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RESEARCH

Western Sydney Migrant and Refugee Youths' Perspectives about Access and Use of Contraception in Australia: A Qualitative Study

Yuk Kit Angus Lam[1,2] · Lisa Fleming[3] · Jacob Nelson[3] · Rashmi Pithavadian[1] · Elias Mpofu[4,5] · Zakia Hossain[5] · Pranee Liamputtong[6] · Michaels Aibangbee[1] · Tinashe Dune[7,8]

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Abstract

Introduction Access to contraception is an essential component of sexual and reproductive health and rights, yet migrant and refugee youth face significant barriers in accessing contraceptive services. This study examines migrant and refugee youth's knowledge, beliefs, and experiences regarding contraception access and utilization in Greater Western Sydney.

Methods A phenomenological qualitative approach was used to explore participants' lived experiences. From 1 June 2020 to 12 June 2021, purposive snowball sampling was used to recruit 87 participants, including eight Youth Project Liaisons. Seventeen focus group discussions were conducted, and thematic analysis was performed using Quirkos software to enhance rigor and consistency.

Results Three key themes were identified: (1) participants' knowledge and beliefs about contraception, (2) cultural and family influences on participants' perceptions and contraceptive use, and (3) participants' experiences in accessing and utilizing contraceptive support in healthcare and school settings in Australia. The results highlighted concerns about contraception use, stigma, and judgment from healthcare providers, emphasizing the need for culturally competent and youth-friendly services.

Conclusions This study provides an overview of participants' knowledge and beliefs about contraception, highlighting the influence of cultural and systemic factors. These factors should be considered in contraception counseling and education programs. Promoting sexual and reproductive rights is crucial for policymakers, health professionals, and organizations.

Policy Implications A rights-based approach to sexual health can enhance migrant and refugee youth access to contraception services and support informed reproductive choices. Policymakers and healthcare providers should prioritize culturally sensitive interventions to better serve this population.

Keywords Migrant and refugee youth · Contraception services · Sexual citizenship · Sexual and reproductive health rights · Qualitative · Western sydney australia

Introduction

Sexual and reproductive health rights (SRHR) represent the full spectrum of recognized human rights as they pertain to both the public and private dimensions of sexuality and sexual health. These rights, encompassing both sexual and reproductive domains, underscore the principle of bodily autonomy—the fundamental human right to exercise control over one's own sexuality, gender, labour, and reproduction (Ertl et al., 2024; Miller et al., 2015). When SRHR are not fully realized, barriers emerge that restrict access to and engagement with essential healthcare services. Such barriers reduce the utilization of vital sexual and reproductive health (SRH) services, including contraception, safe abortion, maternal care, and treatment for sexually transmitted infections, ultimately leading to poorer health outcomes (Wahyuningsih et al., 2024).

Barriers to accessing sexual and reproductive health (SRH) services are particularly pronounced among youth from marginalised populations, including migrants and refugees, whose lived experiences critically shape their ability to realise SRHR (Schindele & Lindroth, 2020; Napier-Raman

Extended author information available on the last page of the article

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et al., 2025). Evidence consistently demonstrates that migrant and refugee youth (MRY) exhibit lower levels of engagement with healthcare systems, encounter greater difficulties in navigating available services, and experience disproportionately adverse SRH outcomes compared to their non-migrant peers (McMichael & Gifford, 2010; Robards et al., 2019). Structural barriers, linguistic challenges, and the lack of culturally safe and responsive care contribute to low uptake of SRH services and exacerbate existing health inequities (Ilami & Winter, 2021; Ussher et al., 2012). Furthermore, the experiences of displacement and resettlement significantly influence MRY's SRH knowledge, attitudes, and practices (Odger et al., 2019). In adapting to new linguistic and cultural environments and establishing social networks, MRY often experience acculturation gaps with their parents, which can generate intergenerational conflict and hinder psychosocial adjustment (Berry & Hou, 2016). Deeply embedded cultural norms and taboos surrounding sexuality further shape SRH perceptions and behaviours (Metusela et al., 2017). Consequently, MRY who engage in discussions of SRH frequently face social stigma within their families and communities, with detrimental effects on their mental wellbeing (Wenze & Żerkowska-Balas, 2019).

Access to and utilization of contraception constitute fundamental dimensions of SRH, directly influencing outcomes such as unintended pregnancy, maternal wellbeing, and broader population health indicators. Migrant and refugee youth experience disproportionately higher rates of unplanned pregnancies, which can lead to profound social, emotional, personal, and economic consequences (Dune et al., 2017). These disparities are compounded by multiple intersecting barriers to contraceptive access, including psychological and physical trauma stemming from pre-migration experiences, perilous migration journeys, prolonged displacement, disrupted education, and challenges associated with citizenship and resettlement processes (McMichael & Gifford, 2009). Globally, inadequate or inaccurate knowledge regarding contraception, coupled with concerns about potential side effects, continues to impede effective pregnancy prevention and management (D'Souza et al., 2022). For MRY, while access to contraception and pregnancy-related healthcare remains critical, discrimination, cultural misunderstanding, and a lack of culturally competent care within healthcare systems persist as significant barriers to obtaining accurate information and timely services (Obach et al., 2024).

Nearly half of all Australians are either born overseas or have at least one parent born overseas (Australian Bureau of Statistics [ABS], 2021), with a substantial proportion originating from refugee backgrounds (Department of Home Affairs, 2019; Napier-Raman et al., 2023). Studies consistently show that MRY in Australia experience poorer health outcomes and encounter significant barriers to accessing healthcare services (Au et al., 2019; Hirani et al., 2019). These barriers are intertwined with broader challenges, including shifting family structures and gender roles, social isolation, limited support networks, and the need to navigate unfamiliar systems while facing societal expectations to adapt rapidly (Renzaho et al., 2016; Ziaian et al., 2018a). For refugee-background youth, these difficulties are further compounded by the demands of cultural transition, evolving identities, language acquisition, and adjustment to the Australian education system—all occurring during the critical developmental stage of adolescence to adulthood (Ziaian et al., 2018b). Consequently, many MRY find themselves negotiating between two cultural worlds, a tension that can generate adverse outcomes at the individual, familial, and societal levels (Renzaho et al., 2017).

Despite Australia's cultural diversity, the nation still lacks a comprehensive national SRH strategy. A recent review highlights that SRH education for MRY does not adequately reflect the diversity of their experiences and fails to address their distinct SRH needs (Aibangbee et al., 2023). Moreover, Australia's vast geographic and demographic variation necessitates caution against overgeneralising MRY's SRH experiences, as access to SRH services and resources varies substantially across regions. The absence of culturally responsive and inclusive SRH frameworks further limits the capacity of healthcare systems to meet the needs of diverse youth populations.

This study examines the lived experiences of MRY in Greater Western Sydney, Australia, with a specific focus on contraception access and utilisation. Through a phenomenological approach, it seeks to elicit reflective accounts and generate a nuanced understanding of how these young people perceive and navigate SRH services. Accordingly, the study addresses the following research question: How do migrant and refugee youth in Australia perceive and experience access to, and use of, contraception services?

Methodology

Research and Theoretical Design

A qualitative participatory action research (PAR) design was employed to capture rich data on an under-researched topic (Pithavadian et al., 2023). The PAR approach is particularly well suited to studies involving MRY due to its collaborative and empowering orientation, which positions marginalised populations as co-researchers and active agents of change (Upreti et al., 2024). To enhance the depth of understanding and interpretive rigour of the inquiry, the study was further informed by a phenomenological theoretical framework, enabling the interview process to elicit firsthand,

high-quality data (Creswell & Baez, 2021). Phenomenology focuses on understanding participants' lived experiences and seeks to reveal the universal essence of those experiences through interpretation and reflection (Aghamiri et al., 2025; Lam et al., 2023).

A natural synergy exists between PAR and interpretive phenomenology, both of which are grounded in social constructivist and interpretivist paradigms derived from hermeneutic philosophy (Lam et al., 2024). Interpretive phenomenology aims to uncover participants' perspectives and experiences as a means of constructing shared meaning, while social constructivism asserts that meaning is created through social interaction and that understanding a phenomenon requires engaging with the perspectives of those who have lived it (Mertens, 2024). PAR aligns closely with these assumptions, emphasising that meaning-making occurs within a community context and that authentic understanding of a group's experiences should emerge from the community itself (Agenor et al., 2022).

Another key point of convergence between PAR and interpretive phenomenology lies in their shared commitment to co-constructing knowledge. Both approaches recognise communities as dynamic social and cultural entities and actively involve participants in multiple stages of the research process—from data generation to the interpretation and dissemination of findings (Leavy, 2022). This epistemological stance not only enhances the validity of the research but also ensures that knowledge production remains participatory, reflective, and responsive to the lived realities of MRY.

Study Population

This study is part of a larger Australian Research Council (ARC) Discovery Grant project (DP200103716) investigating SRH among MRY in Greater Western Sydney. In line with PAR, this study involved participation and collaboration from Advisory Committee members (ACMs), Youth Project Liaisons (YPLs), and MRY. Advisory Committee members were key stakeholders and included clinicians and academics from culturally and linguistically diverse backgrounds who possessed expertise in sexual health and/or experience working with migrant and refugee populations and qualitative research. A purposive snowball sampling strategy was employed to obtain in-depth data on the sexual and reproductive health of MRY, ensuring the inclusion of participants with relevant experiences and perspectives (Parker et al., 2019; Obilor, 2023). Eligibility criteria for focus group discussions (FGDs) participation included: (a) being aged 16–25, (b) self-identifying as a migrant or refugee or having at least one parent who does, and (c) residing in Greater Western Sydney for at least 12 months and able to use English for interview.

The recruitment for this study was conducted in stages commencing 1 June 2020 to 12 June 2021. In total, the study included 87 participants: eight YPLs and 79 MRY. The YPLs were recruited as relatable peers to facilitate connections with other MRY. YPLs were selected based on their active involvement in migrant and refugee communities in Greater Western Sydney and met the same inclusion and exclusion criteria as other participants. Advisory Committee members provided training to YPLs to co-facilitate FGDs in accordance with participatory action research (PAR) principles and to assist in recruiting MRY participants. Recruitment was conducted through multiple channels, including social media, migrant resource centres, community organisations, universities, public health networks, and referrals from YPLs and Advisory Committee members. This process resulted in the recruitment of 79 MRY participants for the FGDs. YPLs received an honorarium of AUD $60 for each FGD they co-facilitated, while MRY participants received AUD $40 for their participation.

Of the total participants, 19 identified as male and 56 as female, with an average age of 20.03 years. Participants represented more than 20 nationalities, with the majority identifying as heterosexual. Three participants were married, and most identified with Christian or Catholic religious affiliations (Table 1).

Ethics Consideration

This study received ethical approval from the University Human Research Ethics Committee at (Approval no. H13798). Details of the ethics were removed for blind peer-review. Written consent was obtained prior to the start of the interview, with voluntary participation and the option to withdraw at any time. Confidentiality and anonymity were rigorously upheld throughout the study, with personal information securely stored on Cloudstor and anonymised. All the participants received information about the nature of the FGDs and general background of potential participants. A debriefing session offered support for any distress during FGDs.

Data Collection

Aligned with a phenomenological approach, the FGD were structured around three domains of inquiry: (1) How do participants understand and make sense of using different contraceptive methods? (2) What are participants' experiences and feelings when discussing sexual relationships and contraceptive use with family members? (3) How do participants describe their experiences with accessing and utilizing both contraceptive healthcare services and support within the school environment? While three FGDs were

Table 1 Demographic characteristics of the participants ($n = 75$[a])

	n	%
Gender		
Male	19	25.3
Female	56	74.7
Other	0	0.0
Country of Birth		
Australia	38	50.7
Nigeria	7	9.3
Fiji	4	5.3
New Zealand	3	4.0
Thailand	3	4.0
Iraq	3	4.0
Philippines	2	2.7
India	2	2.7
Zimbabwe	2	2.7
Sri Lanka	1	1.3
Italy	1	1.3
Vietnam	1	1.3
Myanmar	1	1.3
Sierra Leone	1	1.3
England	1	1.3
Liberia	1	1.3
Egypt	1	1.3
Bangladesh	1	1.3
Pakistan	1	1.3
Malaysia	1	1.3
Religious Affiliation		
No religion	10	13.3
Christian	30	40.0
Catholic	11	14.7
Buddhist	6	8.0
Islamic	6	8.0
Other or missing[b]	12	16.0
Sexual Orientation		
Straight/Heterosexual	63	84.0
Bisexual	5	6.7
Pansexual	2	2.7
Gay/Homosexual	0	0.0
Asexual	0	0.0
Other or missing[b]	5	6.7
Relationship Status		
Single	55	73.3
In a Relationship	18	24.0
Married	3	4.0
De Facto	0	0.0
Divorced	0	0.0
Other or missing	0	0.0

[a] at the end of the focus group discussions, participants were asked to complete a Qualtrics survey for additional demographic data collection. Of the 87 migrant and refugee youths participating in the study, 75 completed the survey

[b] expressions such as 'unsure', 'anything goes', and 'questioning' were reported by participants when describing their sexual orientation. It should also be noted that two participants opted not to share information regarding their sexual orientation

conducted in person—either in a university classroom or a meeting room at a community centre—the remaining 14 FGDs were facilitated via Zoom to comply with COVID-19 restrictions at the time. The FGDs were co-facilitated by YPLs alongside two Advisory Committee members — one university faculty member and the other a PhD candidate — both of whom specialized in qualitative research. Some YPLs initially participated as members of the MRY group before later taking on facilitation roles. Each participant was counted only once in the overall sample size. The FGDs, which averaged five participants per session (ranging from 2 to 10), lasted approximately 60 min and were audio-recorded. This duration and group size were appropriate for exploring sensitive and specialised topics, fostering dynamic interaction while allowing each participant sufficient opportunity to contribute meaningfully to the discussion (Morgan et al., 2013; Morgan, 2019). Audio recordings were transcribed using Trint™ software, and transcripts were manually validated by ACMs and YPLs against the recordings to ensure accuracy and uphold qualitative rigour. After conducting 17 FGDs with a total of 87 participants, repeated analysis and debriefing revealed that additional sessions were producing substantial overlaps in responses rather than novel insights. This point of saturation informed our stopping criterion, ensuring that the data collected adequately captured the diversity and depth required to meet the research objectives (Parker et al., 2019).

Data Analysis

The data from the FGDs were thematically analysed (Braun & Clarke, 2006, 2020) by the first, sixth, and last authors, all of whom are university academics and experienced qualitative researchers. Thematic analysis (TA) is a theoretically flexible method that enables researchers to conduct rich, detailed examinations of patterned meaning across a dataset. Given the phenomenological orientation of the study, the analysis aimed to explore how participants with lived experience described and made sense of a particular phenomenon—in this case, their understanding of SRH and their experiences of utilising related services. The three authors met to discuss and reconcile their initial themes, reaching consensus on a thematic framework that accurately reflected key aspects of the data. The proposed themes were then circulated among all co-authors, who thoroughly reviewed, challenged, and refined the thematic structure through group discussions. This collective validation process resulted in agreement on the final set of themes, ensuring that the analysis incorporated diverse perspectives and minimised individual bias (Braun & Clarke, 2006; Naeem et al., 2023).

Quirkos® is an intuitive qualitative data management software that supported the research team in coding and analysing the data. Version 2.5.3 was used to identify topical responses and emergent substantive categories, with coding focused on word repetition, direct and emotional statements, and discourse markers—including intensifiers, connectives, and evaluative clauses (Aibangbee et al., 2024; Liamputtong, 2020). YPLs also attended a workshop on basic qualitative analysis principles and subsequently worked in pairs to analyse two of the 17 FGDs transcripts. Pseudonyms were assigned during data reporting to safeguard participants' identities. Key quotations were selected to highlight core concepts and themes, ensuring the representation of participants' perspectives and their nuances (Graham et al., 2023).

Result

The analysis identified three primary themes: (1) knowledge and beliefs of MRY about contraception, (2) cultural and family influences on MRYs' perceptions and contraceptive use, and (3) MRYs' experiences in accessing and utilizing contraceptive support in healthcare and school settings in Australia. These themes are presented in detail below.

Theme 1: Knowledge and Beliefs of MRY about Contraception

During the interviews, MRY participants shared their knowledge of sexual and reproductive health, noting that methods such as contraceptive pills and injections were perceived primarily as pregnancy prevention tools, rather than protection against sexually transmitted infections.

> "I think is condom and pills. But pills and needles are just to prevent pregnancy, but not for diseases" (Ruby (female), FGD 14).

> "Um, with me, reproductive health? in my opinion, is, I guess, knowledge regarding contraception……" (Jacob (male), FGD 1).

> "Using protection is just for like really unwanted pregnancies." (Sully (male), FGD 13).

In addition to the above knowledge and understanding, MRY participants also expressed concerns and beliefs regarding the potential side effects of using contraceptive medications.

> "But they're all very painful, like for women, like there are a lot of side effects. Whereas men can just wear a condom, or like, get a vasectomy." (Ari (female), FGD 7).

> "Yeah, the side effects are crazy. And so I stayed away. I was almost going to take them but I was warned off it, and I'm glad I was because I've heard stories where it caused a lot of issues to people. And when they started to try to conceive. Yeah, they couldn't because the pills they took just wreak havoc on their bodies. And that's what I don't like. People like, even the health system, like they advocate for pills so much that the first thing a girl would do, even as young as 16, she would go for the pill. And you don't know what you're doing to your body through a pill. There's other ways to have safe sex and prevent pregnancies, but pill is not the answer all the time. Like I get- like pills, yeah, they're horrid to your body." (Calvina (female), FGD 15).

Theme 2: Cultural and Family Influences on MRYs' Perceptions and Contraceptive Use

The FGDs delved into the cultural and family backgrounds of the participants and how these factors shape their thoughts and perceptions about contraception. In this section, MRY participants shared their perspective as young individuals who migrated from other countries.

> "Definitely culture, as we've been talking about. Feeling afraid to reach out for help or feeling afraid to learn about your sexual and reproductive health because of culture and the stigmas around it. So that definitely stops you from being able to maintain and protect it." (Milli (female), FGD 3).

> "I feel like, yes, culture does kind of place a boundary on your understanding and I guess sometimes being safe, if you're obviously in your religion, it says safe sex is not allowed, you might actually make yourself prone to possible diseases because while you're going along with culture and that conflicted with health itself and that obviously can put you in danger." (Blair (male), FGD 3).

> …when you look at especially African tradition, who gets blamed the most is the girl, you know and they're like. So, most of the consequences come to her because they say she should know better. And a guy is a guy. A guy cannot control themself, need to help him. So for me, it comes to the girl like you didn't do it. I know it takes two to make a baby, but you should know better as a female. You're kind of more mature to understand that when a male is in that state of mind of hormones going everywhere, they don't think straight. It's up to you to kind of level it up with him and stuff like that (Serena (female), FGD 11).

Following the discussion on the broader cultural and traditional beliefs that shape sexuality and contraception, MRY participants elaborated on their more immediate, micro-level experiences within their families—highlighting how generational disconnects and lack of emotional support can lead to feelings of isolation and mental distress.

> "I think it is just different for us because our parents are immigrants and so…… They're very, very old school minded and for us birth control or any other… form of contraception…… yeah, form of contraception was never discussed and was never taught to us." (Ari (female), FGD 7).

> "Ok I feel like that would just probably be very mentally draining if you really needed to talk to someone and you can't even reach, say, your parents, because obviously they are not on the same mindset as you, then I guess the consequence would be like your mental health suffering." (Blair (male), FGD 3).

> "Yeah, I think a lot of people, like, don't feel comfortable with their family. It can depend. It depends on yeah, like some people will be afraid that they might tell your parents or they might tell your relatives" (Kelly (female), FGD 15).

Theme 3: MRYs' experiences in accessing and utilizing contraceptive support in healthcare and school settings in Australia

After discussing the cultural and family backgrounds of the MRY participants, the FGDs shifted to their experiences living in Australia. The participants began by sharing their interactions with healthcare services, particularly regarding access to contraceptive consultations.

> "When I've seen an older doctor, I remember asking for a specific type of contraception. He just brushed it off saying women your age aren't meant to get that like and he's like, you should just stick to the pill. Even though I explained that it doesn't work for me, I have trouble remembering it, blah, blah, blah. He's like. You're just not meant to use that type of contraception, so it's I feel like older, older GP's are quicker to brush off my concerns and my wants, and I find that younger GP's are more inclined to listen to what I have to say." (Cherry (female), FGD 11).

> "I think I would go to a female doctor. I would more prefer in these topics, I would go to a female doctor. I think she would be able to relate more and understand more." (Calvina (female), FGD 15).

Alongside their descriptions of healthcare service experiences, the young participants offered reflections on their experiences within the school setting.

> "Yeah, it's like abstinence because it's like sex after marriage, because of the Catholic school upbringing within the schools and stuff." (Nala (female) FGD 7).

> "Yeah, that's the same for me because like my whole life, I've been in like a Christian school and it was like really brief information, like they didn't- they just like completely just told us like, not to ever have sex. Well, until like, you get married, like and they didn't, like, really talk about, like the different contraceptives and like, yeah exactly like, where you should go and like, all the services and what not." (Elena (female), FGD 16).

Discussion

This study aims to explore the knowledge and perspectives on sexuality and contraception among Migrant and Refugee Youth (MRY) in Australia. The findings reveal three central themes that encapsulate MRY's experiences and needs regarding sexuality and contraception. The first theme focuses on the "what"—participants' knowledge and beliefs about the use of contraception. The second theme highlights the cultural and familial barriers that hinder MRY from positive discussion on the need for contraception. The third theme centers on MRY's lived experiences in Australia and how these experiences influence their utilization of sexual health care services.

In general, the findings indicate that participants possess varying levels of understanding about contraception, including the use of condoms and oral contraceptive pills, as well as the role of contraception in preventing unplanned pregnancies. However, none of the participants mentioned knowledge of long-acting reversible contraception (LARC) or short-term hormonal methods. Additionally, while condom use was discussed, participants did not refer to the precaution of combining condoms with lubricants. The purpose of the FGDs was not to assess the correctness of participants' knowledge; however, these potential gaps may reflect the influence of sex education programs that primarily emphasise health, biology, and anatomy, or that adopt a reactive approach to sexual and reproductive health education (Ritter et al., 2015).

Furthermore, during the discussions, MRY voiced concerns about the side effects of contraceptive methods, particularly their impact on the female body. These findings align with a recent Australian study, which found that worries about side effects were a major barrier to contraceptive use among sexually active individuals—reported by over one-third of females compared to only 8% of males (Napier-Raman et al., 2025). Similarly, participants' anxieties about implant side effects and potential pain during insertion reflect the results of a systematic review on migrant and refugee youth perspectives on SRH in Australia (Napier-Raman et al., 2023).

The second theme highlights the cultural and familial barriers that MRY face when discussing contraception with their families. On the one hand, research suggests that Australia offers a relatively open social environment for addressing topics such as sexual pleasure, same-sex relationships, and challenging stigmas surrounding sexuality (Waling et al., 2021). On the other hand, studies have found that parents from African backgrounds often avoid discussing sexual and reproductive topics with adolescents due to cultural taboos (Kwankye et al., 2021). This conservative and closed family environment not only influences the sexual development of MRY but also contributes to intergenerational conflict. Perceived parental disapproval or rejection frequently leads to feelings of disappointment, distress, anger, and frustration within refugee families, negatively impacting the sexual and mental health of MRY (Dean et al., 2017; Kingori et al., 2016; Tewelde McDonald et al., 2024), and may hinder their autonomy in sexual health decision-making (Botfield et al., 2018; Dune et al., 2017).

Migrant and refugee youth (MRY) come from diverse cultural and experiential backgrounds. Australia, like many advanced liberal democracies, is often celebrated for its cultural, ethnic, and linguistic diversity. However, the third theme of this study reveals a contrasting reality. In Australia, healthcare for refugee and migrant communities is predominantly delivered through mainstream services designed for the general population, rather than tailored to the specific needs of these groups (Olcoń et al., 2023). General practitioners (GPs) are the primary providers for SRH information and care. Participants reported instances in which older GPs dismissed or minimised their concerns related to sexuality. This finding aligns with previous Australian research, where participants expressed a preference for younger clinicians when discussing sexual health. Younger clinicians were perceived by MRY as less judgmental, more knowledgeable, and generally more approachable (Botfield et al., 2018).

Another concern raised by participants was the value-based sex education promoted by religious institutions, particularly within Christian contexts. Christian leaders often advocate abstinence as the most effective strategy for reducing adolescent pregnancies and promoting sexual wellbeing (Golman et al., 2021). However, religious moral education—frequently centred on abstinence—has been widely criticised for failing to encourage consistent condom use or hormonal contraception among sexually active adolescents, resulting in adverse outcomes (Chin et al., 2012; Santelli et al., 2017). A study by Ezer et al. (2019) found that young Australians attending Christian-affiliated schools reported limited access to comprehensive information on contraception and the risks associated with sexual activity. Instead, their sex education focused primarily on basic human anatomy and emphasised abstinence until marriage. Participants in this study perceived the religious framework as a barrier to exploring contraception and developing a deeper understanding of sexuality. Some MRY participants even described their sex education as irrelevant due to its overemphasis on religious values.

Policy Implications

Supporting young individuals in maintaining long-term, healthy, and positive relationships within their ethnic communities is essential for fostering their development (Khawaja & Schweitzer, 2024). In the domain of SRH, this study reveals that MRY often faces constraints imposed by external forces, including cultural expectations, parental regulations, ineffective communication with healthcare providers, and religious doctrines embedded within educational environments. To address these barriers, one potential solution for policymakers is to cultivate a socio-political climate that enables MRY to openly discuss sexual health and contraception-related concerns as an integral aspect of exercising their sexual and reproductive health rights (SRHRs).

Sexual and reproductive health rights refer to the ability to make informed decisions about one's body, including the use of contraception (Starrs & Anderson, 2016; Starrs et al., 2018). An international project on SRHRs found that some female refugees initially understood these rights as "those exercised by the husband over the wife" (International HIV/AIDS Alliance, 2015). This reflects a broader pattern identified in other studies: many migrant and young people remain unaware that sexuality can be conceptualized and asserted as a human right (Baroudi et al., 2021; Napier-Raman et al., 2023). A lack of awareness and understanding may negatively affect vulnerable groups—including refugees, women, children, and youth—by limiting their access to dignified healthcare and their ability to make autonomous, informed choices about contraception (Poljski et al., 2014; Endler et al., 2020). In view of this, recognizing SRHRs through rights-based language is essential. This requires policymakers to actively foster an inclusive socio-political environment—one that removes legal and social barriers

and affirms individual rights. Such an environment enables MRY to access services, express their needs, and participate fully in civil, social, and political life (Napier-Raman et al., 2025; Richardson, 2017). However, such claims are often undermined when individuals are excluded from public discourse, whether formally or informally, due to fear of stigma or reprisal—as is frequently the case for MRY openly asserting their identities. Safeguarding MRYs' meaningful participation in community and societal decision-making is therefore imperative (Honkatukia et al., 2023). By legitimising these dialogues, MRY can collectively articulate, negotiate, and affirm their SRHRs, alongside the pressing need for healthcare and education systems to enhance their capacity to provide welcoming, nonjudgmental services for young people. Policy reform that explicitly endorses the SRHRs of MRY may contribute to greater equity in health services and improved clinical experiences and outcomes (Madden, 2017; Thompson-Lastad et al., 2025). Additionally, as Mpofu et al. (2014) emphasise, harmonising religious and cultural dimensions of sex education policy is essential. This can be achieved through interfaith dialogue and collaboration with cultural leaders, fostering a more inclusive and receptive environment for sex education.

In modern society, social change is weakening traditional sources of knowledge and communication, including expert authority (Van Blerk et al., 2022). As a result, young people encounter an expanding array of choices, leading to increasingly self-reflective life trajectories. Their experiences can be shaped by their capacity to navigate structural influences, make decisions regarding both major and minor life events, and actively shape critical aspects of their lives (Schoon & Heckhausen, 2019). In line with this trend, media platforms could play a pivotal role in normalizing and destigmatizing conversations around sex education. This could include interviews, podcasts, or social media campaigns featuring intergenerational dialogues on these topics. These findings underscore the need of health and education policy to provide accessible, informative online health promotion resources to address the needs of younger generation effectively, for example, empowering young women from migrant and refugee backgrounds make informed decisions about contraceptive methods like implants (Gianna et al., 2024).

Strengths and Limitations

To the best of the authors' knowledge, this study is the first to focus specifically on this topic within the Greater Western Sydney region. These findings can help to inform health professionals, researchers, or policy makers' plans to implement change to improve sexual health services for MRYs. Rigour in the qualitative study was achieved via regular discussions were held to critically reflect on the data and coding decisions, ensuring consistency and transparency throughout the analysis process. Coding was carefully restricted to data segments that explicitly mentioned contraception, enhancing the focus and relevance of the findings. Additionally, reflexivity was practiced acknowledging and mitigate potential researcher biases. Together, these approaches contributed to the credibility, dependability, and trustworthiness of the study. For transferability, descriptions of the research protocol, including data collection strategies, thematic construction, and PAR approach, are provided to allow readers to assess whether the findings are applicable to other contexts and study replication (Pithavadian et al., 2024). Given the qualitative nature of this study, it is important to note that the findings are not intended to be statistically generalisable. Instead, they offer rich, context-specific insights into the contraceptive experiences of MRY participants. However, the sample included only small numbers of participants from certain cultural and linguistic backgrounds. Group dynamics, in which dominant participants may overshadow quieter voices, can lead to skewed results and may limit the transferability of findings to similar subgroups. Future research should aim to include more diverse populations to enhance the depth and applicability of understanding across different contexts.

Conclusion

This study provides an overarching understanding of the knowledge and beliefs about contraception among MRY in the Greater Western Sydney region. While the study did not specifically examine the factors influencing these knowledge and beliefs, the findings suggest that cultural norms, social expectations, and systemic barriers may shape MRY's contraception decision-making. These insights underscore the need for culturally responsive counselling and comprehensive contraceptive education programs. Finally, promoting sexual and reproductive rights for MRY remains a critical priority for policymakers, health professionals, and community organisations in Sydney and beyond.

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Data Availability The dataset generated and/or analysed in the current study is available under restricted access. The data are located in the Research Data Australia portal at https://doi.org/10.26183/2x5y-v748.

Code Availability Not applicable.

Declarations

Informed Consent Informed consent was obtained from all the participants involved in this study. Written informed consent was obtained from the participants to publish this paper.

Competing interests The authors declare no competing interests.

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Authors and Affiliations

Yuk Kit Angus Lam[1,2] · Lisa Fleming[3] · Jacob Nelson[3] · Rashmi Pithavadian[1] · Elias Mpofu[4,5] · Zakia Hossain[5] · Pranee Liamputtong[6] · Michaels Aibangbee[1] · Tinashe Dune[7,8]

✉ Yuk Kit Angus Lam
angus.lam@westernsydney.edu.au

Lisa Fleming
lisa.a.fleming@gmail.com

Jacob Nelson
Jacob.Nelson@acap.edu.au

Rashmi Pithavadian
r.pithavadian@westernsydney.edu.au

Elias Mpofu
elias.mpofu@unt.edu

Zakia Hossain
zakia.hossain@sydney.edu.au

Pranee Liamputtong
pranee.l@vinuni.edu.vn

Michaels Aibangbee
19877828@student.westernsydney.edu.au

Tinashe Dune
tinashe.dune@cdu.edu.au

1 School of Health Sciences, Western Sydney University, Campbelltown, Australia

2 School of Medical and Health Sciences, Tung Wah College, Hong Kong, China

3 Australian College of Applied Professions, Sydney, Australia

4 Rehabilitation and Health Services, University of North Texas, Denton, TX, USA

5 The University of Sydney, Sydney, Australia

6 College of Arts and Sciences and Center for Environmental Intelligence, VinUniversity, Hanoi, Vietnam

7 Faculty of Health, Charles Darwin University, Darwin, Australia

8 Translational Health Research Institute, Western Sydney University, Campbelltown, Australia