An Assessment of Sexual Health Needs of Young Afghan Men with Refugee Background

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Introduction

Newly resettled young people with refugee background have limited knowledge of HIV and AIDS and very low level of sexual health literacy including lack of information about sexually transmissible infections (STI) and are concerned rather about pregnancy related issues (McMichael, 2008; McMichael & Gifford, 2010). Almost 50% of newly settled refugees in Australia are less than 20 years of age (Victorian Refugee Health Network, 2010). Similarly in south east metropolitan Melbourne 44% and 93% refugees are under 18 and under 45 years old, respectively (Cheng, Russell, Bailes, & Block, 2011).The study add that they are more likely to be male than female (ratio 4:3) and generally have lower levels of English proficiency, secondary education, employment and income than mainstream residents. The study recommends that policies should be especially mindful of the fast growing Afghani population with the regional provision of sexual and reproductive health. World Health Organisation (WHO) states that adolescents have different needs according to their stage of development and their personal circumstances which require friendly policies, friendly health workforce and friendly procedures which can ensure confidentiality, flexibility and easy access (McIntyre, Williams, & Peattie, 2002). While accessing sexual health and reproductive health information and services is a right of every one, the newly resettled young people with refugee background experience limited opportunities to realise this right (McMichael & Gifford, 2009, 2010). Newly arrived refugees, including Afghans, are mostly concerned with their basic needs such as housing, employment and other challenges of resettlement. According to the Greater Dandenong City statistics 25% of Afghan youth are unemployed and nine out of ten Afghan families live in rented houses (Social Information of Greater Dandenong website, 2012).

Promoting sexual health of newly resettled young people should be a high priority for Australia, however, to this date little attention has been paid (McMichael & Gifford, 2009). Newly resettled young people have a strong desire to increase their knowledge about sexual health if structural challenges such as cultural identity, public transport and youth-oriented services are addressed properly (McMichael, 2008; McMichael & Gifford, 2009). Prior to arrival to Australia young people have very limited opportunity to learn about sexual health due to disrupted schooling, lack of sexuality education in school and focus of health education only on reproductive health (McMichael, 2008; McMichael & Gifford, 2009). Although sexuality education is compulsory in Victorian schools, some young Afghans, especially girls, avoid attending the sexuality classes by not coming to school (Iqbal, Joyce, Russo, & Earnest, 2012). There is a significant number of youth who do not go to school at all (McMichael, 2008). Therefore, including families in sexuality education to understand the purpose and values of the education and to seek their involvement in shaping the strategies and interventions are very crucial (McMichael & Gifford, 2009).

Health and wellbeing of homeless young people with refugee background in Australia and those living without their parents are negatively affected by becoming socially excluded and vulnerable to risky social behaviours (Correa-Velez, Gifford, & Barnett, 2010; McMichael, 2008). For example, in January 2011 young refugees, including some Afghans, were allegedly involved in a gang rape in Bendigo (Ninenews, 2011). There are also anecdotal reports that male Afghan refugees offering free boarding in exchange of free sex to female homeless Afghans. In some cases the male Afghans resort to younger Afghan boys for sexual intercourse. Considering the lack of comprehensive information on sexual health, these practices can easily transmit STIs among young Afghan refugees. Therefore, there is an

urgent need to raise awareness and understanding on sexual and reproductive health among young Afghans in Victoria (McMichael & Gifford, 2009). Intercultural and inclusive interaction can increase social self-confidence, school satisfaction and critical thinking skills of young Afghans which in turn improve their access to sexuality education (Iqbal, et al., 2012).

Afghans in Australia

History Around 3000 Afghan cameleers first settled in Australia in second half of 19th century (Victorian Multicultural Commission (VMC), 2008). According to VMC (2008) when the camels replaced by motor vehicles in early 20th century, many Afghan migrants returned to Afghanistan. However, due to war in late 20th century till to date, more than 17,000 Afghans have resettled in Australia under the Humanitarian Program, around 32% of them in Victoria, (VMC, 2008).

Afghanistan-born Population in Victoria According to 2011 census, 9913 Afghans are in Victoria of which 69.9% live in Casey and Dandenong municipalities (Census, 2011). Around 10% of 15-24 male age group and 30% of <15 years age self-reported limited English fluency. This limitation is greater among the female age groups (Census, 2011). Limited English fluency of Afghan communities, especially among young age people in Greater Dandenong and Casey municipalities, urge the need for sexual health promotion activities.

Gender composition The ratio between Afghan male and Afghan female population is 120 to 100 (Census, 2011).

Age More than half of Afghan community in Greater Dandenong and Casey are in the age group of 25-54 and around 40% are below the age of 25 years which show younger age profile (Census, 2011).

Assessment Objectives

- To initiate contact with Afghan communities and the centres working with them
- To scope out the sexual health needs of Afghans living in the SE.

Methodology

A brief literature review was done to find out evidence around the sexual health issues of young refugee men. Consultations were done with Afghan parents, young Afghan men and community centres working with them. The consultations were guided by the principles of health equity, health promotion and social determinants of health. Tanahashi framework (measuring coverage of health services) and Piot-Fransen model (showing problems in management of sexually transmissible infections) framed the consultations. According to the World Health Organisation the universal coverage could be provided to everyone to enjoy receiving same package of quality health services according to their needs and preferences (WHOCSDH, 2008). The consultations aimed to gather information about sexual health issues and services for young Afghan men in Dandenong/Casey regions. The consultations focused also on the inventory and mapping of current services and supports and their coverage in terms of access and utilization. Areas of engagement for MHSS/CEH were identified.

Findings

Stakeholders

Recently a monthly coordination meeting on sexual health management of young people has been organised by Southern Health, SCAAB, CEH/MHSS, MYC and DEECD. A Workplan for the Youth Sexual Health Project has been drafted and is being updated during each meeting. The project description is not written yet. The exercise has two phases. In first phase the stakeholders will gather information through formal quantitative data collection and qualitative community consultations with different cultural groups like young Afghan refugee men. Based on the data analysis and broader consultations with other interested stakeholders the project will lead to four areas of targeted interventions. These areas are: Young refugee men (an area that MHSS could play an important role), young students attending schools in Dandenong and Casey municipalities, young people attending alternate schools and homeless, high risk young people. A literature review and mapping of partners and services have already been done.

Sexual health issues of young Afghan men

I met 8 boys of 14-20 years age all of them with Hazara background. They have had primary and high school education in Afghanistan, many in Kabul. They were comfortable with the Kabuli dialect of Dari. I suggested if I could talk in Hazaragi or Iranian Farsi but they encouraged me to talk in Kabuli dialect. They looked confident and participated in the chatting. However, they are concerned about their resettlement and family reunion issues. Many showed their frustration when they learned that the reason for their attendance was only talking about sexual health. They are interested to talk about sexual health and express their needs for more information. They have learned about HIV and AIDS during their stay in refugee camps in Indonesia thus know how HIV transmits from one person to another person. One boy was aware of preventing HIV/AIDS by using condom and was very outspoken in talking about sex and sexual health issues. However, they do not have information about other STIs and Hep B or C and their routes of transmission. They know that centres for youth have condoms for free distribution but do not dare to touch them and just see them ‘from the corner of their eyes’. They do not say anything about bullying or sexual harassment among Afghan boys. They are concerned about their appearance and ask about dark spots (melasma in one boy and grey hair in another boy). They have Medicare cards however due to language barrier and transportation issues they do not see GPs regularly.

Afghan Parents

Parents are concerned about education, health and future of their children. They know about communicable diseases and their routes of transmission. For example one lady, who has lived in Iran, said that communicable diseases are transmitted through air drops, injection and mouth and said that HIV and hepatitis are also transmitted through sexual acts. They also worry their children may contract diseases and get addicted to illicit drugs by hanging out with different people and not doing their home works. Parents claim that they always fight with their children over their education, behaviours and attitudes. Children threaten to call triple zero if parents force them to do something of their own choice or beat them up. The parents do not want to lose them or get involved with police. One man said that these issues originate from arguments and conflicts between mothers and fathers.

They usually argue over the future of their kids. Some fathers try to encourage their wives to let their children fully integrate with the mainstream community. While the mothers push their children to follow Afghan culture, tradition and religion. However, one woman said the vice versa.

Parents know about sexuality education at school. They admit that their children are in need of more health information. One woman with 2 children of 12 and 10 said that equipping children with health information in school is important for their wellbeing. She supports sexuality education at school. However, she said that as a Muslim, she should teach her children on Islamic education, Afghan culture and traditions at home. Other women said that since they get very much exhausted by daily works, Islamic education and cultural teaching should be done through community set ups. One woman said that mothers could do it with daughters and fathers with sons. However, all suggested that Afghan community centres could play positive roles in helping young people learn Afghan culture, traditions, Islam and also health education, including sexual health. They support peer education for the promotion of sexual health among young men.

Community health centres

Community health centres do a systematic health assessment of refugees introduced by Australian Red Cross and Adult Multicultural Education Services (AMES). This is a comprehensive health assessment which includes also testing for Hep B and C and Sexually Transmitted Infections such as Chlamydia, Gonorrhoea, syphilis and HIV. Positive cases are further investigated and proved cases are referred to different facilities for counselling and treatment. Clinics also serve refugees, especially those waiting to get their Medicare cards. A female nurse provides sexual health and reproductive health counselling and support to refugees. However, male refugees do not share their sexual issues with female nurse and prefer to talk with male GPs. Afghan male refugees mostly talk about rushes in their genitals, the physical appearance of their penises, cosmetic of circumcision, healthiness of masturbation, men having sex with men, wet dream and how to perform coitus. Few GPs want to work with refugees because of problems with communication through interpreters and time. Women share their sexual health issues with female nurse and mostly accompanied by their husbands. The centres organise education sessions run by multicultural workers who provide information about contraception, Pap test and other sexual health topics to groups of mothers in MCH centres, primary schools and community health centres. At community health centres Afghan women do not want to talk about sexual health needs of their children, especially daughters. Needles and syringes exchange program is available and apparently no Afghan male uses the program.

Recommendations

Recommendation area	Issue	Recommendation
Stakeholders	**A sustainable, strategic partnership**	MHSS to actively engage with stakeholders in the design, management and evaluation of sexual health programs for young people in South East Melbourne. The stakeholders admit that cultural competency training, peer education and hip hop are important interventions for promotion of sexual health among young people.
	Broadening of partnership	Parents, Imams and community leaders to be recognised as important stakeholders and consulted on sexual health needs of young people. Their support could ease the tension and anxiety surrounding sexual health issues and young people will be encouraged to use available services.
Afghan boys	**Directly talking about sexual health issues triggers discouragement or even cynicism about the intent of sexuality education**	A holistic approach to wrap sexual health issues in other basic needs of young people to be adopted. This way the boys will realise that understanding of sexual health is a part of real life.
	Culturally young Afghan people are not consulted for their personal issues	Young people to be helped to learn that participating in their personal life or community life is their rights. I suggest they learn about Australian values, legal issues and law and order
	Double lives: 1) liberal, open school environment where they can be heard. 2) Conservative closed home environment where they are asked to do things according to Afghan traditions.	Involving Afghan parents and communities in all activities for young people

Persian poetry	**How to make sexuality education more attractive to Afghan families and children?**	Poems and storytelling to be used in educating Afghan youths on Afghan traditions, culture, religion, language and health issues. Afghan parents support this approach because for centuries poetry and storytelling have been strong educational tools in Persian-speaking countries (Atoofi, 2011). Applying this approach will also keep Afghan children connected to their thousands years old traditions and way of life. Poems and proverbs are strong parts of Afghan culture and way of reasoning. Sometime a line of poem can generate sufficient energy to push forward a scientific argument. For example one boy argued that he knew how to prevent sexually transmitted diseases by using condom and thus did not need to learn more about sexual health. A very famous poem of Sa'di Shirazi, a 13th century Persian poet: "What delightful said the truthful prophet///seek knowledge from cradle to grave" made the boy realise that seeking information and knowledge is a continuous job for everybody. To help Afghan parents realise that there have been always differences between parents and children, I argued that 700 years back there was the same situation like what it is now. I read them a line of poem from Hafez Shirazi (b. 1325 d.1390): "what is the passion that I see around the moon? The horizons are full of plots and evils. Girls are fighting their mothers! Boys are fighting their fathers!" They acknowledged that parents belong to one generation older than their children and, therefore, should not force them to be like their fathers and mothers. Some parents frustratingly nodded that their kids have learned about their rights (including sexuality and relationship) and willy-nilly they will practice them.
Parents	**Afghan parents do not have enough health information (low health literacy).**	Parents to be involved in health education sessions and health promotion activities.
	Parents are obsessed and feel guilty by losing their thousands years old identity, especially Islamic way of life	Community based approach to address issues around young people such as drug addiction, education, health and relationship. Since stigmatisation and community pressures are so strong among Afghan communities, challenging issues to be referred to the community to be solved.

	Open talking about sexuality at home is not possible at all.	Sexuality education in schools to be fully coordinated with parents.
Health professionals	**Concerns about friendliness of health services for young people still exist.**	Consultation time for clients with refugee background to be increased to ensure effective communication between GP and patients through interpreters.
	Poor linkage between school health, community health and GPs	Link between school nurse, community nurse and GPs to be established by regular sharing of information and coordinating sexual health programs for young people.

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