

7.4.4 Support from the siblings and extended family members

The siblings’ support during the pregnancy was either non-existent or very modest. This is understandable considering in most cases the siblings were younger and really did not understand what was happening. For the teenagers who had older siblings, they received little or no support because the older siblings (females) felt that the AATs had not listened to them, and thus did not deserve their support or help. When they were supportive, support was somewhat limited and depended on the relationship.

I have a brother here, but he’s like my stepbrother because he came with someone else. Sometimes he helps me and sometimes not … my mum has 13 [children].

(Jessica, AAT)
I used to live with my sister who is older, she is 32 now … I used to live with her and she was married when I was seven [sister was married at 17] … we left Burundi when I was three years old and went to Tanzania … it took three months before she started talking to me and after that it was fine.

(Ayuba, AAT)

AATs who had migrated with extended family members, especially those that were related to them through marriage, had the least support compared to those who had at least one parent or had first degree relatives in Australia.

I came here with my uncle’s wife. I came because I was staying with her, looking after her kids and then we come here together … it’s a good thing [I came with her] but she’s not good since. I get pregnant, she kick me out of the house. Now she doesn’t talk to me, even she finds me in the street she doesn’t say hi to me. It’s not good. So it’s better to have your mum. Even your mum is angry with you it’s not going to be like this. She’s [mum] going to calm down a little bit.

(Daniella, AAT)

Fortunately, there were other friends and their families, aunties and cousins who lend their support and open their doors to AATs during crisis.

When they kicked me out I was staying with my friend for six months until I gave birth and then I looked for a house. My aunty, she’s in Dandenong, I was staying with her too.

(Daniella, AAT)

She [mum] was very angry, she kicked me out and I only came back home when I was about to give birth … She had the right to be angry but not at the level she was. She took my clothes and threw them outside. I took them and went to the park and was there for about two hours by myself. I was four months pregnant [she speaks softly with her head bowed] after that I got a call from my aunty who spoke to me and then came and picked me up. I don’t know who told her about what had happened.

(Candida, AAT)
7.4.5 The community

Support for teenage girls from their own communities was not available. This is understandable considering TP continues to be stigmatised within most African communities. People from the community at an individual level could sympathise with the teenagers and offer them support as evident above, but that was a choice they had to make as individuals.

7.4.6 Support from SP

There was generally much support from government services and agencies, such as Centrelink, for pregnant teenagers. Social workers played a pivotal role in helping pregnant teenagers gain accommodation and financial support. The members of the African community met the support provided to pregnant teenagers by these agencies and SP with some level of resentment.

7.4.6.1 Financial support and the ‘baby bonus’

Centrelink payments and the ‘baby bonus’ (a payment of up to A$5000 depending on other income, paid to families after the birth of a child in Australia) was the main financial support available to teenagers before and after the birth of their child respectively. The ways in which teenagers, SP and parents viewed Centrelink payments, especially the baby bonuses, were mixed but mostly negative. Centrelink payments were perceived to be good in the short term for adults who knew what to do with the money, and who planned to get back into the work force as soon as they were ‘settled’.

In the refugee camp it was bad because my mum was doing everything for us and she was suffering … she used to make that one [palm oil]. She used to go and sell rice and she used to do a farm. Too much for us … But in [another refugee camp] they were having refugee school, so we used to attend refugee school. I have got my little sister and she’s big now, she does everything. I just look after my baby and go to school. And then the government give my mum some money so some of the suffering has gone away.

(Chelsea, AAT)
The baby bonus was highly frowned upon because the community believed that some AATs were getting pregnant because of the financial benefit they stood to gain and the baby bonus of $5,000 that would come with the birth of each child.

The government money. When you have a baby, the money they give you. That’s what everyone wants to have a baby … its good, but some of them are not married and they are just wanting and wanting. Some people are not yet married and have two or three [kids].

(Stephanie, AAT)

SP share this view about TP that African teenage girls are letting themselves pregnant in order to receive the baby bonus payment.

Teenage pregnancies in certain African communities I can confidently say that most of them are getting pregnant to get the $5,000 from the government. There’s no discipline, there’s no father figures, there’s no mother figures, and you’re in a society where you’re confused and you have no idea where you fit in or who you fit in with so if they want to get out of home and do it as quickly as possible, for them they think, ‘$5,000 is a good start, not knowing that it’s a difficult road ahead. We have had to deal with a lot of young people who fell pregnant specifically between 2005–2006 when the money kept going up..

(Elisa, KI/SP/RN) of African descent)

Only one of the girls who had had a TP worked. She worked as a cashier in a Coles supermarket. All the other teenagers and young women depended on social security payments. To their disbelief, the money from Centrelink was not always enough to meet the needs of the baby and the mother.

Before the baby was born, I received $377 from Centrelink. And after the baby, I get $420 for myself and for the baby $230 per fortnight … we have to pay for the house and the bills, so I do not think it is enough.

(Ayuba, AAT)
It was evident from Ayuba’s body language that she was not happy with the amount of money she was currently receiving from Centrelink. After we had finished the interview, she asked if I knew the name of any agency she could go to for help with the bills.

7.4.6.2 Housing support, independence and freedom

Some teenagers had willingly become pregnant because they were lured by the idea that they would be a priority for government housing because of their age and single parent status. Unfortunately, their dreams and expectations of a big new house was not often the reality, nor was the house available within the timeframe that they had anticipated.

I am with the [agency] until I get a house … they rent me a motel. I pay money to them until I get the house and then I was evicted. I was paying $400 a fortnight. One room only … It was very small and a small kitchen. Not a house. Just small. I think like soon I will get a house before I have the baby, because I would have baby soon but it’s not even good for me with the two years, my son. The stairs going down and I don’t like [it]. I feel tired. I don’t know anybody in there in that area, St Kilda. Just feel outside. … Yeah I’m happy when I’m here and when I go home I don’t talk to anybody … because there are no people … I don’t know anybody.

(Alimatou, AAT)

Pregnancy was perceived to be the easiest way out of strict family rules, thus it brought independence and freedom to the AATs. Becoming pregnant meant teenagers could more easily secure government housing, live alone and be independent.

I have a friend and she said, ‘You have a baby and I think it would be better if you move into your own place. You need your privacy’. I went to Centrelink and they gave me a house.

(Stephanie, AAT)

7.4.7 Support services during pregnancy by SP

SP who provided services and support to teenagers during pregnancy included teachers, social workers, doctors and nurses. Their services were highly valued by the teenagers but
not by other people, such as parents and some members of the African community. It was the healthcare providers who sometimes had to break the pregnancy news to the teenagers, who were often unaware of the pregnancy. This could be very difficult for both the SP and the teenager.

Emmmmm [followed by a long silence], I was just like getting fat. My friends said that you are fat; I said maybe I am just eating; so they said let’s go to the hospital. I was then told at the hospital I was five months pregnant. I cried, because I was in school, but what could I do? I knew nothing.

(Josephine, AAT)

For some teenagers, healthcare providers and school teachers gave them the various options and necessary support available in regards to the pregnancy; that is, keeping the baby, adopting the baby after birth or terminating the pregnancy. Some teenagers made choices that they regretted later on during the pregnancy. It is not apparent if the information was not provided efficiently or if the teenagers did not have a deeper understanding of the choices they were making or if they required more support. For example:

I still continued my schooling, until my teacher found out I was pregnant. I was about two months and she advised me to do an abortion and I refused … Emmmmm, I don’t know, I did not want to get rid of it, because he had told me not to and that when he came back he would deal with my parents [in relation to the dowry] … He was going to tell my parents that I am pregnant and he will marry me, but … (followed by silence and bows her head), he started like totally a different person. I told my teacher that I would like to do an abortion now, I was now four months pregnant, but when I went to the Health Centre in Melbourne I was told by the refugee nurse it was already too late.

(Candida, AAT)

Support services and allied healthcare workers were seen as a valuable resource for teenagers during the pregnancy. The teenage mothers-to-be were perceived not old enough to manage their own personal needs in addition to the needs of the unborn baby.

The social work is not a bad thing, it’s a good thing, because sometimes they’re still kids and if they have a child they can’t think and they’re not old enough to manage the things. So they need somebody around them who knows what’s going
on in their lives and has knowledge of the things about teenagers so they can tell them what’s wrong and what’s good. So I think the social worker is great.

(Honorine, AAT/KI)

Having a social worker and all the support services around the teenage girls were not viewed in the same positive light by most parents. African women and AATs felt these readily available services encouraged other teenage girls to intentionally get pregnant in order to gain attention from SP.

Centrelink is here, housing is here to give her a house, Centrelink to give her money, she has social worker to do what she wants, anything, and she does not care.

(Christina, KI/WFG)

For the boys, Centrelink support payments to the girls and the mothers-to-be meant they did not have to take any responsibilities before, during and after the pregnancy. This would not have been the case if they were in Africa; the man has to work to feed his children.

Due to freedom [other members in the focus group agree], Centrelink, even if the boy has 16 years is looking for sex, but back home even 20, no, but here 16 to 17 Because there is no Centrelink [back home]; because if they have a child, and if they do not have cows or goats, how are they going to feed the baby? Here [in Australia] girlfriend can have family benefit.

(Awel KI/WFG)

Some care providers of African descent felt that mainstream care providers were sometimes biased or prejudged the African teenagers negatively when providing care to them. The language barrier that often exists between caregiver and receiver does not help. For example:

One of the clients that I worked with was with the language school in Melbourne and I had to take them to a doctor. When I took them to the doctor, the doctor really had the assumption that she was sexually active who caught probably the disease and was really forcing her to get those STIs, but in a very-how do I say it? Just pressuring her. Instead of making her understand why it is important and why we should get checked. Even though she wasn’t sexually active, she never had sex. But the way he just perceived her and the way she appeared, he just had that
assumption that she was sexually active. Where we train, we want to get health professionals who work with those clients to understand the cultures issues. So once they know their culture then they can understand how to protect the culture as well and mix modern medicine together with their cultural remedies or whatever they use. And understand the settlement processes as well; because they are a disadvantaged group, they’ve been through trauma, and just settling in a western country. So we are making them aware of it. The language barrier-I think that is one of the biggest things, the language barrier.

(Chantal, KI/SP/RN)

7.5 Motherhood

In African culture, motherhood is celebrated and is regarded as a special event in the woman’s life. Motherhood is highly anticipated and valued irrespective of the challenges that may come with it. With teenagers, those challenges are even greater. The birth of a baby is celebrated by family and friends regardless of the circumstances surrounding the pregnancy. The parents, siblings, friends and the community would normally come together to support the new mother and her baby. In this section, I describe the joys of motherhood and the challenges and support persons available to teenagers after the baby’s birth.

7.5.1 Joys of motherhood

Becoming a mother was a blissful moment for teenagers. Teenagers were generally happy to have a baby of their own, even when things were difficult. Teenage mothers were positive and thought their lives changed for the better after motherhood.

In a way, sometimes it’s good, sometimes not good … Sometimes when something happens and we are in the apartment he says, ‘Sorry, Mum.’ Then when I’m tired, like when I’m sleeping, I’ll send him and he’ll go and bring something so that I don’t have to go and bring them.

(Alimatou, AAT)

To some teenagers, motherhood meant they were now adults and more mature irrespective of their age and had to be responsible. Motherhood was good for these teenagers;
motherhood gave them a sense of purpose and provided them with the family they always wanted. Motherhood gave them someone they could truly love and for some, motherhood brought a sense of self-worth.

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, AAT)

7.5.2 Challenges of motherhood

With the joys of motherhood came the challenges of being a mother and taking care of a baby. Teenagers had challenges coping with the responsibilities that came with the birth of the baby from working to attending school.

Yeah, is very hard to take care of the kids and still go to school or look for job, And you don’t have someone to look after you and your baby. It’s very hard.

(Daniella, AAT)

For Ayuba, it was even harder because she had no one to help her at home or lend a hand.

It is not easy to have a baby. It’s very hard, it is better to go to school and get a job first. Once the baby comes, it is very hard, you can’t do anything, especially when you do not have someone to help you it is very hard.

(Ayuba, AAT)

Teenage mothers, like other mothers, had difficulties meeting the needs of the older child, continuing their education, and meeting and socialising with their friends. Feelings of exhaustion were not uncommon.

It’s very difficult. Before it was easy for me before I just had Rosy [she is expecting her second child and she is 17]. Because she couldn’t walk, I couldn’t take her to the shop, I can’t go to school and I can’t do all my stuff but now I don’t do anything because if I take her to the child care I come back home and I’m just tired. I think when the baby is born it will be more difficult because I don’t have a car because he took my car and I don’t even have a car and that’s why everything is getting more difficult. It will be very hard for me to go back to
school now. Everything is not going to be easy like it used to be. But I am happy with my kids.

(Jessica, AAT)

7.5.3 Support for the teenager after the birth of the baby

Luckily, some support was available for teenagers to help them meet the demands and challenges of motherhood. Like the support available during the pregnancy period, significant people in the teenage girl’s life supported her during the immediate post-partum period and thereafter.

7.5.3.1 Support from the teenagers' family
7.5.3.1.1 Teenage girls’ parents/guardians

By parents and guardians, I refer to the people under whose guidance AATs came to Australia. The extent of support that AATs received from these people depended on the relationship they had before the birth of the baby. Thus, if the relationship between parent and daughter or guardian had been good, AATs were more likely to receive support from these people.

7.5.3.1.2 Mother

Support that came from within AATs’ family was often from the mothers. The mothers saw it as their duty and responsibility to take care of their daughter and the baby. These acts of love towards AATs and their baby by their mothers were highly valued and acknowledged by AATs.

Every mum, like my daughter get baby, first time not good, this is my baby I have to help her, though they are not happy, after you forget. You are unhappy but what can you do … I have to take the baby and look after the baby.

(Laura, KI/WFG)
Like support during pregnancy, AATs who lived with at least one biological parent or a first degree relative had the most help and support with the baby compared to those who did not have any of their parents in Australia.

Is not good thing [to be pregnant out of wedlock] but she’s [uncle’s wife] not good since. I get pregnant; she kicked me out of house. Now she doesn’t talk to me, even if she finds me in the street she doesn’t say hi to me. It’s not good. So it’s better to have your mum. Even if your mum is angry with you it’s not going to be like this. She’s going to calm down a little.

(Daniella, AAT)

The support that AATs received was expressed in their actions or intentions to re-engage with mainstream education. Teenagers who received more support from their family, especially from their mothers, were more likely to return or want return to school.

She asked me ‘Are you going to keep the baby?’ and I was like, ‘Yes.’ My mum was upset because of my schooling and stuff and then I talked to my mum and we had a fight for some time … so she says I have to go to school … [went back to school when the baby was] four months. As soon as February, when school started I went back to school. Because I wanted. I wanted to do something for myself in the future that’s good. I want to become a nurse.

(Chelsea, AAT)

I went to Chelsea’s home on two separate occasions, first to discuss the research with her and later to interview her. On both occasions, Chelsea’s mother had Chelsea’s baby on her back as African mothers do, while Chelsea went about her normal duties. When the baby cried, her sister who was about 12 at the time carried the baby and cuddled her. It was evident to me that Chelsea had support from her mother and sibling caring for the baby.

7.5.3.1.3 Father

AATs who had their fathers here did not feel strongly about getting support from them with the baby. Unfortunately, for most of these teenagers, their fathers were partially or completely absent from their lives. This brought feelings of pain. Almost all teenagers
came from single parent homes or their fathers were back in Africa and were married to other women.

Dad, he’s in the USA. It’s very strange, we’re trying to be close to him but his mind is always somewhere else. I’m not sure if he wants to have children and a family even at his age. He left when my brother was about one year and my younger brother is 15, turning 16 so it’s like we haven’t seen him for 15 years. It’s feeling like I’m sad.

(Kayla, AAT)

The parents of Jessica live in her home country. She does not expect any support from them, especially from her father, who has many wives and children.

My dad has a lot of women. He has two wives plus my mum, so three of them.

(Jessica, AAT)

Support was not only lacking from absent biological fathers, but present step-fathers were perceived to be lacking in support for the step-daughters and the children born to them. This young woman had two miscarriages and does not feel supported or loved by any of the ‘fathers’ in her life:

Because I was living with my step-father and he was treating me very bad at home … He’s not happy when I’m home, he don’t feel happy. Sometimes he swears at me. Sometimes when he has some argument with my mum and he brings my name, ‘You and your daughter, and I feel very bad and I feel not good … I don’t know because when I ask my mum, she says she get pregnant with me when she was 15 and then my father said—because he’s married another woman and the other woman said if he didn’t leave this girl we will divorce and he has five children with the other woman so he decided that woman because has five children and this other one only has one child. So he decided to go to the other woman. And the other woman is working in hospital and she’s good and my mum she doesn’t have an education and all that. I call him but he don’t call me. When I call him he’s nice, but he don’t call me at all. He’s rich in Sudan so he has enough money. If he want to call me he has enough money, but he doesn’t call.

(Bikutsi, AAT)
7.5.3.1.4 Siblings

The siblings who were available were often helpful and supportive of their sister. Teenagers received help from their siblings in taking care of the baby so they could attend to school work or go out and socialise.

7.5.3.1.5 The baby’s father and his family

The fathers of the babies were often absent during and after the pregnancy, see Table 7 in the appendix, which shows the place of residence of the mother, the fathers and the perceived level of support provided by the fathers to the teenage mothers during and after pregnancy. For the few fathers who were around, the amount of support, be it financial, emotional or physical to the teenage mother and the baby, can be described as wanting. They boyfriends were more inclined to try to access the social security benefits available to the mother rather than support her with the child.

They don’t go to work, they just want to take money from them and stuff like that. The men they just want to take the money from the ladies. It’s not good.

(Daniella, AAT)

He would pretend that he loved me, but he didn’t love me and he didn’t love my child. It’s very hard to find a good person because when they know you have a baby, they don’t care about you. They love to come around if you have money and ask if you have money and then they just go away with the money. If they know you have a kid, it sends them packing.

(Stephanie, AAT)

During the interview process I attended two homes where the babies’ fathers were present. One of the babies was two weeks old and the other was two months old. The paternal grandmother of the two week old was around to support the teenage mother, who had had the baby circumcised the day before. The grandmother’s son, the baby’s father, was on the computer playing computer games for the whole time I attended. When I asked the teenage mother how much support she was getting from the father, and the family, she
acknowledged that she had been supported by her friend who was present at the time, her own mother and the baby’s paternal grandmother. About the father, she stated:

We are not getting married, yes [we are] in a relationship; no, not serious, just between the baby … Because I don’t love the boy … because my mind is not to love the boy … My heart is not there … I am young and I want to continue my education.

(Veronica, AAT)

The support that the teenage mothers had was from the female friends and female members of the family.

7.5.3.2 Support from AATs’ friends and the extended family

Support received from friends was mixed and the level of support largely depended on the type of friendship before the pregnancy. The loyal friends supported the mothers during the pregnancy and after the baby’s birth.

Some [friends] are very close, like this one who is here now, she visits daily. Even before I had the baby she encourages me. The others are now very distant from me. I think because I was pregnant.

(Veronica, AAT)

This scenario was not the same for many other teenagers, who felt isolated because they had no one they felt connected to, and for others their friends lived far away.

I have one best friend and she has a baby as well, how can she support me? She has to look after her baby so she didn’t have time to support me. So I decided to keep to myself.

(Chelsea, AAT)

Some of the teenagers’ friends were themselves teenage mums, thus they could not support their friends while caring for their own babies.
Yeah I have one [friend] but she lives very far. She lives in but it is on the other side of the city. I do not drive, so it’s very hard to get there.

(Ayuba, AAT)

7.5.3.3 Support from AATs’ community

The members of the African community generally frown on teenage mums. Teenage mothers are perceived to be setting a bad examples to other teenagers, and give a bad image of the community. Thus, there was nothing directly aimed at supporting mothers by members of their community. Like support during pregnancy, individuals could choose to help teenage mothers in need at their own accord. None of the participants in this research discussed receiving support for the baby on behalf of the community.

In contrast, some of the communities organised marriages whereby the boy is made to take responsibility of the teenage mother and the baby. Unfortunately, this is difficult to reinforce, because most often the boys do not have a job themselves, and may have children with several girls.

7.6 Summary

In this chapter, I discussed the journey through pregnancy and the support teenagers receive or do not receive during pregnancy. I described the people who provide support and the type of support they did provide. I went on to discuss the happiness and difficulties that come with motherhood. The different roles played by AATs family members, friends, boyfriends and the wider community was also discussed. Being a teenage mother is difficult, but with the right people and support available, teenager mothers can successfully re-engage in mainstream society.
Chapter 8: Discussion

8.1 Introduction

Maybe some of the girls did not, or do not see any future for themselves and that this [pregnancy] is the only thing that would happen. This becomes the only avenue left, have a family. In a sense, you can understand them; language is still a problem, maybe education because of the war situation back home has not become the big focus for people, and what else have you got if you’re not going to be educated in this country or get into your own business? People I don’t think can see a future for themselves.

(Jacob, KI/SP/RN)

My research explored the relationships between culture, contraception use, pregnancy and motherhood among AATs with a refugee background who have experienced TP. In this discussion chapter, I revisit key themes that emerged during the research process and data analysis, and contextualise these themes with broader theoretical concepts and other relevant research findings. In particular, I discuss gender (in)equality, knowledge and attitudes towards contraception, sexuality and relationships, and attitudes towards and experiences of unplanned pregnancy and teen motherhood, and their optimism. I emphasise that these young women have limited decision making control in regards to their contraception uptake and use. More broadly, cultural issues, gender inequalities, social structures and experiences of forced migration underpin contraception decision making and use. No research in Australia has explored the links that exist between culture, contraception use, TP and eventual motherhood among African teenagers with a refugee background. This research closes that gap.

In this thesis, I have drawn upon several relevant theories. Intersectionality developed by black feminists from America and the developing countries who recognised that black women’s experiences of discrimination and racism could not be sufficiently analysed using single axes, such as gender or race (Crenshaw, 1989; Collins, 1990). They recognised the
importance of multiple factors—for example, race/ethnicity, migration status, age and sexual orientation—as significant in shaping the lives and decisions of women (Crenshaw, 1989; Collins, 1990; Hankivsky, 2012). Intersectionality takes into account the different identities that black women and women of colour live within and how these simultaneously affect their lives, particularly when they are oppressed (Crenshaw, 1989; Hankivsky, 2012). Intersectionalities theory advocates for the recognition of the various intersections that people of colour (including Africans) exist in, including their migration experiences (Collins, 1990). I also drew upon the social model of health and framework, which advocates for health models to expand beyond the sick individual to include environment, culture and belief systems and the socio-economic and SDH (Wilkinson & Marmot, 2003; Liamputtong, Fanany et al., 2012). Gender theories acknowledge the disadvantages women experience and examine how these disadvantages are played out through cultural and social structures (Tsouroufli, Rees et al., 2011). Sexual scripting theory describes the patterns within which sexual relationships occur until eventual sexual enactment (Gagnon, 1990). Finally, motherhood theory was discussed in which pro-natalist ideologies socialise girls from an early age to become mothers and carry out domestic duties (Afable-Munsuz, Speizer et al., 2006).

8.2 Gender (in)equality and health

Gender plays an important role in people’s lives and substantially affects their health and decision making abilities. Gender inequalities exist within cultures that support male superiority over female, a practice common among Sub-Saharan African persons, which continues following migration to western countries like Australia (Khawaja & Milner, 2012; Mellor, Renzaho et al., 2012). According to intersectionality theory, the multiple identities of women of colour mean they face challenges, oppression and discrimination at multiple levels and in many ways (Collins, 1990; Hankivsky, 2012). In many traditional African societies, existing gender norms foster gender inequality through the subjectivity of females by males (Khawaja & Milner, 2012). However, the position of the African woman can be described as both an oppressed and a privileged one. Oppressed because of the patriarchal nature of the social systems (Mellor, Renzaho et al., 2012) and privileged
because of her position of mother (Levi, 2010). This is consistent with intersectionality (Crenshaw, 2001), whereby one can be simultaneously privileged and oppressed (Trahan, 2011).

Gender inequalities can contribute to poor health literacy among women—particularly those with low socio-economic status and limited education—and can create challenges for effective negotiation of contraception use (Pieh-Holder, Callahan et al., 2012). For example, the sexual health decision making abilities of African teenagers are substantially shaped by gender, as well as culture, migration, education and both traditional and modern belief systems (WHO & United States Agency for International Development, 2008). More Sub-Saharan African teenage girls and women are infected with the HIV/AIDS virus compared to males. While efforts are being made globally to narrow gender inequalities in health, the health of women and girls would continue to be adversely affected if their multiple identities are not considered, including when providing health services to migrants (Tsouroufli, Rees et al., 2011).

8.3 Gender, culture, sexual and reproductive health

Health-related behaviours and outcomes—including gender-related health concerns—are shaped by culture. The society in which one lives shapes and influences thinking, behaviour and world view (Papadopoulos, 2006; Carroll, Epstein et al., 2007; Upvall & Bost, 2007; Chapman & Francis, 2011). Indirect modes of knowledge acquisition include observation, living within a culture and participating in rituals and social activities. Direct modes of acquisition include formal institutions of learning and religious and social organisations, such as schools, churches, mosques and community gatherings. Communities with a strong sense of community cohesiveness add to the individual’s ways of doing things that include acceptable gender norms and health behaviours (Donini-Lenhoff & Hendrick, 2000).

Most African parents continue to hold strong traditional norms and virtues where girls are to dress conservatively, minimise interactions with the opposite sex and confine themselves to school work and home duties. Moreover, girls are to be submissive to adults and males,
as such obedience is evidence of a girl’s good character and morals (Mellor, Renzaho et al., 2012). Being obedient increases a girl’s chance of marriage and risks her being oppressed and subjected into an unequal marital relationship. Conversely, it is this submissiveness that parents and the community would rather have for their daughters and women (Khawaja & Milner, 2012). Though the intentions of parents towards daughters are often good, to ensure future marriage prospects, this may affect the girl otherwise.

Submissiveness is not the only social behaviour that emerged in this research to which teenage girls are subjected or expected to conform: maintaining virginity until marriage is encouraged and nurtured as virginity status increases AATs’ marriage chances. Being submissive and maintaining one’s virginity is aimed at securing a good husband and a good marriage. Marriage within such a school of thought is considered a secured social institution that guarantees future financial stability and security for teenagers and their children and respect, including higher status among her peers (Khawaja & Milner, 2012). Such honour and status is also reflected on the teenager’s family within the community. Therefore, the teenage person is not only responsible for her own honour but that of her family. This is consistent with other research, where girls are the keepers of culture, even when this happens to their own detriment (Nguyen, Liamputtong et al., 2006). To understand the degree and levels of expectations from AATs, an in-depth understanding of the interconnections of culture and societal expectations, including parents own expectations/pressures, needs to be dissected and brought to the fore.

Self-reflection and questioning of traditional ways of operating, including rebelling against them, emerged as another interesting finding from this research. AATs questioned traditional norms, their parents and community ways of operating, including questioning or examining their own behaviours after immersion into their ‘new’ Australian culture. This shows there is a level of self-reflection from teenagers rather than teenagers just behaving out of character. Considering gender role theory (Collins, 1990), gender role orientations are perceived to continue to affect females not only after migration but also in the afterlife for those who are religious or believe in the afterlife. Such beliefs may affect the teenage person emotionally because of the fear of the unknown, with them blaming themselves for
what happened to them, even if this is not so. More so, AATs engage in self-reflection, despite common preconceptions that teenagers act without thinking.

Virginity emerged as a key concern for parents and teenage girls alike, and is considered a significant means of preventing unintended pregnancies. African mothers said they wanted their daughters to remain virgins until marriage, and encouraged early marriage. A SP of African background articulated the cultural importance of not engaging in premarital sex. While none of the participants in this study was a virgin, they continued to value premarital virginity, and having an out of wedlock unplanned TP was a regret they all shared. Teenagers regretted losing their virginity because this compromised their future marriage prospects and their families standing within their community (Gartrell, 2007). Virginity and abstinence prior to marriage remain important to AATs, even after an unplanned out of wedlock pregnancy.

The morals of the girl, including her and her family’s standing in the community, was seen as significant (Nguyen, Liamputtong et al., 2006), including towards maintaining virginity (Gartrell, 2007). A girl who marries while still a virgin gains more respect from her husband, in-laws, parents and community. This may attract more gifts from the groom’s family to the bride’s family. A virgin girl and her family are treated with respect in her community, as the family is considered to have good morals and their daughter brought up properly (Kaye, Mirembe et al., 2005; Bishai, Falb et al., 2009). However, males are not scrutinised like their female counterparts within the family unit and by the community, and the level and degree of oppression they experience is different. Women and girls experience both external pressures from the community and internal ones from their husbands, boyfriends and partners. Boys can freely attend social functions and interact with their friends. Males are reportedly free to have sex before marriage, as their virginity at marriage is not under scrutiny compared to females, a finding consistent with other research among Sub-Saharan African teenagers (Maticka-Tyndale, Gallant et al., 2005; O’Sullivan, Harrison et al., 2006; Govender & Penn-Kekana, 2007). This is in part because there is no evidence that a man has had sex unless he admits to it. Girls and women, however, may become pregnant, ‘damage’ their hymen or fail to bleed on the sheets following
consummation of her marriage (although the last two are not reliable evidence of a lack of virginity). FGM was a common practice used in some Africa cultures to ensure that the girl preserved her virginity until marriage, a finding consistent with other research (Worth, 1994; Ngum Chi, 2006). These persistent different gender-specific layers of pressure and expectation need to be understood (Collins, 1990; Crenshaw, 2001). However, post-migration, these gender roles and expectations are challenged, particularly as African women are gaining more freedom both financially and within the household (Khawaja & Milner, 2012).

Gender inequality is further fostered by traditional gender norms, which accept polygamy (Khawaja & Milner, 2012), concurrent sexual partners and imply that men are hyper-sexual (Lewis & Kertzner, 2003; Kaye, Mirembe et al., 2005; Bishai, Falb et al., 2009). Polygamy is an accepted traditional form of marriage among many African cultures (Dei Wal, 2004; Levi, 2010; Khawaja & Milner, 2012). Marriage and polygamy help ensure continuation of the lineage and survival of the group (Gartrell, 2007). Within polygamous marriages, one man marries two or more women. The husband within such circumstances makes the choice to have more than one wife, and this can have adverse sexual health outcomes for the multiple wives (O’Sullivan, Harrison et al., 2006; Boileau, Vissandjee et al., 2008; Dlamini, Taylor et al., 2009; Drummond, Mizan et al., 2011; Khawaja & Milner, 2012).

In Australia, concurrent sexual partnerships among Sub-Saharan men remain a concern as polygamy is not recognised. All the women who participated in the women’s focus group were born within polygamous families, and some of their own husbands were in polygamous relationships. Some of the male AATs reportedly fathered up to three children with different girls from similar backgrounds within very short periods. This demonstrates risky sexual behaviours on the part of the males, but with women bearing most of the burden. For AATs, such gender imbalance effectively limits safe sex negotiations by AATs (Kaye, Mirembe et al., 2005; Moore, Awusabo-Asare et al., 2007; Bishai, Falb et al., 2009).

This opens up questions about the sexual behaviours of Sub-Saharan (fe)males, (Lemoh, Biggs et al., 2008; Drummond, Mizan et al., 2011) and their acceptance of equal roles
within relations (Khawaja & Milner, 2012). With gender norms that support, nurture and promote subjectivity of females to males, submissiveness and obedience of females is seen as ‘good behaviour’ by family and community. The findings from this research question such cultural norms and beliefs, and the effects of such norms on the lives and sexual health of AATs and how this affects their sexual decisions, including the use of contraceptives. These findings raise concerns about the direct link between STIs, including HIV/AIDS, and engrained gender norms following migration, which expand to include financial freedom and less control over women by men (Khawaja & Milner, 2012). Self-awakening and self-reflection after learning about other ways of operating, though wanting to hold on to the parents’ culture, may affect AATs sexual health decision making.

As suggested by Levi (2010), some teenagers admired and wanted to be like their ‘Australian’ counterparts, thereby breaking free from ‘their parent’s ways and cultures’. This is one of the acculturation strategies that migrants and refugees may take on following settlement in another setting (Khawaja & Milner, 2012). Some AATs choose to adopt western culture; they reject what is prescribed by their family and their cultural heritage. For example, dressing becomes a symbol of cultural acceptance or rejection depending on the side one is examining this from. There is a longing to feel part of and belong to the ‘mainstream culture’. In my research, concerns about the dress code of African teenage girls were raised and their knowledge about ‘dressing according to the occasion and place’ was questioned. The multiple identities and intersects that AATs exist within can create complex and competing cultural orientations (Guruge & Khanlou, 2004; Bose, 2012).

Manda and Meyer (2005) argue that low age at marriage is common in Africa. Most of the participants in this research migrated from countries from far West and the Horn of Africa or had lived in Northern African countries. In these countries, maintaining virginity until marriage is an expectation. This attitude was particularly common among those from Sudan and the new country of South Sudan, where patriarchal culture is strong and males have a high level of control over the females (Khawaja & Milner, 2012). Some AATs with babies in my research admitted ‘they would not have become pregnant or even be sexually active if they lived in Sudan’ as their parents would control their sexuality (see also Belton, 2007).
It was observed that parents with strong religious values and teachings expected their children to abstain from sex until marriage. In this research, this expectation was even stronger when supported by religious ideologies. Family and the wider community were responsible for maintaining the girls’ chastity through social systems that control girls’ movements within the community. Consistent with intersectionality theory, AATs face oppression across several social levels (Hankivsky, 2012).

As in many African groups (Manda & Meyer, 2005), marriage was highly valued by teenagers and parents in this study. However, parents wanted to make the decision about the person their child married, the family or clan they came from and when the marriage would occur. To ensure this, early arranged marriages were preferred. Procreation remains an important aspect of marriage within many African cultures and voluntary childlessness is uncommon; childbirth is expected soon after marriage, usually within two years of marriage (Oladokun, Arulogun et al., 2009). However, marrying young means a girl is not health literate nor financially independent, and is under the husband and his family’s directions in regards to childbearing (Phakathi, 2012).

### 8.4 Regulating pregnancy

Fear, beating and intimidation, including threats of payback, were used to fend off boys from girls. Girls had to be accompanied by someone close and known to the family when they went out. Such cultural practices of chaperoning girls are seen in Vietnam by parents chaperoning their daughters (Nguyen, Liamputtong et al., 2006; Rawson & Liamputtong, 2010). In doing so, the teenage persons are not provided with the necessary skills they require when they are faced with situations where they may have sex. Further, entrenched gender sexual behaviours following traditional sexual scripting theories were strengthened (Maticka-Tyndale, Gallant et al., 2005). The finding from my research showed that girls adhered to traditional sexual scripting (Maticka-Tyndale, Gallant et al., 2005), which required boys to approach the girls, request sex or send a friend, and if all these measures do not work in their favour, they simply find a time that she is alone and have sex with her. Such stories were disturbing, but shows that while parents can chaperone their children, in
the absence of a chaperone, the teenage person is at risk of engaging in risky sex whether by choice or by force or passive acceptance, because of their lack of necessary skills and ability to protect herself. The possible health consequences include unintended pregnancy.

Despite all the above measures, some teenagers became pregnant. TP emerged in this research as sometimes intended to avoid an arranged marriage, although the image of the girl and her family was always important to the teenage mothers. Research with Vietnamese youth (Nguyen, Liamputtong et al., 2006) revealed that family honour is significant when making decisions about terminating a pregnancy. My research revealed that forced unions were sometimes used by parents to ensure the honour of the girl and her family, and to avoid embarrassment of the girl within the community when she was thought to have engaged in premarital sex or was found to be pregnant. Forced unions reportedly took place when it was suspected or known that a girl had engaged in sexual intercourse with particular individuals. Such unions were used to protect the girl’s image and prevent her stigmatisation if she was known to not be a virgin, and to send a message to other young people about the fate that awaits them if they engage in premarital sex. Protection of the girl’s image, including that of her family, came first compared to her having a life as a single parent or living with the stigma being of ‘low morals’ in her community. Having a baby while still a teenager and out of wedlock was perceived to diminish girls’ chances of marriage later, though motherhood increased self-esteem among peers. Forced unions existed among African communities in Melbourne and probably Australia-wide, aimed at preventing out of wedlock pregnancies and to prevent a girl from a life as a single parent.

Belton (2007) suggests that abortion is sometimes used to end pregnancies, although the definition of abortion is not specific when cultural interpretations of amenorrhea are considered. As such, some women who may have had an abortion, be it spontaneous or induced, may not necessarily think of it as abortion because of the cultural interpretation and definition of abortion (Belton, 2007). Belton (2007, p. 50) contends that ‘abortion is ambiguous in sites of low-technology’ and argues that definitions and categories have cultural explanations that make sense and the viability of the embryo, foetus or even neonate is dependent on the perceptions of the woman and healthcare provider. Local
understandings of foetal anatomy and physiology need to be included when analysing pregnancy loss, not just legal or bio-medical categories’. 

None of the participants in my research reported having an abortion, although some stated they knew someone who had an abortion with often devastating consequence. Memories of teenagers who were reported to have had abortions seemed to have left negative imprints in the memories of AATs. Teenage mothers had concerns about their health in case of an abortion, augmented by the fear of never being able to have children. Such fears were further influenced by religiosity (Wiebe, Najafi et al., 2011) and the social stigma associated with childlessness (Reissman, 2000; Remennick, 2000; Belton, 2007). This rationale was used by these teenage mothers to justify their decision to carry the pregnancy to term. Teenage mothers who carried their pregnancies to term made a rational decision based on their health and safety, acknowledged the stigma associated with premarital sex and single motherhood, childlessness later in life and motherhood was chosen over all the others. Abortion to these girls was hardly an option, although one thought of having an abortion when it was too late to do so.

The WHO (2012) recommends abortion if the woman chooses to terminate a pregnancy or for health reasons, but cautions that this has to be carried out by skilled professions, within a safe environment, using the appropriate equipment. In Australia, abortion is legal and skilled staff and equipment are available for those who chose to do so, and free services are available (Marie Stopes International, 2006). This is not the same in resource poor settings where infrastructure, equipment essential resources may be and are often absent (Belton, 2007). Many African women and teenagers’ experiences and recollection of abortion have been linked with negative outcomes for the person involved due to lack of skilled personnel or resources to carry out the abortion effectively, amidst laws and cultures that prohibit abortion (Wiebe, Najafi et al., 2011). The teenagers and the women from the focus group came from environments where all the three measures above or some of them were often absent. More so, their health literacy knowledge was low regarding when, why and where to have an abortion. This was further compounded by religious and traditional beliefs that portrayed abortion as a sin (Wiebe, Najafi et al., 2011). Some teenagers who may have
opted for an abortion attempted to do so in the second trimester, when it was too late. Their knowledge about when an abortion could be carried out safely was limited and the decision to terminate a pregnancy was seen as morally too serious compared to having a child out of wedlock.

According to motherhood theories (Afable-Munsuz, Speizer et al., 2006), having a child was regarded a better option to abortion in addition to the stigma associated with childlessness. Motherhood provides the woman with social security and status in the community (Reissman, 2000; Belton, 2007). Within the pro-natalist societies, motherhood is a desirable social occurrence for all women (Remennick, 2000; Liamputtong, 2006). Within such a school of thought, it is not the pregnancy and the age of the mother that is the most concerning, although it is important; the context within which pregnancy occurs is more relevant to family. While abortion is legal and accepted in Australia (Marie Stopes International, 2008) it is not the norm in many African cultures, particularly where motherhood (Oladokun, Arulogun et al., 2009) and high fertility (Khawaja & Milner, 2012) remain the norm.

8.4.1 Knowledge and attitudes towards contraception

Research among Sub-Saharan Africans residing in Africa (Cherutich & Brentlinger, 2008; Wamoyi, Fenwick et al., 2011) and abroad (Worth, Denholm et al., 2003; Lemoh, Biggs et al., 2008; Drummond, Mizan et al., 2011) associates Sub-Saharan Africans with limited sexual health knowledge, risky sexual behaviours and the little knowledge of contraception rife with myths and misinformation. Research among Sub-Saharan refugees in Western Australia showed that sexual health knowledge was low and misconceptions existed regarding contraception and condom use and other STIs. Condoms were particularly disliked and were perceived to be a sign of disrespect or distrust (Drummond, Mizan et al., 2011). Similarly, in my research, AATs’ knowledge of contraception was limited and myths and misconception about contraceptives, particularly condoms, were common. AATs’ confidence about their knowledge of contraception was low and this may have limited their use of contraception overall. There was hardly any mention of other
contraceptive methods like the intrauterine device, tubal ligation, vasectomy or female condoms. Indeed some AATs were surprised that female condoms exist (Russell, Bradford et al., 2005). This may be due to their limited use in Africa and their greater expense compared to male condoms (Dintwa, 2010).

This finding is important because from the social model of health theory (Lin, Smith et al., 2007; Baum, 2008), socio-economic status of the client and their social environment should be considered when providing services. The SDH have been shown to directly affect the health of the individual (Wilkinson & Marmot, 2003; Liamputtong, Fanany et al., 2012). The social environment and the socio-economic background have direct effects on knowledge and service usage. The different intersects of culture, knowledge, education and migration all influence AATs’ and women’s attitudes towards contraception use.

The most commonly named contraceptive methods were the pill, the injection, and the implant. Pills were not a desirable method of contraception by AATs because of their perceived own inability to commit to taking a pill on a daily basis. Implanon and long-term methods were preferred by those who felt contraception was good or necessary. These finding are consistent with research among other groups with low socio-economic backgrounds, where the pill was not a desirable form of contraception, and long-term methods were preferred (Chuang, Hwang et al., 2012). Chuang and colleagues (2012) noted that it was easier for someone on oral contraceptive pills or injections to stop because these decisions were passive in nature, and all the individual had to do was not worry about taking the next dose. In contrast, a conscious decision and a visit to a healthcare provider was required to remove an implant or intra-uterine device (Chuang, Hwang et al., 2012). In my research, there was fear among the participants that long-term contraception was problematic because one may not be able to have children later, hence would never be mothers. Being able to be a mother was always a concern for AATs and women.

In Drummond and colleagues’ (2011) research with Sub-Saharan African refugees in Western Australia, dislike for condoms (male) was common. In my study, the participants expressed their and their partners’ dislike of (male) condoms. Condoms were perceived to
be something to be used with casual partners or when you did not trust or love the person. Similar findings have been reported in research with older Sub-Saharan Africans migrants in Australia (Lemoh, Biggs et al., 2008; Drummond, Mizan et al., 2011). What my research adds is that younger AATs with some knowledge and awareness of condoms in preventing HIV transmission did not necessarily translate this knowledge into positive attitudes towards condoms and condom use. Even those that had lived in Australia for most of their lives experienced cultural aspects that negatively affected their use of condoms. This finding has showed that there is a direct link between culture and sexual health practices, and length of stay in Australia may not necessarily change that because more than one person is involved.

SP in this study, irrespective of their gender, religion or background, were of the opinion that AATs’ and African parents’ knowledge of contraception was limited or sometimes absent. SP noted that contraception use was not the norm among most of their African clients. While this may be true, beliefs and cultural orientation to high parity and frequent births may compound acceptance of contraception. Having many children in Africa gives the ‘man’ and his family status in the community (Phakathi, 2012). More so, past historical events, such as sterilisation to control the number of children and infection of African-Americans with syphilis, remains a contentious issue among African people (Liamputtong, 2010) and explains their distrust, including little regard for western medicine and methods of birth control. However, there were other African women that SP noted had embraced contraception use, and contraception was seen as an empowering tool (Chan, 2012).

Husbands and partners, on the contrary, did not feel the same as women about contraception as an empowerment tool; SP reported a level of reluctance by men to use contraception because men saw contraception use by women as loss of control over their wives and families. Similar findings have been noted elsewhere with Sub-Saharan Africans of men not wanting their wives to use contraception, even when the women want to do so (Phakathi, 2012), but further, men wanting to continue to control women following migration, as was the case in Africa (Khawaja & Milner, 2012). Vasectomy, which is now accepted and used by men to plan their families, is least likely to be used by African men
(WHO, 2012). Although there were some men who accepted contraception use by their wives, women had to take sole responsibility, with some women seeing condom use as a man’s responsibility. Social structures where women are subordinate to their husbands are expected to be submissive and obedient further hinder women’s ability to freely use contraception (Drummond, Mizan et al., 2011). Research has shown that partner input and support is necessary for optimal contraception use by women, especially in Sub-Saharan African (Wagman, Baumgartner et al., 2009; Wamoyi, Fenwick et al., 2011). Unfortunately, traditional thinking seems to continue to shape reproductive and healthcare behaviours post-migration, with women unable to freely use contraception as evident in this research.

As Rawson and Liamputtong (2010) have suggested, in my study I found that parents’ attitudes towards contraception had a direct influence on the way AATs responded to contraception use. After migration, parents—who had gained some knowledge of contraception—were still unlikely to recommend contraception to their daughters. As one of the mothers noted, they could not be seen telling their children to use contraception, even if they knew, but suggested that I could do this on their behalf. I was an ‘outsider’ (because I do not come from any of the participants’ cultural groups) but also an ‘insider’ (because of my African heritage). What this reveals is that while parents hold onto their traditions, they recognise the need for change now that they live in a new setting. However, they may not want to be seen as responsible for ‘destroying’ their culture. However, those AATs whose parents were pro-contraception and more open to sex education were more likely to freely discuss sexual health issues and wanting to use contraception. This positive influence was greatest when it came from mothers.

This reveals a shift in the attitude of resettled African women towards contraception. Women seemed ready to let their children gain more knowledge on sex education and to use contraception, although virginity remained the optimum desire. Women were somewhat flexible towards contraception use, perhaps an indication of their own desires to use contraception themselves and limit their family sizes. Sub-Saharan African women, though holding onto their cultures following migration, recognise the need to adjust to the
Australian society, and understand some of the pressures that their children find themselves under in regards to premarital sex. While cultural beliefs and norms (Drummond, Mizan et al., 2011) may persist following migration, including risky sex behaviour (Lemoh, Biggs et al., 2008; Drummond, Mizan et al., 2011) and high fertility (Mussino & Strozza, 2012), women increasingly recognise that contraception is of benefit to them.

Carrying condoms was perceived to be wanting sex, and/or having indiscriminate sex (Drummond, Mizan et al., 2011). In my research, having condoms with you and using contraception was likened to promiscuity. Women in the focus group stated they would be very sad if they found out that their daughters were using contraception, or had condoms with them. There was a unanimous acknowledgement among women within this group that they disagreed with their daughters using contraception, although they knew that the Australian setting was different to the one they come from. Such acknowledgement in differences and a desire to shift and change behaviour is corroborated by other researchers (Drummond, Mizan et al., 2011; Khawaja & Milner, 2012). Within this school of thought, a mother who put her daughter on contraception is perceived to be of low morals and displaying bad a parenting.

As suggested by other researchers, contraception and condom use was associated with myths (Shearer, Hosterman et al., 2005; Nwankwo & Nwoke, 2009). In my research, myths included condoms getting ‘stuck’ in your stomach, condom use equating to disrespect and lack of love (Drummond, Mizan et al., 2011), and that one does not use condoms in serious or relationships thought to be of a permanent nature. Nonetheless, mothers, who had some knowledge of contraception, were more accepting for their daughters to use contraception. Other myths about contraception were that contraception caused infertility, contraception caused cancer and diseases and that knowing about contraception would make the children to have indiscriminate sex.

Condom use is advocated for by the WHO (2008) because of its dual protection ability against pregnancy and STIs. This dual protective nature of condoms as a contraceptive and a barrier method against STIs and HIV transmission did not seem to be an important factor
for AATs. Condoms, although disliked, when mentioned were to prevent pregnancy, a finding consistent with other research findings in other settings in Africa with Sub-Saharan African teenagers (Dintwa, 2010). Knowledge on STIs and HIV was very limited among AATs, but this was further compounded by myths and cultural beliefs.

Consistent with other research about Sub-Saharan African adults knowledge of contraception and safe sex practices in Australia (Lemoh, Biggs et al., 2008; Drummond, Mizan et al., 2011), my research revealed that AATs perceived their parents lacked contraception knowledge, and so were unable to support them or help them with contraceptive information. AATs turned to friends, magazines, nurses, midwives, doctors, and schools for sexual contraception information, a finding corroborated by researchers (Rawson & Liamputtong, 2010). This finding is of concern considering parents are supposed to be the primary sources of support and information for their children, although parents not providing sexual health information can be directly linked to parents’ own knowledge and beliefs about sex being a private matter for adults only. Information coming from friends, which was the common source, is questionable, as their own knowledge may be limited, although peer support and education can be effective if the peers are provided with the correct information and skills to carry out peer education (Drummond, Mizan et al., 2011).

8.4.2 Sexuality and relationships

Sex between man and woman remains the norm among Africans, with black American men describing one of the things that makes a black man is having sex with women (Bowleg, Teti et al., 2011). In my research, all participants were in heterosexual relationships. Only one SP mentioned that another SP had reportedly come across an African homosexual teenager. The mother of the girl had to be counselled as she reportedly said homosexuality is not in their culture. While this may be true, it may also be that African homosexuals are too afraid to ‘come out’ because of fears of stigmatisation. During this research process, there was hardly any mention of homosexuality, and participants did not feel comfortable discussing the topic.
As suggested by other researchers, (Drummond, Mizan et al., 2011; Mellor, Renzaho et al., 2012) in many African cultures, open expressions of love are not encouraged and are regarded as private. In my research, sexual attraction and need rather than merely affection appeared to be the basis of a majority of the relationships among AATs. Another aspect of African culture is respect towards anyone older than oneself (Mellor, Renzaho et al., 2012), which is associated with good upbringing by one’s parents. One woman narrated how she felt embarrassed after arriving in Australia, walking down the street and saw a couple kissing; she felt this was quite disrespectful of everyone else around them, but more so, the elderly people who were around, old enough to be their parents.

It was not clear from this research if there was actual love between couples and partners, as it was beyond the scope of the research. When the boyfriend assisted with caring duties when a baby was involved, he was thought to be nice, and even though this was seldom the case it was associated with what it was to be a man (Bowleg, Teti et al., 2011). AATs were more likely to say they love or had loved the boy who impregnated them, but did not think the same for the boy if he had another girl, or did not see her often, or came around only when he wanted them to have sex. The boyfriends rarely openly showed their affection for AATs, something they said they had longed for. AATs felt they had been hurt, and often described first sexual experienced as painful, and often felt they were not ready for sex when it happened.

Sexual coercion has been identified as a common occurrence in relationships where one partner is much older (Wagman, Baumgartner et al., 2009), but more in cultural groups where gender inequality is socially accepted (Khawaja & Milner, 2012). In my research, all the participants’ partners were several years older and sexual coercion was a common experience reported by AATs. Girls who have sex with men three or more years older are more likely to engage in risky sexual behaviour, such as not using condoms, be coerced to have sex when they do not want to, be raped, have higher incidences of TP and are at greater risk of STIs (Erhardt & Wasserheit, 1991; Nwankwo & Nwoke, 2009). All these were evident in this research, and raises concerns about AATs’ ability to choose the right
partners and to negotiate safe sex with older partners amidst limited sexual health literacy (Erhardt & Wasserheit, 1991; Wagman, Baumgartner et al., 2009).

Intersectionalities theory advocates for the recognition of the different intersections, interconnections and trajectories, including events that have occurred in one’s life, in order to understand the present (Verloo, 2006; Bose, 2012). More so, the position of the African woman and girl are further challenged, not just because of their gender but in addition to culture, religious beliefs, migration, low socio-economic status, gender, race, age and class (Phoenix, 2006; Tsouroufli, Rees et al., 2011; Bose, 2012; Hankivsky, 2012). AATs with a refugee background have missed out on education and other important ‘normal’ family and community structures, whereby social norms are often learnt. In the absence of significant adult figures and role models (Luster, Qin et al., 2008), finding someone who may say they ‘love’ you, even when they did not, may be difficult to differentiate with feelings of lust. Conversely, girls desire to escape from their own family pressures (Mellor, Renzaho et al., 2012), and meeting someone who was willing to provide them that comfort may have affected their sexual lives. AATs were more likely to give in to sex request when the male person told them he would ‘marry’ her or provide her with gifts (Wamoyi, Fenwick et al., 2011).

The culture of silence about sexual abuse corroborated by other researchers (Shearer, Hosterman et al., 2005; Drummond, Mizan et al., 2011) was another finding from my research. Some AATs experienced sexual abuse from as young as age three, from family and neighbours. Because the victim feared she could be punished if she spoke up, they remained silent. Sexual abuse was a common occurrence among those in long-term relationships, and in one instance, sex was withheld by the man for two years because the partner decided to use a contraceptive. Using contraceptives was reportedly perceived by some men to be a tool that women wanted to use so that they could have sex with other men and not be found out. Most AATs in my research had unintended pregnancies after sexual coercion, which was underlined by limited knowledge of contraception and gender inequality within the relationship. Other forms of abuse included threats to leave the relationship, having other sexual partners and not supporting the girls through the
pregnancy. Aside from abuse and coercion, sexual risk taking was reportedly a common occurrence, mainly by males.

Research with Sub-Saharan African migrants has reported the high incidences of STIs among Sub-Saharan migrants in diaspora in comparison to the host nation (Worth, Denholm et al., 2003). Data from the UK has highlighted that heterosexual Sub-Saharan African migrants are overrepresented in the new incidences of HIV (Burns, Imrie et al., 2007). Such concerns have been raised in New Zealand (Worth, Denholm et al., 2003) and in Australia (Gibney, Mihrshahi et al., 2009). In Australia, Carolan (2010) has noted the higher incidence and prevalence of STIs among Sub-Saharan African refugees. Higher rates of STIs are concerning, and can be attributed in part to low health literacy and cultural beliefs.

Risky sexual behaviour commonly leads to STIs and unintended pregnancies, with unintended pregnancy experienced by almost all AATs in my research. In addition, one AAT reported that she had an STI and noted her partner had infected her and both of them had been treated accordingly. STIs are directly associated with risky sexual behaviours (Shearer, Hosterman et al., 2005) and this is common among Sub-Saharan Africans irrespective of setting. HIV was often mentioned by AATs, and it was commonly associated with sexual promiscuity and death.

The perception among AATs also suggested by other research with Sub-Saharan African migrants was that HIV was not a risk in Australia because ‘everyone’ gets tested for HIV prior arrival in Australia (Sheikh-Mohammed, Macintyre et al., 2006; Lemoh, Biggs et al., 2008). In addition, AATs noted that if you are infected with HIV in Australia, it is different compared to if you were in Africa. There was some level of HIV/AIDS awareness among AATs. This could be linked to the campaigns on HIV/AIDS in Africa where the prevalence and incidence remain high (Brou, Djoohan et al., 2008; Cherutich & Brentlinger, 2008). While it is true that the incidence of HIV/AIDS in Australia is much lower compared to Africa, and better treatment and care is available for HIV infected persons, people do not get retested when they leave for overseas and return to Australia, and HIV is a real risk in
Australia regardless. This research finding shows that young people, even with knowledge and awareness about HIV, do not consider it a risk in Australia.

Lemoh, Biggs et al. (2008) have noted that that Sub-Saharan Africans have risky sexual behaviours and negative attitudes towards condoms, which they associated with limited preventative health knowledge, a finding that also emerged in my research. In Africa, most people seek healthcare only when physically sick and after they have explored alternative treatments. This is directly related to cost and access to healthcare. Visiting healthcare facilities or a doctor just for ‘check up’ is not common practice. Socio-economic backgrounds and cultural beliefs about health and illness influence health and treatment behaviours (Drummond, Mizan et al., 2011). Within the social model of health (Liamputtong, Fanany et al., 2012), these factors should be taken into consideration in order to optimise healthcare delivery (Lin, Smith et al., 2007). Unplanned or early pregnancies with high prevalence of STIs among Sub-Saharan migrants in Australia are linked to such risky sexual behaviours and low preventative healthcare knowledge.

A link between low socio-economic status and TP has been shown by many researchers (Hanna, 2001; Wamoyi, Fenwick et al., 2011). In my research, pregnancies among AATs was associated with low socio-economic status, low education and social security system payments from Centrelink. The perception among boyfriends and male partners as reported by the females was that Centrelink payments covered the expenses and needs of the baby. Parents, including some community people, thought AATs let themselves fall pregnant so they could receive Centrelink payments as single parents, and receive access to government housing and other resources directed at disadvantaged mothers. Centrelink payments were perceived to cause conflicts between AATs and their parents/guardians, compounded by one sided support from the Department of Human Services and its child protection agencies (Levi, 2010) that supported teenagers.
8.5 Pregnancy experiences and motherhood

Pregnancy and the thought of wanting to be a mother is often associated with joy and excitement (Liamputtong, 2006; Belton, 2007). However, when a pregnancy is unplanned and the teenager lives in challenging social situations (Hankivsky, 2012), pregnancy and motherhood expectations and experiences can be different. Most of the pregnancies that occurred among AATs in my research were unplanned, although some were ‘planned’ to secure the relationship and to make the parents accept the partner. I refer to planned pregnancies as those that the teenagers did not actively take any precautions to prevent from occurring, even when they had the opportunity to do so. This could be attributed to the environmental and family situations within which they lived (McMichael, Gifford et al., 2011). Some teenagers became pregnant to escape family pressures from parents and guardians (Mellor, Renzaho et al., 2012). The circumstances within which pregnancies occurred included forced sex, sexual coercion and passive acceptance by the girl. Passive acceptance happened after feeling pressured or ‘asked’ several times by the boy and the female gave in.

Teenagers’ understanding of pregnancy was limited (Hanna, 2001). In my research, AATs’ common reaction on finding out about their pregnancy was surprise and denial at the same time. In two instances, the girls did not know that it was through sexual intercourse that a girl became pregnant and were shocked when they were told they were going to have a baby. In general, there had been the belief that it would not happen to them or having sex once or infrequently could not make them pregnant (Nguyen, Liamputtong et al., 2006). Once pregnant, there was support from their mothers, friends and their parents. However, fathers and boyfriends were less likely to be involved. Pregnancy was clearly a women’s business.

In my research, cultural script patterns (Maticka-Tyndale, Gallant et al., 2005) whereby the male chases, the girl refuses, the boy sends a friend or a brother, sometimes with gifts, the girl refuses and at some stage accepts the gifts were common (Gagnon, 1990). There was a common rhetoric in my research, such as ‘he was my best friend’s brother, and they kept
telling me he like me’ or ‘he used to come to our house and said he liked me’ or ‘he kept asking me to have sex with him’ or ‘said he was going to be with me or marry me’. By listening to teenage girls, it appeared they accepted the subjective positions they were assigned to within their culture. Sexual intercourse within such a context is almost inevitable, because the girls want to be faithful to their brothers and/or best friends who may be benefitting as the ‘middle person’. Forced, coerced or passive acceptance to have sex becomes a reality (Wagman, Baumgartner et al., 2009) with an unintended pregnancy a common outcome among the teenage girls.

As Carolan (2010) suggests, African women value childbirth, but it is not such a ‘special event’ because it is a normal part of a woman’s life. In all, eight of the pregnancies occurred before age 16 and the other eight between 17 and 19 years of age. All the teenagers successfully gave birth while one had two miscarriages, though she is in an ongoing relationship. Different rationales were used to justify pregnancy intent or not. Motherhood within such a context is normal and expected, and this raises the question whether early pregnancy among these teenagers is a ‘problem’ to them or whether it is a problem to the parents, community and the wider society. This question could not be answered within the scope of this research; future research should consider and explore this question. However, childbearing and its associated issues like abortion is contextual and cultural explanations need to be acknowledged (Belton, 2007; Liamputtong, 2007) and interpreted as understood by persons of concern.

Other research has shown that pregnancies may be used by women in some cultures to secure relationships and their own position in the family (Liamputtong, 2006). To some AATs, having a child was proof of fertility status, and a sign on the part of the girl to show commitment to the boy and the relationship. Pregnancy was used as an easy way out of difficult family relationships at home. This was common among teenagers who lived with guardians, step-parents or non-biological parents. Getting pregnant was an opportunity to be expelled from home. AATs perceived expulsion from home as providing an opportunity to have a life without the interference of the people or person they thought disliked them. This was realised as child protection agencies were reliable in providing accommodation
for teenagers who were ‘deemed at risk of abuse at home’ (Levi, 2010); something African mothers and parents in general lament because it is seen as loss of their cultural values and authority over their children within the Australian system.

After living in refugee camps, disconnected from family and cultural roots (Khawaja & Milner, 2012), pregnancy was seen as the one thing that AATs had control over. For other AATs, pregnancy was the one thing they had been waiting for to change their lives for the better. One AAT noted that she is now a mother and that means she is grown up, while for another, she had something to look forward to in life. Such a sense of maturity and purpose among teenagers with unplanned pregnancies was reported among teenagers of Anglo background as well (Hanna, 2001). This indicates that not all TP are problems (Katz, 2011). This is an important finding in this research, as becoming a mother gives a refugee girl who has no parents or immediate family a sense of purpose, identity and future. Isolation and a lack of a sense of belonging is ever present in the literature on refugees and forced migration. Having one’s own child filled some of that gap.

Bride price or dowry remain a part of many African cultures and marriage, with the amount of dowry often defining the worth and status of the girl in the community (Kaye, Mirembe et al., 2005; Bishai, Falb et al., 2009). Pregnancy provided an easy option out of complex dowry negotiations. When a girl becomes pregnant, it is easier for the parents to allow her to go and live with the partner until the baby’s birth. After which, dowry negotiations would take place, but normally the rules are relaxed because there is a baby involved and the parties are living together. Pregnancy made it easier for either family to accept the prospective daughters or son-in-laws. At the same time, out of wedlock pregnancy was perceived to be a sign that the girl had low morals and this reflected on her and on her family negatively, but particularly on her mother. Becoming pregnant while unmarried was seen as a sign that the parents did not control their child. This was a common concern expressed by Sudanese mothers, particularly around the freedom of sexuality in Australia (Levi, 2010).
One of the very essences for which arranged and early marriages were meant to protect was unwanted pregnancy (Manda & Meyer, 2005). However, pregnancy was used by some AATs in my research to escape arranged marriages. Early pregnancy was seen as proof of the girl’s fertility and that she would be able to bear many children. High fertility rates remain and are common and accepted among African societies. Children are perceived to be a sign of wealth. Starting to have children early is a good sign that the woman would bear many children to her husband and in-laws. Pregnancy can be described as a double-edged sword, as it emerged in this research. Pregnancy had both positive and negative associations depending on how one wanted to examine it and on which side you stood. However, adult perceptions about TP was that out of wedlock pregnancy damaged future marriage prospects and the quality of potential suitors, including the amount of bride price. All this, particularly bride price, affected the status of the girl in the community (Kaye, Mirembe et al., 2005; Bishai, Falb et al., 2009).

Family tensions among African refugees following migration to Australia have been widely reported (Levi, 2010; Mellor, Renzaho et al., 2012) and when a teenager becomes pregnant this makes it even more difficult. In my research, when a family found out that the teenage girl was pregnant, the common reaction was for her to be thrown out of home. She would normally spend time with her ‘relatives’ or friends family. Some girls were only allowed back home when their pregnancies reached term and some never. However, more support was received by AATs who had their biological mothers in Australia. Even when the mothers were upset on learning about the pregnancy, they ‘soon got over it’ and started supporting their daughters. Mothers took the girls to antenatal clinics and provided care as required. Mothers ensured that the girls did less housework during the pregnancy and after the birth of the baby. For teenagers whose mothers were not present, siblings, and friends played this role. Guardians were less likely to provide the same level of support as parents when they did provide support. Fathers were almost always absent and when they were present, the daughters did not see them as an important source of support.

In my research, the sexual partners were often happy learning about the pregnancy; this to them meant they were now mature ‘men’ and had reached manhood (Oladokun, Arulogun
et al., 2009). This did not necessarily mean they would support the mother. Indeed, support rarely came from the partners, regardless of the relationship status and most of the partners lived interstate or were in Africa. The boy and his family sometimes suggested other sexual partners were involved with the girl at the time before the pregnancy and contested some pregnancies. In such instances, a paternity test had to be carried out. In one instance, the boy was right as reported by a friend about her friend who was not part of this research. Therefore, there was some merit on the part of the boys to questioning the paternity of the child. This meant that the girls’ morals were under further scrutiny by the friends and the community. As one participant said of her friend, ‘now she does not know who the father of the child is because the person she said was the father is not, and we do not see each other again’.

Girls who receive support from their community, family and peers have a positive outcomes following TP and are more likely to re-engage in education and skills training (Bunting & McAuley, 2004). Like the family, the community did not always support the girl, not because they do not want children, but because of the shame she has brought to herself and her family. Following pregnancy, the girl and her family morals were questioned and she was seen to be bad influence on other teenagers and girls. As such, there existed a sense of stigma, which let to pregnant teenage girls fearing to venture out or meet people from their community. One AAT reported how she felt embarrassed about her pregnancy. Hidden within her words was her lament that she had been known to be of good morals and her parents of good standing in her community, yet she had engaged in premarital sex and was pregnant. This finding is important because the girls do not only feel bad that they have let themselves down, but also the standing of their families within their communities; this indicates the cohesiveness, interconnections and relationship bonds, including respect, that exists within African migrant, specifically refugee, communities in Australia (Levi, 2010).

Research suggests that motherhood is highly desired, especially when fostered during the early years of a girl’s life (Remennick, 2000; Afable-Munsuz, Speizer et al., 2006), as would have been fostered among participants in this research. Women with children are
perceived to have greater standing within the community (Belton, 2007) than women of a similar age or older without children. Irrespective of the reaction at the time of the pregnancy, and the level of support during pregnancy, the mothers-to-be and those who were close to them looked forward to the birth and motherhood. The thought of becoming a mother or of ‘now I am a mother’ brought positive feelings to AATs. The teenage mothers and mothers often spoke about motherhood optimistically, despite past and present protracted issues, particularly if they had support (Bunting & McAuley, 2004).

Teenage motherhood may have a positive effect on some teenagers (Bunting & McAuley, 2004). AATs’ unplanned pregnancies did not often affect their sense of self about who they were. Motherhood was interpreted by AATs as ‘I am now a grown up’ and ‘I have someone to care for’. They now had someone and something to live for, rather than an ‘empty’ life. Motherhood was thought to give more status and respect to the girl within her community, even though the same community had frowned on her for being pregnant. This is an interesting finding, because it is not that the pregnancy or the child is unwanted, rather it is the timing of the pregnancy. Unfortunately, the surrounding circumstances and events leading up to the pregnancy are not explored by the community to give them greater appreciation and insight into an AAT’s life and decision. It was beyond the scope of this research to illicit that. Most importantly, AATs understood the responsibilities and challenges that came with motherhood. It was not always easy doing it alone or with little support from the father, but they did it happily even when there faced challenges along the way.

The day-to-day care of the baby was described as ‘hard’ (Hanna, 2001). In my research, when there was more than one child involved, it made it harder to carry out basic daily living activities. This was particularly pronounced when the partner was completely absent or was only there occasionally. There was always the hope and the wish for more support from the partners by the teenager mothers. AATs found it hard when they had no transport of their own, because they were not old enough to have a license, or could not afford a car. They relied on the good will of friends and public transport to get around. Teenage mothers who receive more support particularly from family are more likely to return to school and
re-engage in education (Bunting and McAuley, 2004; Katz, 2011). For one girl who could not afford a car but lived in Dandenong, in the eastern suburbs of Melbourne, isolation was a reality. She spoke about her loneliness, as the only friend she had after arriving from Sydney pregnant lived in Sunshine in the western suburbs of Melbourne and she had to rely on public transport to visit her. She was hoping to do a course later in children services when her baby was older, but at this stage her life was on hold until her child was older. She regretted her current state but was happy that she was now a mother. Her sister and her husband had raised her; this AAT did not know about her own parents because her sister had told her that their parents died while she was very young. Motherhood to her helped fill a vacuum, even if it was not complete.

Being a young single mother made life harder; it was more difficult to attend classes for those doing or wanting to do a course because of cost related to transportation (Pieh-Holder, Callahan et al., 2012) and child care (even after full subsidy). Low literacy and language skills made it hard for refugee girls to gain employment. For example, one teenager who had arrived pregnant, with the father of her daughter living in a refugee camp, had not been able to improve her literacy skills. She could not read nor write and relied on her cousins to help her with letters or text messages. She said she was too embarrassed to tell her friends that she could neither read nor write, but was unable to attend classes. She said she envied her friends working in factories, but she could not because of her child and because she was illiterate. These teenagers almost all said that while they enjoyed being mothers, they would advise other girls to wait until they were older, finished their schooling, had jobs and were able to support themselves before having a baby. AATs cautioned that other teenagers had to be careful with the boys, because they want sex and after that they move to the next available girl.

CentreLink payments as a source of conflict among sub-Saharan African refugees has been reported elsewhere (Khawaja & Milner, 2012). Such conflicts extended between AATs and their children’s fathers, who did not see the need for them to support the children they had, as they deemed CentreLink was carrying out this responsibility. This led to fathering of multiple children by the same person, with several girls’ babies’ fathers not having to work
and support the children. AATs, women and SP alike noted that it would not happen in Africa because a man who impregnates a girl there has to work hard to support themselves and provide for the child and sometimes the mother in the absence of welfare payments. There was a sense of regret that such traditional practices could not be enforced in Australia because of the Australian laws. Such a sense of culture bereavement was expressed often subjectively in this research. Cultural bereavement has been reported elsewhere among African refugees, with mothers lamenting the loss of their children and culture as a result of migration (Levi, 2010) and erosion of traditional social and cultural systems (Mellor, Renzaho et al., 2012). This happens when the children decide to adopt Australian cultures so they can be accepted or feel they belong with particular behaviours that that the mothers perceived as foreign and threatening to cultural identity, such as drinking alcohol and freedoms around sexuality and relationships (Levi, 2010, p. 192).

8.6 Conclusion

TP occurs within intersections and interconnections that are intricate and challenging to unpack. Intersectionality, as a theoretical framework, provides that medium because of its fluidity to understand and unpack the intersections and connections within which AATs exist (Collins, 1990; Crenshaw, 2001; Tsouroufli, Rees et al., 2011). AATs’ low health literacy skills compounded by culture, migration, gender, religion and low socio-economic status impede in their ability to successfully navigate a complex social system, let alone prevent unplanned pregnancies.

Within the social model of health, an individual’s health is influenced by their socio-economic background, the physical environment in addition to the SDH (Wilkinson & Marmot, 2003; Liamputtong, Fanany et al., 2012). In my research, the SDH intersected with and were interconnected with gender, culture, beliefs and migration to shape and influence AATs’ contraception uptake leading to subsequent pregnancy and motherhood. Motherhood in my research emerged as a challenging issue for teenagers and their families, but teenagers remained positive and optimistic about their future and that of their children.
However, AATs note that if they had a choice, they would delay pregnancy, but are happy they are mothers and remain optimistic about the future.
Chapter 9: Conclusion

In this chapter, the key findings from the thesis are highlighted, followed by the research limitations and strengths. Recommendations and suggestions for future research, including a suggested model for sexual health education for African-Australians, particularly for young refugees, is put forward. The last section of this chapter covers the overall thesis conclusions.

9.1 Overall research findings

The research findings reveal that the occurrences and the contexts within which TP occur among African-Australian refugee migrants that are significant and concerning. It further showed that persistent gender inequalities and social structures within the family and community that favour boys indirectly contribute to the number of TP among this group. Many Sub-Saharan African societies, although not homogenous, are patriarchal, while obedience, respect for authority and dependence are favoured and self-assertion and autonomy discouraged (Mellor, Renzaho et al., 2012). Such cultural mores where girls are expected to be submissive and obedient do not empower the girls and women; instead AATs and women are disempowered as they want to remain loyal to their culture, religion, family and the community of which they are a part.

The acceptance and use of contraception remains a contested issue as the decision making lies outside the hands of the users, the teenage girls and women. Their families, boyfriends, husbands and, to an extent, their community directly and indirectly influence and make the contraception decision making for teenagers and women. Although religion had been strength for refugees while they lived in refugee camps and during settlement, it seems to have had a counter effect on the refugees when it came to their uptake, acceptance and use of contraception. The above ‘outside’ factors (families, boyfriends, husbands and community) are significant in influencing and supporting contraception uptake and use.
This research revealed the low knowledge around sexual health literacy, but particularly myths that exist in regards to contraceptives and condoms. Avoiding pregnancy for AATs who knew about contraception was the main objective of using any method, with little thought given to STDs and HIV transmission and prevention. Social and cultural orientation towards motherhood was significant and contributed to AATs desire to bear children. The absence of loved ones, particularly mothers, and family members further contributed to this desire to want to belong and have their own family. Mothers were a significant support and the AATs who had their mothers with them reported more support than those without their mothers, with some of the AATs processing documents to get their mothers to Australia.

Payments from Centrelink and the quest to be free from family pressures appeared to have indirectly contributed to the desire to become pregnant. Fathers of the girls and the fathers of their own babies were consistently almost always absent in their lives, which may have affected the teenagers adversely. This finding is consistent with other research among Sub-Saharan humanitarian entrants in Australia, where lack of parental involvement, particularly male, had an adverse effect on adolescent children’s body mass index (Mellor, Renzaho et al., 2012). How the absent male affects the girls was not clear, although it appeared a concern for some AATs, even though the present fathers were reportedly not really contributing in supporting their daughters before, during and after the pregnancy. Instead, AATs mothers carried the majority of the blame and responsibilities with their daughters. In this light, it can be stated that TP among AATs occurs within a myriad of social, cultural and economic factors, with pregnancy being what I describe as the ‘tip of the iceberg’.

9.2 Strengths and limitations

The topic for this research was sensitive (Renzetti & Lee, 1993) and the participants were vulnerable (Liamputtong, 2007), with the exception of the SP. A qualitative methodology was deemed the most suitable to answer the research question, because this method lends itself to more understanding of the issue under research when the research wants to gain
insight into people’s lived experiences (Liamputtong, 2009). It was difficult accessing and recruiting sufficient teenagers who had experienced TP because of the sensitivity of the topic. However, this was overcome by using a snowballing technique and asking KI to help identify potential participants (Creswell, 2013). This technique has been advocated for and is reliable to use with difficult to access groups and vulnerable participants (Renzetti & Lee, 1993; Liamputtong, 2007; Liamputtong, 2010). Due to the reluctance of teenage mothers to speak about their experiences, I included three teenage mothers who were in arranged marital relationships when they had their babies. Two women were no longer with the partners, and these participants enriched the data as it gave insight into their experience as teenagers within arranged marriages and contraception negotiation with their partners.

I ensured diversity by recruiting participants from different parts of Melbourne, the eastern and western suburbs, where the majority of refugees had settled. Participants came from different countries and cultural backgrounds. However, the majority of the participants were Sudanese and the focus group was with Sudanese mothers. This is because Sudanese refugees are the majority of recent African migrants in Australia. Due to the diversity between and within African cultures, these results should be interpreted carefully, as they do not reflect one particular culture, although they provide a good insight within the broad themes of contraception, TP and culture among African refugees in Australia. The findings resonate with other research in Australia about refugees of African background, although new information arose in the research process.

The sample for this research was necessarily small: 16 women who had experienced TP and two focus groups with six participants each. The diversity of the research participants and the methodology used for this research was strength, because it lends the research findings to triangulation across different African migrant groups specifically with refugees, although this should be conducted cautiously. Having teenage mothers who have lived and grown up in very different settings with different influences was a strength in this research.

The interviews took between half an hour to two hours depending on how detailed participants wanted to speak. This was advantageous because the oratory nature of speaking
common in African cultures and using proverbs during discussions was illustrated during the lengthy discussions, and this enriched my data. During the focus group discussions, some participants were more vocal than others. While I ensured that everyone was heard and encouraged the quiet members of the group to speak (Liamputtong, 2010; Neuman, 2011), there was a possibility some people may not have expressed their views within this setting for fear of non-confidentiality. Confidentiality remains an issue of concern among African research participants because of the internal dynamics and communal existence of African communities in Melbourne (Levi, 2010). I emphasised the importance of confidentiality before the interviews and focus group discussions. The data collection process lasted about 15 months, giving the researcher enough time in the field to build trust with participants and understand the dynamics. This was a strength combined with my other out of work and social interactions with members of various African communities in general.

The topic for this research was broad; the participants had experienced pregnancy in different settings and contexts, therefore the findings should be interpreted carefully. However, the themes that emerged resonated with each participant, irrespective of the person’s cultural background.

The refugee participants in this research all spoke English, so there is a chance that the views of teenagers and women who did not speak English may have been left out. Participants who did not speak English fluently, but spoke at a level that they could be understood, were included. The views of males and the persons who fathered children were not explored.

Being an insider and an outsider brought both advantages and disadvantages, as noted in the methodology chapter. My African heritage was a strength because it was easy to build trust with participants and for the young women to feel that they could have a ‘young’ female African woman whom they could speak to without being judged. My insider status made it easy for participants to open up and talk about an otherwise difficult discussion subject and personal issues they were facing. For example, African women, who
participated in the focus group wanted me to come and talk to their children about sexual health and intergenerational conflict issues, with one participant offering her home. On other occasions, some of the teenage mothers asked if I could help them with information about getting financial support and how they could improve their literacy skills. There was what I describe as too much expectation from me because participants felt I could understand their issues better because of our shared African heritage, my own migration experience, although I was not a refugee, and my tertiary education. I did provide information about agencies and contraception services to some when asked after the interview process. However, I could not do all that was asked of me by my participants because of the scope of this research, personal constraints and time factors.

I was considered an outsider because I did not come from any of the same countries or cultural groups as the participants; this was advantageous. I knew enough to understand the cultural and community dynamics, but not too much to be a threat either. I was trusted enough at the level where community and personal information could be revealed without fear of me sharing it with other members of the various communities who knew the participants. Information that may otherwise not have been revealed was shared with me confidently, and this enriched my data and the research experience overall.

SP were pleased to have an African woman researching a topic they felt was important and would benefit young African refugee women. My focus groups with KI were partly organised by a participants who were keen to see research conducted in this area but were even more supportive when an African woman took up the challenge. To these providers, I was a role model because I was an African female researcher, academic and healthcare provider myself, and because I had insight into the Australian mainstream culture, health system and African cultures at the same time; this strengthened the research findings. Mothers in the focus group and some KI echoed similar attitudes.

Recall bias was a possibility in this research (Neuman, 2011) and there was a possibility that women may have said what they wanted the researcher to hear. Because most of the
partners were not present in the life of AATs and their children, there was a risk of exaggerating negative experiences.

The research setting was Melbourne, so information from other Australian cities that could have benefitted this research was not included, but this was beyond the scope of this research. The Melbourne findings are transferrable to other settings that are home to migrant and refugee communities from similar backgrounds, although this should be undertaken with care.

9.3 Research implications and recommendations

While this research was more exploratory, the findings have raised questions and concerns about sexual health literacy and the acceptance of contraception use among African teenage girls and women by them, their families and members of the community, with implications to SP and policy makers. Is there a sexual health knowledge and literacy gap, and is contraception accepted and supported by AATs and members of the broader African refugee community in Melbourne? The findings from this research revealed that there is a knowledge gap and that contraception use is not the norm among AATs, and is not necessarily accepted and supported by the wider community. It is not necessarily that AATs and women do not want to use contraception, but the social system plays a role in diminishing their independence when it comes to contraception uptake and use.

In addition, sexual health literacy within the African community remains low, with condoms shown to be disliked by males and females alike, despite the recognised dual protective factors of condoms against STIs and pregnancy. More so, cultural factors that almost mandate motherhood, combined with religiosity, indirectly affects teenagers’ decisions to want to be mothers and to carry pregnancies to term. Existing cultural mores that are patriarchal do not help; male permission is almost always required by their female partners to use contraception. Instability and forced migration experiences of AATs all play a role in their wanting to be mothers and to have families of their own. Low socio-economic factors and intergenerational conflicts added to AATs’ pregnancy intentions. The
implications from this research are directed at policy makers, SP and African parents and the community.

African parents and members of their community reside in Australia but ‘live in their culture’, which they steadfastly want to hold onto. The natural social structures that existed before migration are now eroding or completely absent in Australia. African-Australian children are acquiring knowledge from the media, schools, peers and social dynamics within which they live, which are different to those that their parents were born in or grew up within. In Australian society, issues of sexuality are discussed openly, and equality across the genders is the norm, with laws and policies ensuring this. Parents have to recognise and make the necessary shift as a result of the migration. While this is difficult, especially as roles and dynamics may change within the family, these changes are necessary to avoid conflict within the family and community. Women of African descent have been noted to be making this shift and adjustment (Levi, 2010), although it remains an ongoing process. African men and women have to collaborate and discuss sexual matters with each other; men should recognise that their role in supporting their partners in contraception uptake and use is important, but that women have the right to make this decision independently if their partners choose not to support them.

This research revealed the concerns of parents about social security payments to young girls and the support their children receive from social workers and child protection agencies if the parents were to punish the children or discipline them as they understand from their own cultural perspective. SP need to recognise the cultural and emotional challenges and differences that exist, and should not be judgmental when they provide services to refugees and migrants, but should foster a relationship that is built on trust and respect. Services should be empathetic to a client’s situation, but at the same time the care recipient should not feel undermined. Sexual health literacy and contraception use is closely knit with culture and beliefs, including gender issues, and could be incorporated into service provision.
Parents, teenagers and KI alike voiced their concerns about policies that supported dependency. While there was a recognition that Centrelink payments are important for families and to help struggling families, it was concerning how AATs were provided with almost instant support by protection agencies without proper investigation when AATs complained that they were being subjected to abuse at home, according to KI. Parents felt that child protection agencies were letting them down because it made it difficult for parents to discipline their children, for fear the children would run away or call a support worker who was almost always on the side of the children and could take them away with little understanding of the broader picture. There was a real fear on the part of parents to discipline children. A mother noted that she does not ‘speak’ to her children because she fears the Australian laws will punish her. Policies on child protection should use an intercultural approach, and it should be recognised that there are other ways of parenting, and that there is no one ‘correct’ style of parenting that is based on the western nuclear family model (Levi, 2010). Refugee parents/guardians are loving and have gone through many challenges, and the majority of the parents do the right thing and want the best for their children.

Within the intersectionalities theory (Hankivsky, 2012) and the social model of health (Liamputtong, Fanany et al., 2012), the person’s background, including events that have occurred in the past, should be given weighting when providing care and support, and to understand how current events may have developed. When this happens, the SP is in a better position to support and help the individual in a more objective way. Through the lens of such a framework, one can begin to understand the rational decision for some AATs to let themselves become pregnant or to continue with the pregnancy even when it was unintended.
9.3.1 **Research recommendations**

In light of the above, the following are recommended:

1. There is a need for both males and females to be treated equally by parents. Girls should be empowered through education, which leads to financial independence and personal feelings of self-worth.

2. Peer educators from similar backgrounds should reach out to other teenagers about delaying sex and preventing unwanted pregnancies. I suggest older girls who have experienced TP and who reengaged with education could fill this role.

3. Having role models and women who inspire young women speak to them and having ‘aunties’ speak to pre-teenage girls and teenagers about sexual health is suggested.

4. In-depth understanding of cultural and social structures and how they influence contraceptive decision making among this group of Australian migrants by SP is important. Such knowledge will assist SP to design and provide care that is culturally acceptable. Education for men and women about contraception use among recent migrants, with emphasis on communication, is important and further research in this area is warranted.

5. In-depth understanding of cultural and social structures and how they influence contraceptive decision making among this group of Australian migrants by SP is important. Such knowledge will assist SP to design and provide care that is culturally acceptable.

6. Alternative sexual health education approaches among Sub-Saharan African migrants should be used in sexual health education. A family and community approach that involves the family, boyfriends and husbands is recommended.

7. Policies should not aim at contraceptive use alone, but cultural and social factors that surround the individual should be addressed. The different intersections and trajectories of events past and present should be part of policy, education and action (Levi, 2010). SP providing contraceptive services to AATs and other migrant women should assure them that all contraceptive methods are reversible, except for
sterilisation methods, which involve tubal ligation and total hysterectomy in women and vasectomy in men. Teenagers and women may be more likely to use contraception if they know that a contraceptive method is not permanent. Sexual health education should exist within broader education and a cultural acceptable approach, which acknowledges cultural and socio-economic aspects of the individual, should be included.

8. SP should be aware of the relationships between culture and sexual health practices and the interdependence that continues to exist among African persons following migration that may influence their use of contraception (Levi, 2010; Khawaja & Milner, 2012).

9. In Meredith Levi’s (2010) thesis on Sudanese mothers raising their teenage children in Australia, Levi (p. 203) suggests alternatives to the parenting style in Australia, which is individualistic compared to the African interdependent tradition of sharing childbearing responsibilities among African parents. An integrated model is suggested, which I term the Austrafrocentric contraception model for sexual health education. Within the Austrafrocentric contraception model, mothers and significant females in the teenagers lives are a focus. The African person, their culture, beliefs, social and socio-economic background are at the centre of the education programme. In relation to sexual health education, within the Austrafrocentric model there is an education process that focuses on the whole family, and this includes, fathers, husbands and (pre-)teenage children and the broader community. Previous sexual health knowledge and practices are understood from the person’s cultural perspective, which is then integrated into scientific approaches. Positive aspects are affirmed and supported, while myths and misconceptions are discouraged, with explanations provided. Cultural beliefs and the traditional knowledge and background information is considered and factored into the education programme. The family is then supported to freely discuss sexual health issues with each other, with emphasis placed on open discussion, within their own private place. Once they are comfortable to share personal sexual health information with each other, they are more likely to do the same with close family, and gradually with their community. Through such an Austrafrocentric model, the
whole community will gain sexual health information that is culturally sensitive and acceptable.

10. Long-term contraceptive methods that will last for at least three months (depoprovera) or three years (implanon) should be considered for this cohort of migrants, although informed consent should be provided prior to uptake and use.

11. More education is required about condoms to dispel myths and to emphasise the importance of condoms in preventing STIs and HIV transmissions and infections, and not just preventing pregnancy (WHO & United States Agency for International Development, 2008). Hence, the dual protective factors of condoms should be emphasised.

12. Campaigns on HIV should be made more visible, and the real risks should be included in refugee information packages after arrival in Australia. Sub-Saharan African migrants in Australia need more education on the risks of HIV/AIDS in Australia (Lemoh, Biggs et al., 2008).

13. The Department of Immigration and Citizenship needs to rethink family reunion and visitors visas for African migrants and refugees, and lessen restrictions by making it easier for significant people like parents, particularly mothers, to be able to visit their children living in Australia more often particularly for refugees and young mothers.

14. Government policies on the issuing of drivers’ licenses and restrictions should examine ways in which teenage mothers with babies can be supported to acquire licenses to enable mobility and reduce isolation. This may increase their access to education and other opportunities that may be restricted by not being able to drive; it prevents further isolation that may lead to post-natal depression.

15. Sexual health education and communication between husbands and wives or partners is recommended. Community education about the benefits of contraception should be vital because of the interdependency and connections that exist within African groups.

16. Health professionals and SP working with AATs and African women need to understand the social and cultural background and the context in which AATs and
African women base their decision to continue with a pregnancy, even when it is unplanned or mistimed.

17. Past historical events, such as sterilisation and the infection of African-Americans with syphilis, remains a contentious issue among Africans; cultural history and orientation should be acknowledged when giving sexual and reproductive health information to migrants.

9.3.2 Recommendations for future research

Future research should explore:

1. Forced unions among African communities aimed at preventing out of wedlock pregnancies; more research in this area is warranted.

2. Sub-Saharan African teenage girls’ decisions to keep or terminate a pregnancy, including their knowledge and attitudes, would give more insight into TP decision making in this group.

3. Barriers to contraception use are directly linked to knowledge and culture even after migration. More research is warranted in relation to the type of sexual health information that AATs receive from different sources and the most reliable sources identified and used in sexual health education with AATs, including the link to culture.

4. African’s perception and practice of homosexuality in Australia and the effects of homosexuality in the individual’s life requires more research.

5. There were concerns about some African Australian males not wanting to have a sexual partner who had undergone female genital mutilation (FGM); a practice that seem to continue otherwise. More research on FGM, views, attitudes and current FGM practice in Australia by or with second and third generation African Australians is warranted.

6. Sexual coercion and abuse seemed to be a common occurrence within relationships and more research in this area is required.

7. The notion of AATs letting themselves fall pregnant to receive a ‘baby bonus’, including single parent payments from Centrelink, requires more research.
8. The phenomena of leaving a non-welfare system for a pro-welfare system, the implications on family cohesiveness and conflicts should be explored. This should involve the definition of family being expanded to include extended family and not just the nuclear family.

9. The support provided by male partners and fathers, including male relatives to their pregnant teenage girlfriends, daughters or siblings, should be further examined.

10. Adolescent African Australian males’ experiences and perspectives of unplanned or mistimed early fatherhood.
9.4 Thesis conclusion

This thesis set out to explore the culture, contraceptive uptake and use, TP and motherhood experiences of AATs with a refugee background in greater Melbourne. A QR design underpinned by phenomenology, a cultural competency framework and intersectionality formed the theoretical background for the research. In-depth interviews were completed with African teenagers and women who had experienced TP. KI, who were either members of the African community or worked closely with AATs and the African community, were also interviewed. In addition, two focus groups with SP and African women respectively further provided insight into the topic under exploration and enabled checking of some of the information gathered during interviews. After data collection, the data were transcribed verbatim and coded using thematic analysis.

The findings revealed that TP is an issue and a concern among AATs and their communities, that health literacy was low and that this was closely associated with low contraception use. Myths and misconceptions existed among AATs and members of their community regarding contraception, and had a negative influence on AATs’ decisions to use contraceptives. Gender inequality, together with inequitable social and cultural norms that disadvantaged women, further compounded teenagers’ and women’s ability to use contraceptives.

TP among AATs occurs within many interconnections; they include migration, gender, culture, religion, socio-economic and refugee status. To provide effective support for these teenagers and to prevent mistimed TP, the context within which AATs live should be examined and understood in order to provide them with necessary support.
References


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Australian Research Centre in Sex, Health and Society, and Footscray Youth Housing Group.


Pittaway, E. & Muli, C. (2009). *We have a voice, hear us: The settlement experiences of refugees and migrants from the horn of Africa*. Sydney: Centre for Refugee Research, University of NSW.


Pittaway, E. (2002). We are sad not mad: The role of social work in the successful resettlement of refugee families who have experienced torture and trauma. *Women in Welfare Education, 5*(September), 63–72.


May 2010.


### Tables

**Table 1: Epidemiological Definitions**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Birth Rate (BR)</td>
<td>The BR is defined as the number of life births in a given population over a period of time, usually one year.</td>
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<tr>
<td>Infant Mortality Rate (IMR)</td>
<td>The IMR is calculated by dividing the number of deaths among children under the age of one by the number of live births in that year, and finally multiplied by 1000.</td>
</tr>
<tr>
<td>Population Growth Rate (PGR)</td>
<td>The PGR is calculated by adding the total number of newborns to the general population and then subtracting the total number of deaths excluding all migrations to measure the growth rate of a population.</td>
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<tr>
<td>Fertility Rate (FR)</td>
<td>The FR is calculated by dividing the number of live births in an area during the year with the midyear female population age 15–44 within the same year and then multiplying by one thousand.</td>
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<tr>
<td>Life expectancy</td>
<td>The number of years a child is expected to live at birth.</td>
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<td>Prevalence Rate (PR)</td>
<td>The prevalence rate is the number of persons who have a disease or an attribute at a particular point in time or midway through the period.</td>
</tr>
<tr>
<td>Maternal Mortality Rate (MMR)</td>
<td>The death of a woman as a result of child bearing or due to complications of child bearing.</td>
</tr>
<tr>
<td>Annual Mortality Rate (AMR)</td>
<td>Total number of deaths from all causes in one year divided by number of persons in the population at midyear and then multiplied by a thousand.</td>
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Source: Dictionary of Epidemiology
Table 2: FRs, Contraception Needs, Use and Knowledge

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*# Percentage of men and women who had more than one sexual partner in the past 12 months reporting the use of condoms during their last sexual intercourse

*a, *b Prevalence of men and women aged 15–24 who both correctly identified ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Source: Adapted from WHO statistics data (WHO, 2011)
Table 3: Estimates of MMR in 2010

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<thead>
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<th>Region</th>
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Source: Adapted from the WHO, UNICEF, UNFPA, and the World Bank publications, 2012
Table 4: Estimates of MMR in 2010

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Source: Adapted from the WHO, UNICEF, UNFPA, and the World Bank publications, 2012
Table 5: Fertility Rates and Unmet Need for Contraception in Selected African Countries for Women 15 to 49 Years

<table>
<thead>
<tr>
<th>Country/ year</th>
<th>TFR</th>
<th>% Using any method of contraception</th>
<th>% Using modern method of contraception</th>
<th>% Want to space births</th>
<th>% Want to limit births</th>
<th>% Total unmet need</th>
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<td>Benin (2006)</td>
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Source: WHO/UNDESA and DHS, 2011
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<th>Pseudonyms of interviewees</th>
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<th>Gender</th>
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<th>Other countries of residence</th>
<th>Year of arrival in Australia</th>
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c) Focus Group 1: Service providers (FG SP)

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<th>Language(s)</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marima</td>
<td>Registered Nurse</td>
<td>SP</td>
<td>50</td>
<td>Australia</td>
<td>-</td>
<td>English</td>
</tr>
<tr>
<td>Name</td>
<td>Occupation</td>
<td>Gender</td>
<td>Age</td>
<td>Country 1</td>
<td>Country 2</td>
<td>Language(s)</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------</td>
<td>--------</td>
<td>-----</td>
<td>-----------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Jonathan</td>
<td>Church and community Support person</td>
<td>M</td>
<td>40</td>
<td>Sudan</td>
<td>Kenya</td>
<td>Dinka, Arabic</td>
</tr>
<tr>
<td>Cameron</td>
<td>Bi Cultural Worker</td>
<td>M</td>
<td>42</td>
<td>Ethiopia</td>
<td>Kenya</td>
<td>Tigrinya,</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>School principal</td>
<td>F</td>
<td>&gt;50</td>
<td>Australia</td>
<td>-</td>
<td>English</td>
</tr>
<tr>
<td>Ruben</td>
<td>Medical Doctor</td>
<td>M</td>
<td>52</td>
<td>Australia</td>
<td>-</td>
<td>English</td>
</tr>
<tr>
<td>Charlie</td>
<td>Church Minister</td>
<td>M</td>
<td>77</td>
<td>Australia</td>
<td>-</td>
<td>English</td>
</tr>
</tbody>
</table>

**d) Focus Group 2: women/mothers**

<table>
<thead>
<tr>
<th>Name</th>
<th>Occupation</th>
<th>Gender</th>
<th>Age</th>
<th>Country 1</th>
<th>Country 2</th>
<th>Language(s)</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awel</td>
<td>Employed (casual) Cleaning services</td>
<td>F</td>
<td>28</td>
<td>Sudan</td>
<td>Egypt</td>
<td>Dinka, Arabic</td>
<td>Christian</td>
</tr>
<tr>
<td>Akot</td>
<td>Employed (Personal care assistant)</td>
<td>F</td>
<td>31</td>
<td>Sudan</td>
<td>Egypt</td>
<td>Arabic, Dinka</td>
<td>Christian</td>
</tr>
<tr>
<td>Amina</td>
<td>Employed Factory worker</td>
<td>F</td>
<td>42</td>
<td>Sudan</td>
<td>Egypt</td>
<td>Dinka, Arabic</td>
<td>Christian</td>
</tr>
<tr>
<td>Christina</td>
<td>(Unemployed) Former school Teacher in Sudan</td>
<td>F</td>
<td>37</td>
<td>Sudan</td>
<td>Egypt</td>
<td>Arabic, Dinka</td>
<td>Muslim</td>
</tr>
<tr>
<td>Laura</td>
<td>Unemployed- (Former school teacher in Sudan)</td>
<td>F</td>
<td>41</td>
<td>Sudan</td>
<td>Egypt</td>
<td>Arabic, Dinka</td>
<td>Muslim</td>
</tr>
<tr>
<td>Patricia</td>
<td>Unemployed</td>
<td>MAATs</td>
<td>F</td>
<td>28</td>
<td>Sudan</td>
<td>Egypt</td>
<td>6</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>-------</td>
<td>---</td>
<td>----</td>
<td>-------</td>
<td>-------</td>
<td>---</td>
</tr>
<tr>
<td>Total = .32</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 7: Place of Residence of the Mother, the Fathers and the Perceived Level of Support Provided by the Fathers to the Teenage Mothers during and After Pregnancy

<table>
<thead>
<tr>
<th>Names of AATs</th>
<th>AATs’ country of birth and background</th>
<th>AATs’ place of residence</th>
<th>AATs’ partner’s place of residence during her pregnancy</th>
<th>AATs’ partner’s place of residence after pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayuba</td>
<td>Burundi</td>
<td>Dandenong</td>
<td>‘He helps at times’</td>
<td>Live together and plan to marry</td>
</tr>
<tr>
<td>Chelsea</td>
<td>Liberia</td>
<td>Western Suburbs</td>
<td>Melbourne</td>
<td>Melbourne</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No support</td>
<td>The father has never seen the baby who was one year old at the time</td>
</tr>
<tr>
<td>Daniella</td>
<td>Sudan</td>
<td>Western Suburbs</td>
<td>Baby one and baby two</td>
<td>Baby one</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Melbourne and hardly sees him</td>
<td>Sometimes helps</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Baby two N/A—Pregnant</td>
</tr>
<tr>
<td>Alimatou</td>
<td>Sudan</td>
<td>St Kilda</td>
<td>Baby one</td>
<td>Baby one</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Limited support</td>
<td>Limited support</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lived together in refugee camp had an arranged marriage</td>
<td>Baby two</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A—pregnant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Josephine</td>
<td>Liberia</td>
<td>Western Melbourne</td>
<td>Refugee camp—Africa</td>
<td>Lives in Africa, not sure where</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Support from the boy’s family</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Country</td>
<td>Location</td>
<td>Details</td>
<td>Support</td>
</tr>
<tr>
<td>-----------</td>
<td>---------</td>
<td>---------------</td>
<td>------------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Candida</td>
<td>Sudan</td>
<td>Western Suburbs</td>
<td>Unsure of place of residence</td>
<td>Nil Support—has had no contact with the child who was five years at the time of this interview</td>
</tr>
<tr>
<td>Carmen</td>
<td>Sudan</td>
<td>Melbourne city</td>
<td>Baby one&lt;br&gt;Father in prison in Sydney—No support&lt;br&gt;Baby two&lt;br&gt;Father In Melbourne—Support from family</td>
<td>Baby one—Sydney out of prison never seen the baby—nil support&lt;br&gt;Baby two—Live together the father supports her</td>
</tr>
<tr>
<td>Madonna</td>
<td>Sudan</td>
<td>Melbourne city</td>
<td>Overseas—Sudan</td>
<td>Overseas—Sudan</td>
</tr>
<tr>
<td>Jessica</td>
<td>Ethiopia</td>
<td>Western Melbourne</td>
<td>Baby one&lt;br&gt;Overseas—refugee camp&lt;br&gt;Baby two&lt;br&gt;Melbourne—seldom sees the father, very limited support</td>
<td>Baby one—Nil support Never seen the baby&lt;br&gt;Baby two—N/A—pregnant</td>
</tr>
<tr>
<td>Honorine</td>
<td>Sudan</td>
<td>Western Suburbs</td>
<td>Africa—Support from family was made to marry him in Africa</td>
<td>Have now separated and live in different states in Australia—Nil support</td>
</tr>
<tr>
<td>Francisca</td>
<td>Sudan</td>
<td>Western Suburbs</td>
<td>Baby one&lt;br&gt;Perth no support</td>
<td>Baby One—Nil support lives in Perth</td>
</tr>
<tr>
<td>Bikutsi</td>
<td>Sudan</td>
<td>Western Suburbs</td>
<td>Baby one and baby two&lt;br&gt;Live together&lt;br&gt;Support her</td>
<td>N/A—had two miscarriages</td>
</tr>
<tr>
<td>Kayla</td>
<td>Sudan</td>
<td>Western Suburbs</td>
<td>Lives in Perth—feels he supports her and she plans to move to Perth to live with him after the birth of the</td>
<td>N/A—Pregnant</td>
</tr>
<tr>
<td>Name</td>
<td>Country</td>
<td>Location</td>
<td>Baby Information</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Stephanie</td>
<td>Liberia</td>
<td>Western Suburbs</td>
<td>Overseas-Refugee camp Nil support The father has never seen the child who is now four years old</td>
<td></td>
</tr>
<tr>
<td>Veronica</td>
<td>Sierra Leone</td>
<td>Western suburbs</td>
<td>Live apart but in the same suburb in Melbourne. Received support from his mother not him Sees baby, and the two grandmothers help with the baby. The father has a physical presence only</td>
<td></td>
</tr>
<tr>
<td>Faustina</td>
<td>Sudan</td>
<td>Western Melbourne</td>
<td>Lived together Received support from the family as they had arranged for her to marry him. Lived together but the father goes back to Sudan for lengthy periods of time –up to 6 months</td>
<td></td>
</tr>
</tbody>
</table>
Appendix A

Interview questionnaire for Key informants
Contraception, TP and culture issues among African-Australian girls with a refugee background

Part 1: Demographic Information
i. Name of Person Interviewed:
ii. Name of Organisation or Service:
iii. Position in Organisation
iv. Type of Services Provided
v. Location of Service
vi. Mainstream or African Service Provider

Part 2: In-depth semi-structured questions
1. How long have you been involved with teenagers with African-Australian Background in your service?
2. What are the types of services that are available to teenagers of African descent in your service?
3. What are the cross-cultural and settlement issues that AATs face?
4. What are the key issues for AATs in relation to Contraception, Pregnancy and Sexual relationships?
5. How do AATs receive information? What are the sources for information relating to contraception? From your experience, what are the best ways to provide information on reproductive health?
6. What type of advice is provided by your service to teenagers of African descent about the uptake and use of contraceptives? What cultural considerations are have emerged as relevant or important in this advice (probe for advice, information provided and data on uptake/use)
7. How does the heritage of AATs influence the sexual health education and contraceptive methods provided to them?

8. What does your service/ organisation do that is different from other services in order meet the sexual and reproductive health needs of AATs?

9. Is there something that I left out that you would like to add?

Thank you for accepting to taking part in this research project.
Appendix B

Interview Questionnaires SP

Contraception, TP and culture issues among African-Australian girls with a refugee background

Part 1: Demographic Information

i. Name of Person Interviewed:
ii. Name of Organisation or Service:
iii. Position in Organisation
iv. What type of services does your organisation provided?
v. Location of Service
vi. Mainstream or African Service Provider

Part 2: In-depth semi-structured questions

1. How long have you been involved with teenagers with African-Australian Background in your service?
2. What are the types of services that are available to teenagers of African descent in your service?
3. What are the cross-cultural and settlement issues that AATs face?
4. What are the key issues for AATs in relation to Contraception, Pregnancy and sexual relationships?
5. How do AATs receive information? What are the sources for information relating to contraception? From your experience, what are the best ways to provide information on reproductive health?
6. What type of advice is provided by your service to teenagers of African descent about the uptake and use of contraceptives? What cultural considerations are have emerged as relevant or important in this advice (probe for advice, information provided and data on uptake/use)
7. How does their heritage influence the sexual health education and contraceptive methods provided to them?
8. What does your service/organisation do that is different from other services in order meet the sexual and reproductive health needs of AATs?
9. Is there something that I left out that you would like to add?

Thank you for accepting to take part in this research project.
Appendix C

Interview Questionnaires Teenagers

Contraception, TP and culture issues among African Australia unmarried teenage girls with a refugee background

NB: For the purpose of this research married teenagers will be excluded

Part 1: Demographic Information

a. How old are you?
b. What is the primary language you speak at home?
c. What other languages do you speak?
d. Are you employed?
e. How many years of schooling have you completed?
f. What is your highest level of education?
g. What is your net income after tax?
h. What is your post code

i. Are you currently in a sexual relationship?
j. Can you tell me if it is a serious or committed relationship?
k. Can you tell me if it is a monogamous (one sexual partner only) relationship?
l. How long have you been in this relationship?

Part 2: In-depth semi-structured questions

1. Tell me what you understand by contraception and TP and what you knew about contraceptives prior to becoming pregnant.
2. Tell what happened when you first had sexual relations and if you used a contraceptive; and if you are currently using a contraceptive method.
3. How did you learn about the different types of contraceptives and where did you learn this from?
4. What influenced your decision to take up and use contraceptives?
5. If you do not use any contraceptives can you tell me why?
6. Are you normally happy with the information, help and support given to you by the service provider about your contraceptive? Why or why not?

7. Has living in Australia affected your decision about the uptake and use of contraceptives?

8. Can you explain if the decision to use or not to use contraceptives would have been different if you were living in Africa (Sudan, Somalia, and Ethiopia)?

9. Has TP affected your personal life and/or relationships with friends and family? If yes how?

10. What would you suggest SP do to help other teenagers about issues of unwanted pregnancy?

11. Can you suggest how SP and African parents can help teenagers when communicating information about contraception and TP?

12. Is there something that I left out that you would like to add?

Thank you for accepting to taking part in this research project.
Appendix D

Focus Group Discussion Guide

Contraception, TP and culture issues among African-Australian girls with a refugee background

Part 1: Demographic Information

Number of attendees

a. Sex  Male Female
b. Age

c. Ancestry
d. Languages spoken at home
e. Highest level of education and professional background
f. Your post code
g. Are you a parent of a teenager (a child aged 10–19)
h. How many teenage children do you have
i. Did any of your children have a child while still living at home and unmarried?

Part 2: In-depth semi-structured questions

1. How is TP before marriage viewed in your community?
2. How would you react to the news of pregnancy of an unmarried daughter, how would this affect your relationship?
3. Is TP an important issue for your community and why?
4. What can be done to prevent TP (probe what can be done by parents, elders, religious leaders, SP, schools)
5. Do you believe teenagers should be given sexual health education and information, particularly about contraception?
6. Should teenagers have access to contraception? Why or why not?
7. What should happen in the case of unwanted TP? What supports should be in place for the teenager? What further information will be needed?
8. Has settlement in Australia contributed to increased TP? If yes, in what way?
9. What do you think would have been the case if you were living in Africa (in your home town or village)?
10. How did parents (back home) where you came from prevent their children from becoming pregnant before marriage unwanted pregnancy among teenagers?
11. How does your heritage influence the sexual health education and contraceptive information you give to your children?
12. What suggestions do you have for SP and policy makers about helping African teenagers to avoid unwanted pregnancy?
13. Is there something that I left out that this group would like to add?

Thank you for accepting to taking part in this research project!
Appendix E

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

Interview participants

INFORMATION TO PARTICIPANTS

We would like to invite you to be a part of a study titled: Contraception, TP, Culture Issues and African-Australian Girls with a Refugee Background.

I am a PhD student at Victoria University, Faculty of Arts Education and Human Development. I am supervised by Prof. Hurriyet Babacan (Institute of Community Engagement and Policy Alternatives). This research is conducted for my thesis for the award of the degree of Doctor of Philosophy (PhD).

The research involves conducting interviews with teenagers who have experienced TP and interviews with SP providing services to teenagers with an African-Australian background. The interviews will take approximately one to one and a half hours.

There may be some social or psychological risks involved if you choose to participate in this research. There is no cost to you for participating in the study. You may not benefit directly from this research but the information you provide will be used to contribute to knowledge.

The information you provide will remain confidential and your personal details will not be identifiable to anyone other than the researcher. The findings from this research will be published in academic papers and presented at conferences.

There will be no cost to you if you choose to withdraw from this research at any time or withdraw the information you have provided at no cost to you. This research has received Human Research Ethics approval from Victoria University Human Research Ethics Committee.
CERTIFICATION BY SUBJECT

I, ...........................................................................................................................................( participants’)

Of ........................................................................................................................................... (Participant’s suburb) certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in this research; or I am the legal guardian or parent of ...........................................................................................................( daughter’s name ) who is ..............................................(daughter’s age) and I give consent for her to participate in the study Contraception, TP, Culture Issues and African-Australian Girls with a Refugee Background being conducted at Victoria University by: PhD Student Mimmie Ngum Chi supervised by Prof Hurriyet Babacan.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by:

Mimmie Ngum Chi and that I freely consent to participation involving the below mentioned procedures:

Interview.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed...........................................

Date: ........................................
CONFIDENTIALITY AGREEMENT BY SUBJECT

I, ........................................................................................................................................ (participants’, legal guardian or parent)

Daughters name
............................................................................................................................................... Of
.................................................................................................................................................. (Participant’s suburb) agree that all information provided during this interview for the research
Contraception, TP, Culture Issues and African-Australian Girls with a Refugee Background being conducted at Victoria University by: PhD Student Mimmie Ngum Chi supervised by Prof Hurriyet Babacan will be kept confidential.

Signed..............................

Date: ..............................

Any queries about your participation in this project may be directed to the researcher

Prof Hurriyet Babacan: 03 99 19 4000

Mimmie Ngum Chi: 0399 19 2766

If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box, 14428, Melbourne, VIC 8001 phone (03) 99194781
Appendix F

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

Focus group Members

INFORMATION TO PARTICIPANTS

We would like to invite you to be a part of a study titled: Contraception, TP, Culture Issues and African-Australian Girls with a Refugee Background.

I am a PhD student at Victoria University, Faculty of Arts Education and Human Development. I am supervised by Prof. Hurriyet Babacan (Institute of Community Engagement and Policy Alternatives). This research is conducted for my thesis for the award of the degree of Doctor of Philosophy (PhD).

The research involves conducting a focus group with parents of teenagers and KI. The focus group will take approximately one to two hours.

There may be minimal social or psychological risks involved if you choose to participate in this research. There is no cost to you for participating in the study. You may not benefit directly from this research but the information you provide will be used to contribute to knowledge.

The information you provide will remain confidential and your personal details will not be identifiable to anyone other than the researcher. The findings from this research will be published in academic papers and presented at conferences.

There will be no cost to you if you choose to withdraw from this research at any time or withdraw the information you have provided at no cost to you. This research has received Human Research Ethics approval from Victoria University Human Research Ethics Committee.
CERTIFICATION BY SUBJECT

I, ...........................................................................................................................................(participants')

Of ............................................................................................................................................. (Participant’s suburb) certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in this research; Contraception, TP, Culture Issues and African-Australian Girls with a Refugee Background being conducted at Victoria University by: PhD Student Mimmie Ngum Chi supervised by Prof Hurriyet Babacan.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by:

Mimmie Ngum Chi and that I freely consent to participation involving the below mentioned procedures:

Focus group.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed...........................................

Date: ........................................
CONFIDENTIALITY AGREEMENT BY SUBJECT

I, ………………………………………………………………………………………………………………..(participants name)

Of ……………………………………………………………………………………………………………..(Participant’s suburb) agree that all information provided during this focus group for the research Contraception, TP, Culture Issues and African-Australian Girls with a Refugee Background being conducted at Victoria University by: PhD Student Mimmie Ngum Chi supervised by Prof Hurriyet Babacan will be kept confidential.

Signed…………………………..

Date: ……………………………

Any queries about your participation in this project may be directed to the researcher

Prof Hurriyet Babacan: 03 9919 4000

Mimmie Ngum Chi: 03 9919 27 66

If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box, 14428, Melbourne, VIC, 8001 phone (03), 9919 4781
Appendix G

Invitation to Participate in Research

Dear Madam/sir,

We are conducting a research project titled Contraception, TP, Culture Issues and African-Australian Girls with a Refugee Background. The research is conducted by Mimmie C. Ngum Chi a PhD student at Victoria University. Mimmie is supervised by Professor Hurriyet Babacan from Victoria University.

The research will involve interviews with teenagers African-Australian girls who have experienced TP and SP who provide services to African-Australian girls with a refugee background.

A focus group discussion will be conducted with parents of teenagers and SP who provide services to this cohort of girls. If you are interested in participating in this research project and for more details and information about this research contact the researcher on:

03 9919 2766 (Office hours)
0424181801 (Mobile)
Mimmie.ngumchi@live.vu.edu.au

Thank you!
Appendix H

Recruitment process for research participants

Title of research project: Contraception, TP, Culture Issues and African-Australian Girls with a Refugee Background

Participants will be invited to participate in this research through formal and informal networks.

**Recruitment Through Formal Networks**

I shall approach SP, such as church leaders, community leaders, school nurses and school principals, community organisations and groups, government agencies and provide them with information about the research, (I would like to add that I have well established networks within the community sector through my involvement with community organisations).

This shall be followed by asking this group of people to announce to people within their organisation and to inform potential participants about the research and to display ‘the invitation to participate in research (appendix 7)’ and ‘information to potential participants (appendix 8A, 8B and 8C)’ on their notice boards or anywhere deemed appropriate.

Advertisements (Appendix 7) about this research shall be placed in community newspapers, such as the leader, church newsletters and ethnic community newsletters inviting potential participants or those interested in this research to contact the researcher for detailed information.

The research shall contact local and community radio stations, provide them with ‘the invitation to participate in research (appendix 7)’ and ‘information to potential participants (appendix 8A, 8B and 8C) sheet’ to make an announcement in their different radio stations informing community members about this research project.

Once a, b, c, and d above are completed potential participants will then contact me by email or by telephone expressing their intention to participate in the research project.
If a potential participant contacts me, I shall use this opportunity to explain to the participant what the research is about. Potential participants will be advised if they will be suitable for interviews or form part of the focus group.

If potential participants agree with this and wish to continue with the research procedure, I will go ahead to discuss with them about getting consent from them or their legal guardians (in the case of minors, under 18 years of age) prior to them participating in the research.

If the potential participant agrees to this, a date and time will be organised so the information to participants can be given to potential participants and for the consent forms to be signed. Alternatively these forms could be mailed to participants if they wish and returned to the researcher by mail or at the time of interview or focus group meeting.

Once steps e, f, g, and h above have been completed, an interview date and time will be organised with the potential participant at an agreed venue.

At this meeting the researcher will ensure that the consent form has been signed and the researcher will answer any potential questions or concerns that potential participants may have.

If the potential participant is still interested in participating in the interview or focus group, the interview will go ahead on the same day or at a later date. For potential focus group participants, they will be provided with information about the date and time of the focus group meeting.

A. Recruitment Through Informal Networks and Snowballing

a) If a participant informs me about someone they know who may be interested in participating in the research, I will advise them to contact that person and provide them with my contact details.
b) If that potential participant then contacts me, all the steps in f, g, h, i, j, and k above will be pursued.

Exclusion criteria

Participants who do not follow the above steps shall be excluded from the research even if they meet other selection criteria for this research.

Thank you!
Appendix I

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

Information to Teenagers and SP

You are invited to participate
You are invited to participate in a research project entitled Contraception, TP, Culture Issues and African-Australian Girls with a Refugee Background.

This project is being conducted by a student researcher Mimmie Ngum Chi as part of her PhD study at Victoria University under the supervision of Prof Hurriyet Babacan (Supervisor) and Prof Ian Rouse (co-supervisor) from the Institute of Community Engagement and policy alternatives and the Faculty of Health Engineering and science respectively.

Project explanation
The aim of this project is to

- Explore the role of culture in selected African communities in the uptake and use of contraceptives and eventual TP among teenagers of African-Australian descent.
- Identify and explore the effect of TP on teenagers of African-Australian descent and their families.
- Explore the effect of migration, settlement and the acculturation processes on the sexual health needs of AATs.
- Identify policy and service responses to the issue of TP among AATs.

We want to know if there are more unwanted TP among African-Australian girls than their Australian born friends; what are the of unwanted pregnancy and what can be done to help other teenagers from unwanted pregnancies. We would like to know and understand more about the type of contraceptives used by teenage African girls; and if there are cultural issues preventing the uptake and use of contraceptives. We also want to know how
teenagers’ access information in relation to sexual health issues and how safe sex education is best promoted in a way that is culturally appropriate. The knowledge gained from this project will be used to inform policy makers, SP about the ways in which they can provide culturally appropriate sex education and services to AATs that will be culturally appropriate and acceptable to the teenagers. The knowledge gained will also be used to contribute to knowledge in this area of research.

What will I be asked to do?

Teenagers and SP

We would like you to attend an interview with the researcher at your home, Victoria University or any other place where you feel safe, comfortable and privacy between you and the researcher can be maintained at all times. The interview will take approximately one to one and a half hours. During the interview all the information provided will be recorded using a digital voice recorder.

What will I gain from participating?

The information you provide shall be used to shed more light on the problem of TP. After the data has been analysed the information will be made available to policy makers and SP to help them with their work with teenagers from an African-Australian background. You may not see the direct benefit to you, however others in the community, including your family may benefit from the information gathered because of your contribution.

How will the information I give be used?

The information you provide will be typed by the interviewer and will be kept confidential. Your name or anything that may identify you will not be used; pseudonyms or numbers will be assigned to all the participants, which will be identifiable only to the researcher.
What are the potential risks of participating in this project?

There may be some social and psychological risks, though this is very unlikely to happen. Some people may not be happy after discussing personal issues with other people. Inform the researcher immediately if you are stressed during or after the interview (researcher has a health background and will know where to refer you to). Alternatively if you are stressed you can speak to Dr Chris Watts (general practitioner) on, 9301, 6777 (Westgate Health Cooperative, Spotswood) or, 9091, 8200 (Visy care Hub Sunshine).

How will this project be conducted?

The participants will include AATs with a refugee background, who have experienced TP; parents of teenagers, KI from the community and SP. One-on-one interviews will be conducted with teenagers and SP.

The information gathered from interviews will be transcribed verbatim. Once this stage is completed, information will be coded and analysed using thematic analysis. The findings will then be used to contribute to new knowledge in this area and inform policy makers and SP about supporting teenagers in preventing TP and promoting safe sex.

Who is conducting the study?

This research is conducted by Mimmie Ngum Chi who is a PhD student at Victoria University. Mimmie is supervised by Professor Hurriyet. For the purpose of this research Mimmie shall be based at the Institute of Community Ethnicity and Policy Alternatives (ICEPA). Mimmie is also a lecturer in the School of Nursing and Midwifery, Faculty of Health Engineering and Science. You can contact the researchers on:

Prof Hurriyet Babacan: 03 9919 5485; Mimmie Ngum Chi: 03, 9919, 2766
Mimmie.ngumchi@live.vu.edu.au
Any queries about your participation in this project may be directed to the Principal Researcher listed above.

If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box, 14428, Melbourne, VIC, 8001 phone (03), 9919, 4781.
Appendix J

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

Information to Parents of Teenagers and KI

You are invited to participate

You are invited to participate in a research project entitled Contraception, TP, Culture Issues and African
Australian Girls with a Refugee Background.

This project is being conducted by a student researcher Mimmie Ngum Chi as part of her PhD study at
Victoria University under the supervision of Prof Hurriyet Babacan (Supervisor) and Prof Ian Rouse (co-
supervisor) from the Institute of Community Engagement and policy alternatives and the Faculty of Health
Engineering and science respectively.

Project explanation

The aim of this project is to

- Explore the role of culture in selected African communities in the uptake and use of contraceptives
  and eventual TP among teenagers of African-Australian descent.
- Identify and explore the effect of TP on teenagers of African-Australian descent and their families.
- Explore the effect of migration, settlement and the acculturation processes on the sexual health needs
  of AATs.
- Identify policy and service responses to the issue of TP among AATs.

We want to know if there are more unwanted TP among African-Australian girls than their Australian born
friends; what are the of unwanted pregnancy and what can be done to help other teenagers from unwanted
pregnancies. We would like to know and understand more about the type of contraceptives used by teenage
African girls; and if there are cultural issues preventing the uptake and use of contraceptives. We also want to
know how teenagers access information in relation to sexual health issues and how safe sex education be best
promoted in a way that is culturally appropriate. The knowledge gained from this project will be used to
inform policy makers, SP about the ways in which they can provide culturally appropriate sex education and
services to AATs that will be culturally appropriate and acceptable to the teenagers. The knowledge gained
will also be used to contribute to knowledge in this area of research.
What will I be asked to do?

Parents of teenagers and KI
We would like you to attend an interview with the researcher at your home, Victoria University or any other place where you feel safe, comfortable and privacy between you and the researcher can be maintained at all times. The interview will take approximately one to one and a half hours. During the interview all the information provided will be recorded using a digital voice recorder.

What will I gain from participating?

The information you provide shall be used to shed more light on the problem of TP. After the data has been analysed the information will be made available to policy makers and SP to help them with their work with teenagers from an African-Australian background. You may not see the direct benefit to you, however others in the community, including your family may benefit from the information gathered because of your contribution.

How will the information I give be used?

The information you provide will be typed by the interviewer and will be kept confidential. Your name or anything that may identify you will not be used; pseudonyms or numbers will be assigned to all the participants, which will be identifiable only to the researcher.

What are the potential risks of participating in this project?

There may be minimal social and psychological risks though this is very unlikely to happen. Some people may not be happy after discussing personal issues with other people. Inform the researcher immediately if you are stressed during or after the interview (researcher has a health background and will know where to refer you to). Alternatively if you are stressed you can speak to the Victoria University chaplain on 03 9919 2292 /2399 or a counsellor at the university on 03 9919 4035 at no cost to you.

How will this project be conducted?

The participants will include AATs with a refugee background, who have experienced TP; parents of teenagers, KI from the community and SP. One-on-one interviews will be conducted with teenagers and SP. The information gathered from interviews will be transcribed verbatim. Once this stage is completed, information will be coded and analysed using thematic analysis. The findings will then be used to contribute to new knowledge in this area and inform policy makers and SP about supporting teenagers in preventing TP and promoting safe sex.
Who is conducting the study?

This research is conducted by Mimmie Ngum Chi who is a PhD student at Victoria University. Mimmie is supervised by Professor Hurriyet. For the purpose of this research Mimmie shall be based at the Institute of Community Ethnicity and Policy Alternatives (ICEPA). Mimmie is also a lecturer in the School of Nursing and Midwifery, Faculty of Health Engineering and Science. You can contact the researchers on:

**Prof Hurriyet Babacan: 03 9919 5485**

**Mimmie Ngum Chi: 03 9919 27 66**

Mimmie.ngumchi@live.vu.edu.au

Any queries about your participation in this project may be directed to the Principal Researcher listed above. If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box, 14428, Melbourne, VIC, 8001 phone (03) 99194781.
Appendix K

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

Information to Focus Group Members

You are invited to participate

You are invited to participate in a research project entitled *Contraception, TP, Culture Issues and African-Australian Girls with a Refugee Background.*

This project is being conducted by a student researcher Mimmie Ngum Chi as part of her PhD study at Victoria University under the supervision of Prof Hurriyet Babacan (Supervisor) and Prof Ian Rouse (co-supervisor) from the Institute of Community Engagement and policy alternatives and the Faculty of Health Engineering and science respectively.

Project explanation

The aim of this project is to

- Explore the role of culture in selected African communities in the uptake and use of contraceptives and eventual TP among teenagers of African-Australian descent.
- Identify and explore the effect of TP on teenagers of African-Australian descent and their families.
- Explore the effect of migration, settlement and the acculturation processes on the sexual health needs of AATs.
- Identify policy and service responses to the issue of TP among AATs.

We want to know if there are more unwanted TP among African-Australian girls than their Australian born friends; what are the of unwanted pregnancy and what can be done to help other teenagers from unwanted pregnancies. We would like to know and understand more about the type of contraceptives used by teenage African girls; and if there are cultural
issues preventing the uptake and use of contraceptives. We also want to know how teenagers access information in relation to sexual health issues and how safe sex education be best promoted in a way that is culturally appropriate. The knowledge gained from this project will be used to inform policy makers, SP about the ways in which they can provide culturally appropriate sex education and services to AATs that will be culturally appropriate and acceptable to the teenagers. The knowledge gained will also be used to contribute to knowledge in this area of research.

What will I be asked to do?

Focus Group Members
We would like you to attend a focus group at the holy Eucharist school hall or as advised at Victoria University. Privacy between participants and the researcher shall be maintained at all times. The focus group discussion will take approximately one to two hours. During the focus group discussion the researcher will record all the information, which will be transcribed later verbatim. All participants are advised that what is discussed during this focus group should remain confidential and not discussed with other people at any time any where.

What will I gain from participating?

The information you provide shall be used to shed more light on the problem of TP. After the data has been analysed the information will be made available to policy makers and SP to help them with their work with teenagers from an African-Australian background. You may not see the direct benefit to you, however others in the community, including your family may benefit from the information gathered because of your contribution.

How will the information I give be used?
The information you provide will be typed by the interviewer and will be kept confidential. Your name or anything that may identify you will not be used; pseudonyms or numbers will be assigned to all the participants, which will be identifiable only to the researcher.

**What are the potential risks of participating in this project?**

There may be minimal social and psychological risks though this is very unlikely to happen. Some people may not be happy after discussing personal issues with other people. Inform the researcher immediately if you are stressed during or after the interview (researcher has a health background and will know where to refer you to). Alternatively if you are stressed you can speak to the Victoria University chaplain on 03, 9919, 2292 /, 2399 or a counsellor at the university on 03, 9919, 4035 at no cost to you.

**How will this project be conducted?**

The participants will include AATs with a refugee background, who have experienced TP; parents of teenagers, KI from the community and SP. One-on-one interviews will be conducted with teenagers and SP.

The information gathered from interviews will be transcribed verbatim. Once this stage is completed, information will be coded and analysed using thematic analysis. The findings will then be used to contribute to new knowledge in this area and inform policy makers and SP about supporting teenagers in preventing TP and promoting safe sex.

**Who is conducting the study?**

This research is conducted by Mimmie Ngum Chi who is a PhD student at Victoria University. Mimmie is supervised by Professor Hurriyet. For the purpose of this research Mimmie shall be based at the Institute of Community Ethnicity and Policy Alternatives (ICEPA). Mimmie is also a lecturer in the School of Nursing and Midwifery, Faculty of Health Engineering and Science. You can contact the researchers on:
Prof Hurriyet Babacan: 03 9919 4000

Mimmie Ngum Chi: 03 9919 2766
Mimmie.ngumchi@live.vu.edu.au

Any queries about your participation in this project may be directed to the Principal Researcher listed above.

If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box, 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.
Appendix L

RECRUITMENT PROCESS FOR PARTICIPANTS INVOLVED IN RESEARCH

I have been informed that the information I provide will be kept confidential.

Signed…………………………..

Date: …………………………

Any queries about your participation in this project may be directed to the researcher

Prof Hurriyet Babacan: 03 9919 5485
Mimmie Ngum Chi: 03 99 192766

If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box, 14428, Melbourne, VIC, 8001 phone (03) 9919 4781
Appendix M

Recruitment process for research participants

Title of research project: Contraception, TP, Culture Issues and African-Australian Girls with a Refugee Background

Participants will be invited to participate in this research through formal and informal networks.

A. Recruitment Through Formal Networks
   a) As I will be using a snowball technique I shall approach SP, such as church leaders (parish priests, pastors and Imams), community leaders, school nurses and school principals, community organisations and groups, government agencies and provide them with information about the research; (I would like to add that I have well established networks within the community sector through my involvement with community organisations).
   b) This shall be followed by asking this group of people to announce to people within their organisation and to inform potential participants about the research and to display ‘the invitation to participate in research (appendix 7)’ and ‘information to potential participants (appendix 8A, 8B and 8C) on their notice boards or any where deemed appropriate.
   c) Advertisements (Appendix 7) about this research shall be placed in community newspapers, church newsletters and ethnic community newsletters by the research student and or the relevant persons within the organisations as stated in a) above inviting potential participants, or those interested in this research to contact the researcher for detailed information about the research.
d) Once a, b, c, and d above are completed potential participants will then contact me by email or by telephone expressing their intention to participate in the research project.

e) If a potential participant contacts me, I shall use this opportunity to explain to the participant what the research is about. Potential participants will be advised if they will be suitable for interviews or form part of the focus group.

f) If potential participants agree with this and wish to continue with the research procedure, I will go ahead to discuss with them about getting consent from them or their legal guardians (in the case of minors, under 18 years of age) prior to them participating in the research.

g) If the potential participant agrees to this, a date and time will be organised so the information to participants can be given to potential participants’ and for the consent forms to be signed. Alternatively these forms could be mailed to participants if they wish and returned to the researcher by mail or at the time of interview or focus group meeting.

h) Once steps e, f, g, and h above have been completed, an interview date and time will be organised with the potential participant at an agreed venue.

i) At this meeting the researcher will ensure that the consent form has been signed and the researcher will answer any potential questions or concerns that potential participants may have.

j) If the potential participant is still interested in participating in the interview or focus group, the interview will go ahead on the same day or at a later date. For potential focus group participants, they will be provided with information about the date and time of the focus group meeting.

B. Recruitment Through Informal Networks and Snowballing
a) If a participant informs me about someone they know who may be interested in participating in the research, I will advise them to contact that person and provide them with my contact details.

b) If that potential participant then contacts me, all the steps in f, g, h, I, j, and k above will be pursued.

Exclusion criteria

Participants who are minors and do not have parental consent will be excluded from the research.

Thank you!
Chair,

Human Research Ethics Committee,

Faculty of Arts, Education & Human Development,

Victoria University.

Dear Sir/Madam,

Re: PhD Research Project—Ms. Mimmie Ngum Chi

This letter is to indicate my support of Ms Mimmie Ngum Chi’s PhD research project about TP among African refugees. This project will provide valuable and very useful information for all primary health providers, in the western suburbs and elsewhere, who provide care for African refugees.
I also undertake to provide a general practice service to any research participants who might require it for any reason. In usual circumstances, a consultation should be available within a day or two, either at this clinic or at Headspace Western Melbourne in Sunshine, a specialist mental health service for young people aged 12–25. At both clinics, ready access to psychological and other counselling services is also available. These consultations can all be provided at no out-of-pocket cost to the individual.

Yours sincerely,

Dr. Chris Watts
MEMO

TO	Prof Hurriyet Babacan
ICEPA
Footscray Park

DATE	13/07/2009

FROM	Dr Harriet Speed
Chair
Victoria University Human Research Ethics Committee

SUBJECT	Ethics Application – HRETH 09/77

Dear Prof Babacan,

Thank you for submitting this application for ethical approval of the project:

**HRETH 09/77** Contraception, Teenage Pregnancy, Culture Issues and African Australian Girls with a Refugee Background

The proposed research project has been accepted and deemed to meet the requirements of the National Health and Medical Research Council (NHMRC) 'National Statement on Ethical Conduct in Human Research (2007)' by the Victoria University Human Research Ethics Committee. Approval has been granted from 9 July 2009 to 31 October 2010.

Continued approval of this research project by the Victoria University Human Research Ethics Committee (VUHREC) is conditional upon the provision of a report within 12 months of the above approval date (by 9 July 2009) or upon the completion of the project (if earlier). A report proforma may be downloaded from the VUHREC web site at: [http://research.vu.edu.au/hrec.php](http://research.vu.edu.au/hrec.php).

Please note that the Human Research Ethics Committee must be informed of the following: any changes to the approved research protocol, project timelines, any serious events or adverse and/or unforeseen events that may affect continued ethical acceptability of the project. In these unlikely events, researchers must immediately cease all data collection until the Committee has approved the changes. Researchers are also reminded of the need to notify the approving HREC of changes to personnel in research projects via a request for a minor amendment.

If you have any queries, please do not hesitate to contact me on 9919 5412.

On behalf of the Committee, I wish you all the best for the conduct of the project.

Dr Harriet Speed
Chair
Victoria University Human Research Ethics Committee
Appendix P

Summaries about the 16, AATs in this research

Alimatou

Alimatou was born in South Sudan and arrived in Australia seven months ago. She left Sudan in 2005 age 14 for Uganda where she lived in a refugee camp for four years with family. Her father gave her as a wife, to a man who came from Australia in 2008. The husband returned to Australia while she went to Kenya after the traditional ceremony. Alimatou was pregnant before the husband left Uganda; she has a two-year-old son and is expecting another child in a couple of months. Alimatou was pregnant within a month after arriving in Sydney. She separated from her husband soon after because of ‘violence’ and has moved to Melbourne.

Prior to arriving in Australia, Alimatou said she had never heard of contraception and when she did hear about contraception, she thought it was something that would stop you from ever having children. Alimatou was a virgin when she was given to her husband. She describes her first sexual experience as painful and she ‘just wanted to run away’. Alimatou has not had the opportunity to consider using contraceptives, but says if you can have children after using contraceptives, then the young girls should be encouraged to use them. She says back in her country, contraception is not required but in Australia, because there is freedom and the girls have indiscriminate sex before marriage, they need to do something to prevent pregnancy.

Alimatou does not like the accommodation and the part of town she lives in. There are very few people from her community, she feels isolated because the neighbours do not speak to her and her son. She likes attending classes where she meets other young women from her country and Africa with similar background.
Ayuba

Ayuba is 20 years old and lives with her twenty two-year-old boyfriend and their baby. Ayuba was born in Burundi and is the eighth of nine children. Ayuba does not remember her life in Burundi; she left during the civil war, age three. Both her parents are deceased, including three of her older siblings in Burundi. Ayuba does not remember them much. Ayuba grew up in a refugee camp in Tanzania, lived there until her arrival in Australia five years ago age 16. She has lived with her eldest sister from the age of two and considers her and her husband as the mother and father figures in her life. She attended school for five years in the refugee camp, prior to arrival in Australia, where she was matched into a class, year ten, according to her age. She completed year 12 successfully. Her sister was looking forward to Ayuba attending university, when she got pregnant. Her sister did not speak to her for all of the first trimester of the pregnancy and part of the second trimester. With the support of her boyfriend, Ayuba was reconciled to her sister.

Ayuba met her boyfriend in Sydney when he came from Melbourne to visit his friend who was a friend’s brother. The friend told Ayuba, the brother’s friend liked Ayuba. Ayuba was a virgin at the time, nut Ayuba became pregnant within a month of meeting him, her sister was very furious. Ayuba left the sister and her husband in Sydney to live with him in Melbourne. Ayuba regrets her actions, and adds that she did not know about contraception before her pregnancy. Her midwife told her about contraception during the antenatal visits. Ayuba now has an implant insitu and plans wait for at least six years before having another child. She regrets having a baby at this age, without any skills or a job to support her and the baby. Her boyfriend is unemployed and they depend on Centrelink payments to support themselves and the baby.

Ayuba hopes to be a nurse one day but says, it is too difficult to study when you have a baby. She has one friend, who lives on the other side of the city, and they don’t see each other often, because Ayuba does not drive. She says, her boyfriend helps her sometimes, but caring for the baby and doing the house chores, are primary left the woman’s responsibilities. In her culture, these roles are for women and if you are unable to fulfil
them, the man will leave you for another woman. Ayuba says, girls need to be submissive and obey their partners and husbands as expected of them in their culture. To Ayuba, ‘if a man says no, that means no’. She says men are different to women. Ayuba although she did not grow up in Burundi, she has learnt Burundian culture and traditions from the Burundians in the refugee camp and the Burundian community in Australia.
Bikutsi

Bikutsi arrived in Australia, seven years ago from Sudan via Egypt. She was born in Khartoum, in North Sudan, but she identifies as a Southern Sudanese. She speaks Arabic and English and lived in Egypt for a year and a half. She says she does not like to speak about life in Egypt because of the difficulties they faced there and racism. This I heard from women in the focus, and they choose to bury their experiences about their lives in Egypt. Bikutsi arrived in Australia aged 14, left school in year ten to get marry. Her mother was against her marrying but Bikutsi wanted a family of her own. Bikutsi says her step-father hated her, and when he fought or quarreled with her mother, he always involved her and insulted Bikutsi. Her biological father is a wealthy businessman, who lives in Khartoum, Sudan according to her. She was born after an extramarital affair between her much older father with her mother who was a teenager at the time. Bikutsi has met her father a couple of times and longs for him. She says her life would be different if her mother had married him and stayed with him. Her mother couldn’t because he was married at the time and had a family and would not leave his wife for her. More so his wife was educated and worked while Bikutsi’s mother was uneducated and unemployed. As she describe, he was never going to leave his educated wife for a poor uneducated girl. More so he had five children with the wife before the affair with her mother.

Bikutsi hears her stepsister in Sudan all have university degrees and are not allowed to marry without finishing university. Bikutsi left school in year ten, she has had two miscarriages in the last two years and attributes this as to a curse from her biological father who did not approve of the relationship. Bikutsi says although she has not have much to do with her father, she plans to go and ‘beg’ him for forgiveness. She hates the idea of step parenting and says she would never have a child with one person, and then leave to be with another man. She continues to question her mother’s decision about her affair with a married man, and then marrying someone else, whom she says, it was not her decision.

Bikutsi knows about contraceptives and has used contraceptives in the past. She blames the health professionals for her first miscarriage, because says she was not told she had a
problem, yet she lost the baby. It was only after the second miscarriage she was told she had ‘an infection’, which they have to treat before she can get pregnant again. Bikutsi is a very bright young woman who wants the best for herself and hopes to be a mother one day; even if that means going to Sudan, to look for her biological father and make peace with him.
Candida

Candida was born in South Sudan where she lived until age 13. She is one of seven children. Her father died during the civil war in Sudan and her mother had to marry her father’s brother according to her culture. She had two more children with him in addition to the five from her late husband. Her step-father rejected the five children from his late brother. The family left South Sudan for Egypt where they lived in transit for two years prior to being accepted to come to Australia. Candida had four years of schooling in South Sudan, and one year in Egypt. On arrival in Australia at age 16, she was put in grade ten. She says this was very difficult because she found it hard to keep up with other students in her class and it made her hate school. Candida’s mother broke up with her ‘second husband’ after arriving in Australia. A year and a half later in Australia Candida became pregnant to a Sudanese refugee man. Candida’s mother had disapproved of the relationship, but Candida did not listen. Candida knew she was pregnant at two months into the pregnancy. Her teacher advised her to do an abortion, which she refused. The boyfriend initially wanted an abortion but changed his mind and promised to marry her. The boyfriend left his factory job in the west of Melbourne, for a three month holiday to South Sudan soon after. He promised to organise the dowry upon his return from his holiday.

Candida said she did not know about contraception before the pregnancy, and that she thought pregnancy would make her mother change her attitude towards her older boyfriend, he was alcoholic. The two had started dating when Candida was 17, and him, 20 six. Candida soon realised it will be difficult to manage alone and that he would not be there for her as previously thought. Though she did not want an abortion, she felt it was now necessary. She decided to take her teachers advice to have an abortion. Unfortunately, she was well into the second trimester of the pregnancy and was told by the refugee nurses, it was too late for an abortion. Her mother soon found out about the pregnancy through an aunt that Candida confided in. Her mother kicked Candida out of the house. Candida lived with friends and family until she was about to give birth, when her mother asked her to return home.
Candida regrets her decision to keep the pregnancy, but says, she knew nothing about contraception at the time of her pregnancy. The father of the baby has no input by choice into the child’s life, aged five. Candida says looking back she would have taken her mums advice although she does not agree with the way she was treated after the pregnancy.

Of the seven children in Candida’s family, the three eldest have experienced TP. All seven children and three grand children live in the same household, and Candida’s mother is the head of the family and main bread winner working in a meat factory two hours from home. The mother goes to live with other workers on Sundays close to her work and returns home of Friday evening. When I returned later to see how the family was going, Candida’s mum had been made redundant; she was enrolled in a language course and was learning to read and write. She feels her eldest children have let her down, but hopes it will be different for the other four.
Carmen

Carmen is an eighteen-year-old mother of two. She is the eldest of five children, all girls. She was born in a refugee camp in Kenya, and was brought to Australia when she was two years old. She speaks English and a little bit of Dinka. She says identifies as Sudanese because of her parents. Carmen left school in year ten, age 16 because she was pregnant. The father of her two-year-old daughter has never seen the daughter because he was in prison in Sydney while Carmen was pregnant and had only just got out. Carmen does not like to speak about him, but says it will be good for him to meet his daughter. She had the second child within 18 months of the birth of the first child with another Sudanese boy.

Carmen grew up in Melbourne; she knew about contraception but says she was too scared to use it. She feared that if her parents found out she was using contraception, she was going to be in trouble, and could be punished by been sent to Africa because the contraception was evidence she was sexually active. Carmen says some parents have resorted to sending their children to be disciplined by family in Africa, because the parents fear getting into trouble with the Australian law if they punish their here. Secondly she did not want her parents to know she is sexually active. The parents did not only discover she was sexually active; they found out later she was pregnant. She had hidden the pregnancy from them until her father noticed the physical changes in her. Carmen decided after the second baby to use contraception and had an implant inserted. Unfortunately, she had it taken out because her then boyfriend and his family were against her using contraception. Her boyfriend thinks, Carmen is using contraception because she wants to be involved with other men, and not being found out or get pregnant. Carmen’s mother thinks it is a good thing for her daughter to use contraception until she starts working. Carmen plans to get her implanon re-inserted because she says she has her mother’s support.

Carmen who says she has learnt about Sudanese culture from her family and friends in Australia, questions how the boy are treated differently from the girls. Carmen says Sudanese girls have no freedom compared to the boys; she thinks girls are like servants to the men a position she clearly does not want to be in. Carmen sees herself as an Australian
with a Sudanese heritage; Carmen does not understand why women are treated differently from the boys within the same family based on stories heard from her friends who were born and raised in Sudan.
Chelsea

Chelsea was born in Liberia, and her family fled Liberia for Guinea when she was two months old where she would live for the next 15 years. She received support and some education in the refugee camp from the Red Cross and other humanitarian agencies. Chelsea’s father was ‘lost’ when the family was fleeing from the war in Liberia and has never been seen or heard from again. Chelsea’s mother remarried in the camp years later and her step-father, who brought her up, died just before they migrated to Australia. While in the camp, she used to help her mother make and sell palm oil. Sometimes her mother worked on people’s farms for pay. Chelsea says she helped her mother a lot so as she was a sole parent. When Chelsea arrived in Australia she was placed in year nine. Chelsea spent all her time with her mother and other females in the camp and dressed like fellow Muslim girls fully covered.

While in the camp, Chelsea had heard of a Muslim girl, like herself who died trying to commit an abortion. Chelsea said this left all the girls very scared. Christians had to be called in to bury the girl, because she was considered an abomination and Muslims could not touch her. Another girl in the camp had a condom stuck inside of her, so other girls were cautioned not to touch condoms ever. Chelsea says something changed after arrival in Australia. She would put on jeans and pants, which she could not in the camp. In Australia, Chelsea was taught about contraceptives, but she did not take the information given to her by the nurse seriously according to her. She bought the oral contraceptive pills as prescribed but kept them in the cupboard. She was pregnant within three months of becoming sexually active, within a year in Australia.

The father of her child had promised her he would marry her so she shouldn’t be scared to have sex with him. She was excited and said she had been raised to know that marriage was very important for women. He was her first boyfriend, but he had previous female sexual partners. Just before she found out about the pregnancy, they had a disagreement, and she never saw him again. Her daughter was just about to turn one during our interview; she had never met her father. Chelsea stopped school when she was in the third trimester of the
pregnancy and went back to complete year 12 when her daughter was four months old. Chelsea wants to do nursing at university. Her decision to do nursing she says was influenced by the work of refugee nurses in the refugee camps. Chelsea’s mother and junior sister were very supportive of her during and after the pregnancy, although her mother had been very disappointed when she found out about the pregnancy initially. Chelsea thinks her sister has learnt a lot from her, after the person who promised her marriage abandoned her with the pregnancy and baby; and secondly seeing her struggle to complete school work with the baby. When I met Chelsea a year later, she had finished year 12 and was enrolled in a TAFE course.
Daniella

Daniella arrived in Australia six years ago aged 16 with her uncle and his family. She used to care for their children back in Sudan in Khartoum, and was expected to do same in Australia, be a maid. All that changed when they arrived in Australia, Daniella could no longer be left behind, to cook and clean while his uncle’s children sat back did nothing and go to school as she said. Daniella’s parents are back in South Sudan and her father has multiple wives. Daniella had two years of formal schooling in Sudan, but all her uncles’ children attended school full time. Since arrival, she has attended various language centres to become literate and improve her English. She got pregnant just over a year after arrival to a fellow Sudanese refugee. Daniella was kicked out of home the pregnancy by her guardians. Its been four years now and her uncle and his wife have not spoken to her since then.

Daniella says the first pregnancy was an accident, but not the second. The first child and the baby she is expecting now have the same father, although he has not been there to support her with the first child. When I asked why she went on to have another child, the response was not clear. She says the father of the child and her unborn baby pays child support. Daniella says the children’s father does not want to live with her; ‘No. Because he doesn’t want to stay with us, he still wants to have fun. So of course he will have different girlfriends. So he’s not ready to get, you know, to look after the kids and stuff’.

Daniella has heard about contraceptives since arrival in Australia but says she did not like using them. Her reason was because in Sudan, people do not use contraceptives, it’s not her culture. However, she thinks after the birth of the second child, she will start using some form of contraception because she does not want another baby soon. She says her change of mind to use contraception is because, it is spoken about openly in Australia, compared to Africa where it is not spoken of. Daniella adds that she is sure there are ‘tablets’ for women to use in Africa, but they don’t and she says the husbands will beat the women up, if they found out she was using contraceptives. When I ask her about STDs, she says she has heard of HIV/AIDS while in Africa, although it was only mentioned when someone died of
AIDS. Daniella is concerned by the poor treatment of African women by their husbands after living in Australia and learning about women rights. She says this is why many women in her community are separated or divorced from their husbands. The men she says do not want to work, and want the women to give them all the Centrelink benefits, which they squander on alcohol, with other women, instead of using the money to support their families. Daniella spoke about other uncle’s daughter who was raped aged 13 and is pregnant. She says the case is in court and the family will let the boy free if he agrees to marry her cousin and care for her and the baby.

Daniella regrets not having her parents in Australia. She thinks it was fair for the uncle and his wife to be upset with her, but not for so long. Her parents she says would have taken her back after a certain period of time if they were in Australia. She had to stay with friends and their families who provided her with support throughout the pregnancy and after the birth. She currently lives in a two bedroom unit with her son and the other child will be born soon. She hopes to get her mother to Australia to help her out.
Francisca

Francisca left Sudan when she was seven. She lived in a refugee camp in Uganda for another seven years and came to Australia with her uncle’s wife that she refers to as her step-mum when she was 14. They settled in the west of Sydney. Later Francisca went to visit another aunt in Perth where she fell pregnant to a Sudanese boy she met while there. Because Francisca had no real support in Perth, she moved to Melbourne where she thought her sibling who had come in with another family could support her. At the time of the pregnancy, Francisca was 15 and the father of her baby, 25.

Francisca has heard of contraceptives but does not like them and her boyfriend did not like them too. Francisca thinks the injections have many side effects, such as rendering the woman infertile. She says her doctor has spoken to her about using contraceptives and because she trusts them, she is considering it. Francisca mentions condoms during our interview, but says she has never used them so she does not know how condoms work. Daniella says she heard about condoms in Africa, when she was a ‘girl’ then and thinks condoms would have been around now for about ten years. She proudly says she is now a ‘woman’ because she is a mother though she is still a teenager.

Daniella is very pleased to be a mother and does not think, she was too young to have a baby, though the pregnancy was unplanned. She says back in her country, Sudan girls marry and have children early, and often even younger compared to when she had her baby. She thinks it is good, because that is their culture and people ‘are used to what they do’. However, she says because girls are now attending school in South Sudan early motherhood may be delayed in the future. When asked about the state of her current relationship to the baby’s father, she describes it as ’in the middle’. She says she is committed to the relationship but the boy is not, he has other partners but she sees him as her husband because she has a baby with him.

Daniella goes on to talk about the many pregnancies from young girls in her community here in Melbourne. She says she attended two young mothers groups in Melbourne and
most of the attendees were Sudanese. She says the increasing number of pregnancies, have something to do with the freedom given to children in Australia and secondly the African style of parenting. She says, parents do not speak or explain things in a rational way to their children, they just yell, so the kids stop listening to them.

Daniella says she misses her own parents in Sudan. She misses her mother the most but does not to care much about her father who has eight wives. Daniella does not know much about her siblings and half siblings in Sudan. However, she would like to meet them and reconnect with the family one day.
Faustina

Faustina is studying for a degree in a tertiary institution in Melbourne. Faustina was born in South Sudan but moved to Uganda as a refugee because of the war in Sudan. While in Uganda, her father informed her that her grandmother was gravely ill and that they wanted her back in Sudan to say goodbye to her; they had been very close. Faustina went home only to be given in marriage to a neighbour that the grand mother and her father had arranged for her. Faustina was 16 years while her husband was 30 at the time. Faustina’s says ‘my dad told me to come home (from Uganda) to visit my grand ma, then when I came they decided to give me to this man. So I asked him why? He told me that ‘I have 2 brothers in year 12, he could not afford to pay their fees, so if they married me off, that will mean they will use the dowry to pay for my brothers fees. The dowry was 150 cows‘.

Faustina had her first child at 17; she is now a mother to five children, aged 6 months to 9 years, and she lives with her brother, 2 brother-laws; the ‘husband returned to Sudan. Faustina does not know when he shall be back, but says she is happy he is away, because she can study and care for her children without interruptions from him and his friends. When asked about what she thought about marriage and her life at the time, she responded, We came home we lived together, and then I got pregnant, I did not know about it (pregnancy). Then I went to my mum, I told my mother that I was sick, she was laughing, and she was happy and then she asked me if I had been to the hospital. I said no. We were living in Kenya at the time and so I went to the hospital, then I did some tests and I was told I was pregnant and that I was going to have a baby. My mother then told me to go home, that there is nothing that we can do about it and that I should just look after myself‘.

The challenge that Faustina faces while studying, is not the language barrier nor caring for 5 children under the age of ten. Her biggest obstacle is resisting the pressure on her, exerted by members of her own community who do not think she should be going to school, instead of staying at home and ‘bringing’ more babies.
Faustina, who came to Australia as a refugee, will be completing her degree shortly and aims to help support and empower other women from her community about the value of education. As she says, ‘I do not have to depend on the man to take me or the children to the doctor when they are sick, I know what to do’. Faustina, who normally has 11 people living in her household in the west of Melbourne, also support her family back in South Sudan by sending money sometimes. Luckily for Faustina one of the brothers’s that she had to leave school so their father could use Faustina’s dowry to pay for his fees has been her main support person. He tells her not listen to anyone and just focus on finishing her studies. The brother completed his Engineering degree and returned to South Sudan to help rebuild his country.
Honorine

Honorine is a 30 year old single mother of five and was born in South Sudan. Honorine was 15 years old when she was given as a wife to a 36 year old man as a wife. She had her first child at 16 and she says her family who had given her into marriage supported her. Honorine says she knew nothing, about her sexual health and becoming pregnant. Honorine says she did not understand what was happening to her at the time, and she still remembers fighting and scratching the man’s face during their first night together, but he over powered her. Honorine says she is very nervous around men, because of the trauma she experienced the first time she had sex. She remembers it as she says as it was yesterday. Honorine’s understanding of family planning was to breastfeed your child until they were at least two years old and during that time, you had to abstain from sexual intercourse with the man.

Honorine’s speaks Dinka and Arabic fluently and has been learning English since arriving in Australia two years ago. She spoke about the trauma she experienced as a young bride and how other girls and women suffer as a result of their traditional practices. Since coming to Australia, Honorine thinks she is more empowered to ask questions about her life and her culture, and she has learnt about contraception, which her husband did not want her to use. She left him, because the husband would not let her use contraception or attend school coupled with other forms of abuses. According to Honorine, her ex-husband felt that learning English will empower her, and this he did not desire. She regrets being a teenage mother and says she is very traumatized and fears being with men.

Honorine has learnt basic reading and writing skills at language school. Honorine thinks African girls in Australia, especially those from her community, have a lot of freedom and opportunities, but because they have not been exposed to the challenging situations and experiences, such as hers, they do not know how to use those opportunities. Honorine is unemployed but gets fortnightly payments from Centrelink to support herself and her children. She says, while the money is not enough, at least she has something to ‘work’ with, while trying to rebuild her life. Honorine wants to be a childcare worker or get into the job market one day. Honorine says she has no friends because she has not had a stable
place to call home for a long time. However, her main aim is to have a skill that she can use to improve her situation and become more independent.
Jessica

Jessica has been in Australia for four years. She was born in a refugee camp in Ethiopia, but her parents were Sudanese. Although officially she is Ethiopian, she considers herself Sudanese, and regrets not being born in Sudan because she says her Ethiopian identity has been imposed upon her. Jessica’s mother is the eldest wife of three wives and she has 13 children alive. Jessica does not know how many children the co-wives have. Jessica had come to Australia on a spouse visa. Her father had arranged a husband for her while in the camp. The man was 28 years old and was a Sudanese refugee in Australia. Jessica was 13 years old on arrival but her date of birth had been changed to reflect 18 to reflect the acceptable age at marriage under Australia law.

Jessica rejected the marriage but was too scared to tell her dad. She knew her mum and sister would support her but her father would beat them up, if they did speak about it openly. She started seeing another boy who was 18 years old. Her sister soon found out Jessica was pregnant at just 13. Jessica herself did not know. She was granted a visa to Australia. She lived with the sister of her ‘spouse’ for two weeks according to her culture on arrival, but moved to her ‘husband’s’ house later. They fought every night and he would beat her up because she refused to have sex with him. Jessica had been informed by the midwife when they did routine examination on her after her arrival that she was pregnant. She did not understand what pregnant meant as she says, so they told her ‘she was going to have a baby of her own’. Jessica did not understand how she got pregnant. She says she did not know it was by having sex that made a woman pregnant. She told the ‘spouse’ about the pregnancy, which he did not care about very much, and requested for an abortion. She refused to have an abortion and with the help of friends and social workers, she was sent to a women’s refuge to escape the violence from her ‘spouse’. Jessica’s visa status was changed from accompanying spouse to a refugee status. She was later provided with accommodation by government housing where she lived until she had her baby.

Jessica met another Sudanese boy a year later and is now expecting her second child, at age 16. She thinks he has other girlfriends because she goes for a month without seeing him and
when he comes to her house, he wants them to have sex, then he leaves shortly after that. Before getting pregnant the first time, Jessica had no knowledge of contraception and pregnancy. However, after the birth of the first child, she had an implanon, which she took out soon after because she was having ‘trouble’ with it. She was to go back and get another form of contraception from her doctor but she got pregnant before it could happen. Jessica has never been to formal school and currently attends a language school. She sends money to her family back in the refugee camp sometimes and hopes to bring her mother out to Australia to help her care for the baby. She hopes to change her age back to the correct age with the various departments, but she says that would mean she wouldn’t be allowed to drive, or be able to sponsor her mother to Australia, as that will make her a minor. Jessica I observed is a very happy bubbly girl, and has the best smile. She is very optimistic about her future, and seems to be very confident but resilient. She asked me to keep in touch and is preparing for the birth of her second child due in two months.
Josephine

Josephine came to Australia as a Liberia refugee in 2002. Josephine says: ‘we left in 1990 when the war began and I was about 9 years old. We went to Ivory Coast stayed there until, 2002, then we moved to Guinea and stayed there from, 2003-, 1007 then we went to Australia. In Guinea she lived in a refugee camp but not in Ivory Coast. War broke out in later in Ivory Coast and everyone fled again. Josephine got pregnant in the refugee camp to her friends brother. According to Josephine ‘I did not know anything about myself. I knew nothing about girlfriend and boyfriend or something about life‘. She had sex once with her friend’s brother, who had forced himself unto her one night when she had gone to visit her friend and she was not home. She did not know she was pregnant until five months later. Her friends noticed a change in her; she was getting ‘fat’ and thought she was just eating a lot.

Her friends encouraged her to go to the hospital for a checkup. She did and it was then she got informed she was pregnant. It was too late for an abortion she said and her father with whom she was living with at the time, was very angry. At the time of her pregnancy, Josephine’s mother had gone back to her country of birth Liberia to visit family she had not seen for many years. Unfortunately, war broke out again while she was away and made it difficult for her to rejoin the family in the refugee camp in Ivory Coast. She has never reunited with her again, but hopes to. The boy’s family she says ‘apologised’ to her family about what had happened and offered to help prepare for the birth. The family asked her to move in and live with them, but she refused stating she did not want to marry him. She was 18 at the time but her memories from that time are vividly clear. She talks about the pain of that night and how he over powered her.

Josephine lives with her daughter in Australia but the daughter has limited contact with her biological father. Josephine cannot afford the phone bills to call Liberia often. Josephine has completed a certificate three in age care and certificates 2 and 4 in hospitality; unfortunately she is still unemployed and is looking for work. Since coming to Australia Josephine has heard about contraception from her doctor. She knows about the oral
contraceptive pill and condoms but is afraid to use the pills. She thinks there are many side effects associated with the pills and that the pills can cause a growth in her stomach, which may stop her from having other children later.

Josephine sometimes uses the condom with her Liberian boyfriend who lives in Perth. He has another girlfriend also from Liberia, and the other girlfriend is a mother to two children from other relationships. The other girlfriend in Perth calls and insults Josephine sometimes on the telephone, and Josephine plans to stop the relationship because she thinks he is not serious. She thinks it is very hard for girls here, and if a ‘girls takes a step, everyone is going to talk about her, but if he (a boy) takes 2 or 3 steps, no one cares, why because he is a boy and she is a girl.
Kayla

Kayla was born in Khartoum, the capital city of North Sudan, and was raised in Cairo Egypt. Her parents were from the Dinka tribe of South Sudan, but Kayla has had no lived experience in South Sudan. Kayla’s primary language is Arabic, though her mother makes her speak Dinka sometimes so they do not forget it. Kayla speaks very good English. Kayla’s education has been interrupted at several levels because in Egypt it was too expensive for her mother to pay for their fees. Her father had fled Sudan and gone to live in the United States when Kayla was about two years old. He married another woman and had nothing to do with Kayla, and her brothers. Kayla’s step-father rejected her. Her mother also informed Kayla a later that the person she had told her was her father was not actually her biological father. Kayla refused to accept the new ‘biological father’, she ‘did not want to have a different father to her brothers’. Kayla says her family was isolated sometimes because her friends’ parents feared Kayla’s mother may ‘take’ their husband as she was single. This Kayla said was a painful thing to observe growing up.

Kayla says she was sexually abused repeatedly by cousins and neighbours from age three. The abuse was said to occur when Kayla’s mother left her at home and went to work. Kayla was afraid initially to speak about the abuse to her mother for fear she would be accused of being the perpetrator. Kayla plans to confront her cousins and the former neighbours about the abuse if she ever met them and has spoken to a councilor. Kayla says she made a rational decision to drop out of school, stay at home and care for her siblings for fear they may be abused by relatives and neighbours if they were left in their care like before. Kayla thought herself how to read and write but says she feels she has let her brothers down because, being the eldest child and the only daughter, they all looked up to her. Kayla became pregnant with the person she considers her second boyfriend. He lives interstate and works in a factory. Kayla let herself get pregnant because she wanted to prove her fertility to her previous boyfriend. During their two years romance, when Kayla was about 16, he had tried to impregnate her. He accused Kayla of being infertile. According to her when the next boyfriend came around all she wanted to do was become pregnant. Kayla said she feared the ‘bad things’ that had happened to her when she was young may her
affected her ability to have children. Kayla had heard about contraception but did not want to use any before her pregnancy. Kayla’s mother was not supportive of her when she first got pregnant, but soon realised she had to support her daughter. Kayla seemed a resilient young woman, but was very emotional as she spoke to me during the interview.
Madonna

Madonna migrated to Australia recently as a refugee. The father of her children is back in Sudan where she was born. Madonna was given as a wife to her husband when she was 14 years old, he was 30 then. Madonna is now 18 years old, she had her first child at 15 and the second within two years. Prior to coming to Australia she had never set foot into a classroom she says. Madonna is learning to read and write.

Madonna says she knew nothing about contraception prior to coming to Australia, she had never heard of contraception. But since been here, she has heard about family planning. She has not given it a thought because she is still breastfeeding and the father of her children is back in Sudan. She says ‘Your husband sleeps by themselves and you sleep by yourself, you [mother] sleep with the baby’. In some instances where the man has several wives he will go to the other women, and comes back to you when the baby is about a year and a half old. Madonna thinks this is a good practice because the women are free to care for the baby without the man’s interference. According to Madonna, girls do not need contraception in Sudan because they are not allowed boyfriends. Girls remain virgins until marriage, after, which they can have children, and they stop when they can no longer conceive. She thinks it is good to have children early, from the age of about 16 or 18. Because by the time the women are 25 years of age, her fertility declines and she would not be able to have as many children. She feels that Australia is good because, men accept to marry 24 and 25 year old women. Back in her homeland, if a girl is not married by age 18, she is considered too old, and would have to be given to an old man, because,’ the old men have to marry the old women’.

The family decides who the girl marries and she could be ‘killed’ if she refuses to marry the person, chosen by her family. Madonna feels the rules in Australia are over relaxed and the girls can have boyfriends and have sex, something unheard of in her country. She feels the parents should have the ultimate say, about who the children marry. Madonna feels it is okay to use ‘medicine’ (oral contraception pill) if the doctor says so.
Stephanie

Stephanie had her daughter when she was 17; she is now 22 years old. Stephanie was born in Liberia where she lived for just two years before war broke out in 1990. She was separated from her parents during the war and has never seen them again. Her maternal aunt took her to Sierra Leone, where they lived until, 2003. War broke out in Sierra Leone and they had to flee to Guinea where they lived until, 2005 before leaving for Australia. Stephanie has not been able to attend school formal due to constant mobility. Stephanie speaks five languages fluently, which she learnt in the different countries she lived in. English is her sixth language that she learnt in Australia. Stephanie can neither read nor write. She says she feels embarrassed to tell her friends about her situation. The only person who knows about this is her aunt and cousins. If Stephanie receives a text message from someone, she redials the number on the phone and gets the person to tell her what they wanted to tell her. Stephanie’s friends work in the meat and chicken factories around the western suburbs, she would like to do same, but says she can’t work because of her inability to read and write.

She has not been able to attend school because she arrived in Australia one month pregnant. She did not know she was pregnant. Stephanie is shy and is reluctant to speak about the circumstances surrounding her pregnancy in detail. She did not know she was pregnant when she left Guinea and says she only had sexual intercourse once. The father of the child is back in the camp in Guinea, but her aunt does not want her to sponsor him to Australia. Stephanie and her daughter live in a two bedroom unit provided by the housing department. Her friends advised her to move out of her aunt’s house, because it was over crowded and she needed some ‘privacy’ with her child. She supports her daughter and herself with the money she receives from Centrelink. She visits her aunt often, and has friends who are also refugees from various African countries. Stephanie adds, she has never been to a ‘white Australian’ persons house, since her arrival five years ago.

Stephanie heard about contraception, from her midwife and through her friends. She is not too keen about using them because she has not found the right boyfriend. She thinks the
boys are only after money from Centrelink when you are a single mother. Stephanie has a very positive vision for her future. She would like to find someone to teach her to read and write so she can work and be able to take her child to her country of birth one day.
Veronica

Veronica is 17 years of age, came to Australia two years ago as a refugee from Sierra Leone with her father to join her mother who had come four years earlier. The parents separated shortly after the father arrived and Veronica and her siblings live with their mother. While in Africa, Veronica had attended school for six years. On arrival in Australia, she was placed in year nine, she studied for year before becoming pregnant.

The father of her baby is a refugee from Sierra Leone. He lives with his mother and siblings. His own father is back in Sierra Leone. The boy used to visit the Veronica’s family and kept telling Veronica, he loved her and that they should have sex. Veronica had never had sex before, and she did not know how to turn him down without offending him, they did engage in sexual intercourse at least once weekly for about six months. Veronica later found out she was pregnant. Her boyfriend had other girlfriends at the time; Veronica thinks they were at least three other girls involved with him while he was with her. Veronica says she felt embarrassed about the pregnancy within her community. She says she does not love the boy and does not want to continue a relationship with him. The boy’s mother helped Veronica prepare for the arrival of the baby and she comes to Veronica’s mother’s house daily to help her with the baby. Veronica appreciates her baby’s paternal grandmother’s efforts. She was there helping with the baby while I did this interview.

Veronica says she knew nothing about contraception at the time of her pregnancy and would have protected herself if she knew. Veronica receives a lot of support from some of her former school friends but says some have distant themselves from her since she became pregnant. Veronica’s mother was very upset with her when she got pregnant, because Veronica had to leave school. Fortunately her mother changed her attitude and has been of great help to her and the baby, she and her baby live with her. Veronica thinks other teenagers should join family planning and use contraception. Veronica plans to go back to school, complete year 12 although she does not know when as yet. Veronica spoke with confidence, seemed to regret what happened but is happy to be a mother.