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Review Article

Hearing from Refugee Adolescent Girls and Their Parents about Sexual Health Programming: Are We Listening?

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The world is facing a huge voluntary and involuntary migration across continents. In the U.S., more than 6000,00 refugees have been re-settled and more than half of these persons are children, adolescents, and emerging adults (US Dept of State, 2020) [1]. Developmentally, teens and young adults are at a stage where they are developing life skills, establishing social and romantic partnerships, and often experience testing of boundaries and exposure to risk-taking behaviors. Experimentation in the "s" aspects of life - social, sexual, substances, and safety – pose challenges to the health and well-being of both the adolescent and emerging adult as well as their parents and other connected adults.

Females in these age groups, in particular, face threats to their well-being and futures as they are disproportionately impacted by unplanned pregnancies, Sexually-Transmitted Infections (STIs), and HIV. Compounding these issues, diasporic populations – persons who migrated, moved, or been resettled suddenly or involuntarily - can enter a new country and face overwhelming obstacles to the transition. Successful and safe transition for young females includes preventing exposure to, or intervening early, in potential sexual risk situations to avoid pregnancy, STIs or HIV. Often concerning, is their lack of related experiences and exposures needed to build sexual risk prevention knowledge, attitudes, and skills including communication and negotiation competence [2,3] and being able to navigate potential risk situations and identifying triggers to unsafe decision-making (e.g., substance use, depression and anxiety).

We conducted studies with both resettled refugee adolescent girls (ages 15-17) and their parents to learn from them why they (or their daughters) were interested in participating in an evidence-based sexual health promotion program, The Health Improvement Project for Teens (*HIP Teens*). We also assessed outcomes based on qualitative thematic data analysis from separate interviews to more clearly understand the utility and acceptability of the program. Overall, study participants represented ten different countries providing a broad swath of impressions and feedback.

Recruited from an internationally-recognized refugee resettlement service in the U.S.F that offered this CDC- and DHHS-recognized evidence-based sexual health intervention, interviewers sought to gain an understanding of how the program was received and applied by the participants. Originally developed through extensive formative qualitative and quantitative studies and randomized controlled trial [4], this manualized intervention is theoretically-driven, using trauma-informed care approaches and uses interactive activities, games, and role plays to provide medically-accurate sexual risk reduction information. It enables participants to expand a personal "menu" of healthy behavior choices and reduce risk, while providing skills training in negotiation, assertive communication, risk appraisal, safer behaviors, and goal setting. Following individual interviews with the girls accompanied by interpreters, our qualitative content analysis identified three themes: (1) *My cultural norm is not to ask*; (2) *Groups were a safe way for me to learn and share*; and (3) *I learned to use my voice* [5].

Interviews, again accompanied by interpreters, with mothers (N=8) and fathers (N=5) provided insight into motivations and concerns driving their decision to consent for their daughter's participation as well as discussions with their daughter during the program and after completion that they may have had that would provide insight on impact . We identified five predominant themes using in-depth qualitative thematic analysis including: (1) *Protecting our daughters with knowledge*; (2) *A different country, a different approach to protection*; (3) *Consent and understanding can be different*; (4) *Parents cannot do it all*; and (5) *My daughter gained a voice* [6].

Through the voices of both the girls who participated in the program and the parents who consented for their participation, we heard very clearly about the need for, and desire to learn from, a program tailored for the needs of refugee teens to improve sexual health outcomes. By providing information, increasing motivation, and, most importantly, developing risk-prevention and healthy choices behavioral skills, we addressed their deficits in this area while building on the strengths they brought to the program. Both parents and girls recognized the challenges they might face in a different country with a vast array of potential risk exposures. They were committed to preparing themselves as best they could and this intervention offered a targeted approach conducted within a trusted setting and with facilitators that they had already built relationships.

While refugee populations may enter into a new culture and country with hopes of both acclimating to their new residence while, importantly, maintaining their own mores, traditions, and customs, we still need to work hand-in-hand with them about the many challenges they often face in this transition. Parents may not be ready to address all these challenges solely within their home setting or communities and it was evident in our work that they wanted a guiding partnership with agencies that acknowledged and included them in approaches to meeting the needs of their families. Building upon the strengths that these communities bring to the partnership and integrating members into the organization's team for programming and services is key to successful results. Identifying multiple approaches to providing opportunities for their voices to not only be heard, but listened to, can help create and grow approaches that are feasible, acceptable, and embraced by these vulnerable communities. Never is this more important than when addressing sexual health programming for girls and young women who continue to bear a disproportionate negative burden for health, education, employment, and social consequences as a result of pregnancy, STIs and HIV around the world.

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