Promoting sexual and reproductive health for ‘culturally diverse’ women in NSW, Australia

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Project Details

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Executive summary

Background: People from culturally and linguistically diverse backgrounds in Australia may experience poorer sexual and reproductive health compared to those from Anglo-Australian backgrounds. A study was undertaken in two localities of New South Wales (NSW) to provide further insights in relation to this.

Methods: Data was collected in 2016/17 via surveys completed by 'culturally diverse' community members. Bivariate and multivariable regression analyses were employed to examine associations between participant characteristics and survey responses.

Results: Ninety-nine surveys completed by women from Syria, Iraq, Lebanon, Korea, the Philippines, Vietnam, India, China and Thailand were included in the analysis. Women who arrived in Australia three or more years ago were more likely to report cost and being unsure where to go as barriers to accessing sexual and reproductive health services. Women who arrived less than three years ago were more likely to suggest these services are not relevant to them.

Conclusion: This study reports issues identified by women from culturally diverse communities residing in NSW in relation to sexual and reproductive health. Findings highlight the importance of discussing sexual and reproductive health opportunistically with clients, including issues unrelated to sexual activity, and creating awareness of referral pathways to sexual and reproductive health services.

Introduction

Australia is a multicultural nation of people from a range of cultural, ethnic, language and religious backgrounds. As of 2015, Australia had the ninth largest number of overseas-born people in the world, with nearly half of the population born overseas or with at least one parent born overseas (Australian Bureau of Statistics [ABS], 2017a). Australia is now home to people from 190 different countries and 300 different ancestries who speak more than 300 different languages (ABS, 2017a; ABS, 2017b). The term "culturally and linguistically diverse" is commonly used in Australia to describe this; particularly people who were born, or have a parent who was born, in a predominantly non-English speaking country (Ethnic Communities Council of Victoria, 2012).

People from culturally and linguistically diverse backgrounds in Australia may experience poorer sexual and reproductive health than those from an Anglo-Australian background. They may experience higher rates of unintended pregnancies and sexually transmissible infections (Dean et al., 2017; Watts et al., 2014), yet have lower rates of testing for sexually transmissible infections (Grulich et al., 2014). They may also have lower uptake of some methods of contraception, including the oral contraceptive pill and subdermal implant, and higher use of less effective options such as condoms and withdrawal (Richters et al., 2016). These disparities may be attributed, in part, to lower utilisation of services for sexual and reproductive health by culturally diverse communities. This could be due to unfamiliarity with the health system, low health literacy, financial constraints and language barriers (Hach, 2102; Mengesha, Dune & Perz, 2016). People from culturally diverse backgrounds may also be reluctant to utilise sexual and reproductive health services because of confidentiality concerns or fears that others from their community may find out they have attended that service (Beck, Majumdar, Estcourt & Petrak, 2005; Botfield et al., 2018). This may be a particular issue for unmarried women (Ussher et al., 2012).

To contribute to better understanding the sexual and reproductive health needs and experiences of these communities in New South Wales (NSW), and whether these changed over time, an exploratory study was undertaken in two localities with high populations of culturally diverse communities – one in metropolitan Sydney and the other in a more regional area of NSW. It was anticipated that findings might help to inform sexual and reproductive health promotion activities and service provision for services working in these localities and in comparable settings.

Methods

The study was undertaken in two Local Health Districts (LHDs) in NSW with high populations of culturally diverse communities: metropolitan south-western Sydney LHD (SWSLHD) and regional Hunter New England LHD (HNELHD). A desk review was conducted to determine the demographic characteristics of the cultural groups residing in each, and a decision was made to focus the study on the three most populous cultural groups and three most populous 'newly emerging' cultural groups; for SWSLHD these were India, Lebanon, Iraq, Syria, China and Vietnam, and for HNELHD these were the Philippines, Thailand, Korea, China, Syria and Lebanon. The eligibility criteria for participation in the study included: aged between 20-60 years, residing in SWSLHD or HNELHD, lived in Australia for ten years or less, and identify with one of the participating cultural groups. The criterion for participation was purposely broad in order to capture a range of perspectives and insights. Ethics approval was obtained from the Family Planning NSW Ethics Committee (approval numbers R2015-11 and R2016-04).

Men and women from the target communities were invited to complete a short, plain-English survey; this was also translated into seven different languages to promote accessibility. The survey first asked about demographic information such as age, country of birth, year of arrival in Australia, migration path (visa), and gender. It then focused on questions regarding sexual and reproductive health issues of concern, sources of information utilised, challenges or barriers experienced in accessing information and services, and preferences for information and care. Survey questions were a mix of multiple-choice and open-answer.

Participants were recruited through organisations and groups working with culturally diverse communities in the two localities, for example, English language centers, play groups, mothers' groups and youth groups. Emails were sent to organisations/groups who were known to be working with these communities, to inform them of the research and invite them to support recruitment activities. Most responded to the email and were very supportive and happy to assist. Those willing to support the study were invited to mention the research to the community groups they worked with and to contact the research team if members of that group were happy to consider completing a survey. A member of the research team then liaised with the 'group coordinator' to establish a time and date for the research team to visit the group. During this visit the team discussed the research, answered questions, and facilitated completion of surveys for those who consented to participate. An interpreter was arranged for groups who required one. Most groups were comprised of people from the same cultural background, although a small few had a mix of cultural backgrounds. It was made clear during all discussions that participation was entirely voluntary, and that no personal information would be

collected in the survey. Copies of the information sheet and consent form were provided to all prospective participants (both plain English and translated versions). Discussions were kept very informal and people were able to leave the room if they did not wish to participate, which was the case for several. Following provision of informed written consent, surveys were distributed and participants were asked to hand them to the research team upon completion. All participants completed the survey individually. A $20 gift voucher was provided to each as an acknowledgement of their participation. In addition to this method of recruitment, community organisations were also provided with information sheets, consent forms, surveys and self-addressed pre-paid envelopes to give to prospective participants. Community members then posted back their consent form and completed survey to the research team. These participants were given the option of collecting their gift voucher from a local clinic associated with the research team or providing their address for it to be posted to them.

Completed surveys were sorted into language groups, and Bilingual Community Educators and a translation company accredited by the National Accreditation Authority for Translators and Interpreters translated survey responses into English for analysis. Descriptive statistics of frequency counts and percentages were used to present demographic characteristics of participants and their views regarding sexual and reproductive health issues. Differences between the two LHDs and year of arrival in Australia were assessed using the Chi square test. Multivariable logistic regression models were further employed to examine the association between year of arrival and participants' views. Adjusted odds ratio (OR) and 95% confidence interval (CI) were reported for significant predicators in the multivariable models. The significance level was set at 0.05. Quantitative data were analysed using SPSS (IBM SPSS Statistics, version 19). Responses to open-answer questions were reviewed and collated to supplement the quantitative findings.

Results

A total of 128 surveys were completed across both LHDs. Of these, 22 were excluded as they did not meet the eligibility criteria, and 106 surveys were deemed eligible to be included (99 female participants and 7 male participants). Given the small number of male participants, these surveys have not been included in this paper. Table 1 shows the demographic characteristics of the 99 female participants. Approximately half of participants had arrived in Australia less than three years ago. The top three reported countries of birth were Syria (33%), Korea (20%) and the Philippines (20%) in HNELHD, and Vietnam (25%), India (20%) and China (18%) in SWSLHD. There were significant differences in country of birth between the two LHDs ($P<0.05$), however, no significant differences were observed in age group or years of arrival (<3 years, and 3 years and over) between the two LHDs.

Table 1: Demographic characteristics of survey respondents in HNE and SWS LHDs (n/%)

Demographics	HNELHD n=39	SWSLHD n=60	Total*
Age group^			
20 to 24	3 (7.9)	0	3 (7.9)
25 to 30	8 (21.0)	16 (26.7)	27 (27.6)
31 to 35	11 (28.9)	10 (16.7)	21 (21.4)
36 to 40	6 (15.8)	13 (21.7)	19 (19.4)
41 to 45	4 (10.5)	10 (16.7)	14 (14.3)
46 to 60	6 (15.8)	11 (18.3)	17 (17.3)
Arrived in Australia			
Less than 3 years	17 (43.6)	33 (55.0)	50 (50.5)
3 years or over	22 (56.4)	24 (40.0)	46 (46.5)
Country of Birth#			
China	2 (5.1)	11 (18.3)	13 (13.1)
India	0 (0)	12 (20.0)	12 (12.1)
Iraq	0 (0)	8 (13.3)	8 (8.1)
Korea	8 (20.5)	0 (0)	8 (8.1)
Lebanon	1 (2.6)	8 (13.3)	9 (9.1)
Philippines	8 (20.5)	0 (0)	8 (8.1)
Syria	13 (33.3)	6 (10)	19 (19.2)
Thailand	7 (17.9)	0 (0)	7 (7.1)
Vietnam	0 (0)	15 (25.0)	15 (15.2)
Visa type#			
Migration	21 (61.8)	43 (78.2)	64 (71.9)
Refugee	11 (32.4)	4 (7.3)	15 (16.9)
Student	2 (5.9)	3 (5.5)	5 (5.6)
Asylum seeker	0 (0)	5 (9.1)	5 (5.6)

*: the sum of numbers or percentages may not be equal due to missing values.

#: P<0.05 between the two LHDs

^: The SWSLHD survey provided age options by five-year age group; the HNELD survey allowed for open responses to age.

In relation to seeking information or help for sexual and reproductive health, most participants selected searching on the internet/Google or asking for help from a GP/local doctor (75% and 80%

respectively). The open-ended comments to this question suggested that many participants would see a GP because “doctors can give reliable information” (37 years) and the “family doctor should know everything about my health condition and make referral to specialist” (56-60 years).

The barriers to information and service access selected by participants are presented in Table 2. The top barriers selected were “language” (53%), “unsure where to go for information” (30%), “too embarrassed” (23%) and “cost” (22%). There were no statistical differences in reported barriers between the two LHDs, apart from cost, which was reported as more of a barrier in HNELHD (P<0.05).

Table 2: Barriers to accessing sexual and reproductive health services by LHD [n(%)]

Barriers	HNELHD (n=39)	SWSLHD (n=60)	Total
a. Language	21(53.8)	32(53.3)	53(53.5)
b. Unsure where to go for information	13(33.3)	17(28.3)	30(30.3)
c. Too embarrassed	10(25.6)	13(21.7)	23(23.2)
d. Shame if anyone sees me	6(15.4)	6(10.0)	12(12.1)
e. Cost[#]	13(33.3)	9(15.0)	22(22.2)
f. Not enough time	5(12.8)	13(21.7)	18(18.2)
g. Hard to get to appointments because of transportation	8(20.5)	7(11.7)	15(15.2)
h. Doctors and nurses in Australia don’t understand my problems	1(2.6)	4(6.7)	5(5.1)
i. These issues are not important to me	3(7.7)	4(6.7)	7(7.1)
j. I won’t/ did not have sex before marriage so this is not relevant to me	6(15.4)	10(16.7)	16(16.2)

[#]: P<0.05 between the two LHDs

Statistically significant differences were observed for three responses between those who had lived in Australia for less than three years and those who had lived in Australia for three years or more: “unsure where to go for information”, “cost” and “I won’t/did not have sex before marriage so this is not relevant to me” (P<0.05) (see Table 3). The multivariable model identified that arrival year was associated with these barriers, after adjusting by participants’ age group and LHD. Women who arrived in Australia three or more years ago were approximately three times more likely to report they were “unsure where to go for information” (OR=2.89, 95% CI: 1.13-7.42) and that “cost” was a barrier (OR=3.46, 95% CI: 1.16-10.37). Women who arrived in Australia less than three years ago were five

times more likely to respond “I won’t/ did not have sex before marriage so this is not relevant to me” (OR=5.38, 95% CI: 1.36-21.20).

When asked what could be done to make access to services and information easier, a number of participants recommended provision of community information and education sessions, including through services they already access. They made suggestions such as "organise some women organisation to give information about reproductive health topics” (31-35 years), “organise a monthly talk on reproductive and sexual health services in community organisations” (25-30 years), “provide some information in Navitas English centres[1]” (25-30 years), and “provide information and education activities” (35 years). Provision of information in different languages by using interpreters and translated material was also suggested: “Provide an interpreter all the time in clinic to make communication with the doctor easy” (33 years), “advertising in various languages” (36-40 years), and “provide more pamphlets and booklets in multi-languages” (33 years).

Table 3: Barriers to accessing sexual and reproductive health services by year of arrival (logistic regression model*, n=95)

Variables	n(%)	OR	95% CI	P
Barrier 1: Unsure where to go for information				
Arrived in Australia				
Less than 3 years (reference group)	10 (20.0)			
3 years or over	20 (43.5)	2.89	1.13-7.42	0.027
Barrier 2: Cost				
Arrived in Australia				
Less than 3 years (reference group)	6 (12.0)			
3 years or over	16 (34.8)	3.46	1.16-10.37	0.027
Barrier 3: I won’t/ did not have sex before marriage so this is not relevant to me				
Arrived in Australia				
Less than 3 years	13 (26.0)	5.38	1.36-21.20	0.016
3 years or over (reference group)	3 (6.5)			

*also adjusted for age group and LHD

[1] Navitas English centres are government funded services that provide English language, literacy and employment services.

Discussion

The sample of women participating in the survey was similar across the two LHDs in terms of age group and year of arrival in Australia, although there were significant differences in countries of birth. This is to be expected as different cultural groups were targeted according to the main cultural groups residing in the two LHDs. The main barriers to accessing sexual and reproductive health services identified by women in the survey were language, being unsure of where to go, being too embarrassed, and cost. These are consistent with findings of other research (see, for example, Taylor & Lamaro Haintz, 2018; Mengesha, Dune & Perz, 2016). Significant differences were observed between those who had lived in Australia for less than three years compared to those who had lived in Australia for three or more years, in relation to being "unsure where to go for information", "cost" and "I won't/did not have sex before marriage so this is not relevant to me". These are briefly discussed below.

Women who had been in Australia for less than three years were more likely to state that they will not/did not have sex before marriage and therefore accessing services was not seen as being relevant to them. Women who had been in Australia longer were less likely to report this as a concern, but were also more likely to report they were unsure where to access sexual and reproductive health information. The reason for these differences in responses is not clear. As marital status was not asked in the survey it is not known if participants were married or not, which may have influenced their responses. Women who feel that sexual and reproductive health services are not relevant to them may be missing the opportunity to engage with services regarding issues not related to sexual activity, for example, menarche, menstruation, puberty, healthy relationships, breast health, and menopause. Promoting these particular aspects of services could help to better engage women from culturally diverse backgrounds and reduce the perception that sexual and reproductive health services are only relevant for sexually active or married women.

Women who arrived in Australia three or more years ago were also more likely to report that cost was a barrier to service utilisation. It may be assumed that with more time in Australia cost might become less of an issue once people were more 'settled, however this may not always be the case. Refugees, asylum seekers and some migrants receive initial support when arriving in Australia including in finding employment or enrolling in education, in accessing English language classes, and in connecting with health and community services, as well as receiving access to Medicare[2] and income support (Department of Social Services, 2018; Department of Human Services [DHS], 2018a; Settlement Services International, n.d.; DHS, 2018b). Whilst support is often available in the initial

[2] Government benefit to subsidise costs of healthcare access for Australian citizens and some overseas visitors

years of settlement for refugees and asylum seekers in particular, this may become less available over time. Additionally, when people arrive in Australia they often have competing priorities in finding employment, housing and education, and their health may not be prioritised (Hach, 2012; Sheikh-Mohammed et al., 2006). Women may therefore need sustained support in accessing sexual and reproductive health information and services beyond the more immediate settlement period in Australia. This should include provision of accessible information and education, promotion of affordable and relevant health services, and health promotion strategies aimed at reducing barriers to service utilisation.

As this was a small, exploratory study there are a number of limitations. The sample of women was small and focussed on a broad range of ages and cultural backgrounds, making it difficult to find significant differences within the sample or generalise findings. Only a limited number of women from each cultural background participated in the study, which does not provide a representative sample of women from these or other backgrounds. The sample was also a convenience sample of women recruited through participating organisations which is likely to have led to a sample already engaged with services.

This study provides some insights into the sexual and reproductive health needs and experiences of women from culturally diverse communities residing in two localities of NSW, and provides a comparison between those more recently arrived in Australia and those who have lived in Australia longer. Findings suggest a need to support women from culturally diverse backgrounds in this area of health regardless of how long they have lived in Australia. Supporting general practitioners (GPs) and other primary healthcare clinicians to facilitate discussions about sexual and reproductive health with their clients opportunistically, and create awareness of referral pathways to sexual and reproductive health services if required may also promote access and enhance sexual and reproductive health outcomes. This should include promotion of sexual and reproductive health topics not specifically related to sexual activity. As this was an exploratory study, further research is warranted to better understand these issues for different groups of women, including by age and cultural background.

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