Breaking down the barriers to Health Literacy in Sexual and Reproductive Health and Rights

- A qualitative study of the experience of culture sensitive health communication among newly arrived refugees in Sweden

June, 2013

Author
Pia Svensson

Supervisor
Anette Agardh

Social Medicine and Global Health,
Department of Clinical Sciences Malmö
Lund University
Abstract

In Sweden, migrants suffer from poorer sexual and reproductive health than the general population due to exposures associated with pre- and post-migration process and difficulties that arise when meeting a new heath system. Health literacy is a term that is increasingly used for explaining people’s access to health preventive services, and where migrant populations has shown to possess lower levels compared to the overall population. Culture sensitive health communication is a method for reaching vulnerable groups at an early stage with information and for increasing health literacy. Since 2012, health information in sexual and reproductive health and rights (SRHR) has been provided by social orientation- and health communicators (SHK) to newly arrived refugees in Skåne. Aim: The specific objective of this study was to explore how information in SRHR has been received among female participants. The overall aim was to investigate if the information had affected their levels of health literacy within the area. Methods: A qualitative research approach was used, with semi-structured interviews performed with nine women from three different language groups (Dari, Arabic, Somali), and analysed with content analysis. Findings: The main findings were covered in two themes; assumed homogeneity- failing to reach all, and planting a seed for future engagement. These represent how the perception of the information was deeply influenced by culture where the current form constrained the perceived access, but how it also contributed to increased knowledge, motivation and engagement in health. Conclusion: To provide information in SRHR in same-sex groups benefit those with lower pre-knowledge in SRHR topics and where cultural barriers are greater, whereas opportunities for discussions concerning cultural norms benefit from existing forms. Providing with tools for further information seeking is a strategy for empower the women to take control of their health, outside the scope of the SHK project.

Keywords: Newly arrived refugees, sexual health, culture sensitive, health communication, health literacy.
Abbreviation list

FHI: Folkhälsoinstitutet
CIOMS: Council for International Organizations of Medical Sciences
HIV: Human Immunity Deficiency Virus
SHK: Samhälls och hälsokommunikatörer
SRHR: Sexual and Reproductive Health and Rights
STI: Sexually Transmitted Infections
UD: Utrikesdepartementet
UNHCR: United Nations High Commissioner for Refugees
WHO: World Health Organization
# Table of Contents

1. Introduction .......................................................................................................................... 5  
   1.1. Barriers to a good sexual and reproductive health among migrants ............... 6  
   1.2. Health literacy and public health ............................................................................. 7  
   1.3. The role of culture sensitive health communication for achieving health literacy  
2. Methods ............................................................................................................................... 12  
   2.1. Research design ......................................................................................................... 12  
   2.3. Sampling of participants .......................................................................................... 12  
   2.4. Data collection .......................................................................................................... 13  
   2.6. Content analysis ....................................................................................................... 15  
   2.7. Ethical Considerations ............................................................................................. 16  
3. Findings .............................................................................................................................. 17  
   3.1. Assumed homogeneity- failing to reach all ............................................................. 18  
   3.2. Planting a seed for future engagement ..................................................................... 23  
4. Discussion ............................................................................................................................ 26  
   4.1. Methodological considerations ................................................................................ 31  
Conclusion ............................................................................................................................... 33  
References ............................................................................................................................... 34  
Tables ....................................................................................................................................... 38  
Appendix I .............................................................................................................................. 40  
APPENDIX II ......................................................................................................................... 41  
Appendix III............................................................................................................................ 43  
APPENDIX IX ......................................................................................................................... 45  
APPENDIX X ........................................................................................................................... 46
1. Introduction

Migration in a globalized world of today should not be seen as something temporary; instead it should be regarded as an ongoing process. There is a constant flow of migration which to a large degree is determined by the world situation. Many people do not have a choice but to leave their home countries and start a new life elsewhere, with new rules and regulations to follow and new norms and values to relate to. Depending on the circumstances, this can be perceived as a quite traumatic experience. In 2010 there were in total 214 million international migrants globally (WHO, 2010), out of which 10, 5 million had refugee status and were under the concern of UNHCR. In 2011,327 200 refugees applied for asylum in Europe, and where Sweden with 29 600 asylum seekers was ranked the fifth most receiving country of the 44, by the UNHCR determined, industrialized countries (UNHCR, 2011a). In Sweden, a person is given refugee status in accordance to the Geneva Convention in which a person who leaves his or her country of origin due to a fear of persecution founded on race, religion, political views, gender, or sexual orientation (UNHCR, 2011b).

In the position of being a refugee there are many sources of risk exposure that can have negative health consequences. Besides from a possible reduced health at baseline, there are many social determinants in relation to the migration process that can lead to poor health, such as poor living conditions, poor economy, social exclusion, discrimination, and stigmatization (WHO, 2010). In addition to this, many health promoting and disease preventing activities targeting the public have a tendency to a larger extent reach those with higher socio economic status (SES), and consequently becomes less accessible to vulnerable groups such as newly arrived refugees and minority groups, contributing to a knowledge gap that maintain unequal structures (Finnegan Jr & Viswanath, 2008). Thus many adverse health outcomes that are preventive are constrained due to people’s lower access to, and lower ability to act upon health information, a phenomena that is increasingly explained with the concept health literacy (Nutbeam, 2009). Lower levels of health literacy among migrants should according to Zanchetta and Poureslami (2006) be regarded as an underestimated problem in multicultural societies.
Reviewing other literature, the constructs; migrant, new coming immigrants, and refugees seems to be used rather interchangeably. Instead of referring to migrants as a group, discussions often concern the risks in relation to the migration process as such, including pre- and post-migration circumstances (Carballo & Nerukar, 2001, WHO, 2010) or by discussing the difficulties for the receiving countries to meeting the health need of cultural diverse groups (Zanchetta & Poureslami, 2006). According to WHO, the concept of migrant is used inconsistently due to the lack of a commonly agreed upon definition. In their report, the term migrant gets to represent all persons who have migrated to another country, regardless of the reason behind it (WHO, 2010).

The modern characteristics of migration contributes to that this group often represents a great proportion of the receiving country’s national population, which makes migrant health of great concern for public health (WHO, 2010). An expected growth of the migrant population in Europe causes challenges for the health system and calls for attention to be paid for recognizing the impact cultural diversity has in relation to health care services and preventive health (Rafnsson & Bhopal, 2008). This also calls for the need for reaching out with preventive efforts to these persons at an early state in the migration process, which has been recognized in the Swedish receiving system (SOU 2010:16). A public health approach to migrant health is to strive for equal access to health services and work against the social determinants of health (WHO, 2010).

1.1. Barriers to a good sexual and reproductive health among migrants

Migrants generally constitute a group with poorer health in a number of lifestyle related conditions than that of the general population in a receiving country in Europe. As mentioned previously, this is explained by exposure to risk factors associated the migration process. Similar trends can be seen in in Sweden and the result is that migrants in Sweden to a larger degree are faced with the risk of developing life style related conditions, such as cardiovascular diseases and mental disorders, than the general population, and where newly arrived refugees represent the group with poorest health (fhi, 2011).

The migration process is also a source of risk exposure related to Sexual Transmitted Infections (STI) and Human Immunodeficiency Virus (HIV) and is an important determinant
of migrant’s sexual health in Europe. This is explained by an increased risk taking, together with lower knowledge of sexual health topics (Carballo & Nerukar, 2001). The same pattern is seen in Sweden and confirmed in statistics showing higher incidences of STIs among people with foreign background (smi, 2011, fhi, 2012 a). Flodströms (2011) study showed how limited knowledge, language difficulties, and differences in health cultures were identified hinders to access to information about sexual health and health services for newly arrived Iraqi refugees in Sweden. The knowledge gaps were explained by missed opportunities for education due to the migration process, and were more pronounced among the women as they faced greater cultural barriers to access to information. Unwanted pregnancies or complications in relation to pregnancies are other frequently reported sources to poor reproductive health among migrant women in Europe, due to lower knowledge about contraceptives and where to turn for help and advice. Overall, women are more vulnerable to the social and economic determinants of health caused by the migration process and the lack of access to health care (Carballo & Nerukar, 2001). In this process, women are also suffering worse consequences in relation to sexual and reproductive health than men (Webber, 2007). On the other hand, women who migrate from a low to a high income country can benefit from the health system and health culture in the receiving country; although the benefits are often constrained due to poor language skills (Adanu & Johnson, 2009).

Universal access to sexual and reproductive health and rights (SRHR) was called for during the international conference on population and development held in Cairo 1994. The agreement incorporates people’s right to be informed about their sexual health and rights, as well as the right to a satisfied, respected, and protected sexual life. The treaty underlines the right to seek and receive information and to be protected from discrimination and protected from sexual violence (Glasier et al, 2006). How this agreement is translated into national guidelines has a great impact on migrant women’s sexual health and their access to preventive services (Webber, 2007). In Sweden, SRHR is defined in accordance to international definitions and agreements (UD, 2006).

1.2. Health literacy and public health

The concept of health literacy has become increasingly important in explaining people’s access to health promoting and disease preventing activities. From a public health perspective the concept has progressed from being defined as reading and writing abilities in connection
to a medical context, to the incorporation of the social context and its function in everyday life, which can have both individual and social benefits (Nutbeam, 2008, 2009). This is reflected in the WHO definition that is used in present study, where health literacy is described as:

“health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways that promote and maintain good health” (Nutbeam, 1998, p.10).

According to this definition, health literacy refers to the ability to achieve knowledge, process it, and communicate it. This ability is, according to Nutbeam (2008) and Kickbusch (2001) critical to empowerment. Nutbeam (2000) has divided the construct into three dimensions; functional, interactive and critical, each indicating different abilities connected to an increased autonomy and engagement in relation to health. The three dimensions are deconstructing the WHO definition into smaller elements, where the functional health literacy implies knowledge of health topics and risk factors, and how to navigate the health system. Interactive health literacy incorporates a social aspect, with more advanced communication skills in relation to health, together with an increased motivation and self-efficacy for action. The critical dimension involves action taking in relation to the own and other people’s health and an awareness of the social determinants of health. It also involves more developed skills for finding and critically analyzing different sources of information (Nutbeam, 2000).

Low health literacy is associated with limited knowledge of health topics and about bodily functions. As a consequence of this is that the understandings of linkages between life style and health outcomes may be deteriorated, it may also give rise to misconceptions founded on traditional or cultural beliefs, leading to difficulties to take care of the own health appropriately (U.S department of Health and Human services, 2005). In the end this leads to poor health outcomes, all of which can be translated and calculated into numbers, resulting in high societal costs. Health literacy is context bound and should be understood in the interrelation with language and socio-cultural elements and the meaning it has for people in their everyday life (Andrulis & Brach, 2007, Papen, 2009). Although education is valuable in its association to health literacy, change of context can explain variations in this connection (Sentell & Braun, 2012). Therefore contextual changes in relation to the migration process

1.3. The role of culture sensitive health communication for achieving health literacy

To educate health professionals in cultural competence has been a strategy for increasing access to health information to a culturally diverse population (WHO, 2010). Another alternative, claimed to be more sustainable, is to build individual capacities by enhancing people’s health literacy through health communication (Kickbusch, 2001). However, health communication efforts can be available but still not culturally appropriate, which affects the perceived accessibility of information and may deteriorate the intended purpose with the activities (Ishikawa & Kiuchi, 2010). The accepted way of communicating about sexual health differs between cultures and is often related to the conceptualization of sexual health. Unfortunately important health information can be lost due to the failure of communicating it in a culturally sensitive way. This was shown in a study where immigrant women in Australia rejected information in SRHR due to perceived cultural inappropriateness, even though they regarded the information as needed (Khoei & Richters, 2008).

The term health culture refers to how cultural norms and values influence our perception of illness and health, and the meaning we ascribe to it (Andrulis & Brach, 2007). This in turn affect the attitudes to health promoting activities, how information is received, and the final health decision (Glanz, Rimer, Viswanath, 2008., Andrulis & Brach, 2007). According to Saint-Jacques (2012) multicultural communication should be understood as the learned behavior that influences perceptions, beliefs, thoughts, and values, and culture as language. The way language can contribute to a sense of togetherness facilitates the transfer of a health message (Saint-Jacques, 2012).

The rise of multicultural societies has contributed to a growing awareness about how different meanings can be ascribed to public health messages. Involving culture has therefore become
crucial to consider in the design and implementation of health interventions. As culture is a barrier to health literacy, using a culturally sensitive health communication approach has the possibility to break down the barriers (Schiavo, 2007), and opportunity to reach those who otherwise would not have access to the information (Dutta, 2007). The peripheral, evidential, linguistic, constituent-involving, and the socio cultural strategies are examples of methods taking culture into consideration (Kreuter et al, 2003) The socio- cultural strategy has been emphasized by Zou and Parry (2012) who mean that there must be an understanding of health outcomes as a consequence of the migration process in order to reach this group with health information.

Few health literacy models according to a public health perspective have been empirically validated (Sorensen, 2012). Some studies have been conducted using qualitative methods and explored health literacy as outcomes to health communication. A study investigating maternal health literacy as an outcome to an education program found that in order to achieve increased levels of health literacy the program should strive to empower women to gain confidence and skills to independently seek information and to critically view such information (Renkert & Nutbeam, 2001). Thomson and Hoffman-Goetz (2011) explored how health information was considered among immigrant women in Canada. Health literacy levels were assessed based on the participants understanding of the link between diet and cancer and the women’s way of requesting for general or specific information and action taking was connected with levels of functional and interactive health literacy respectively. The result provided with data according to which the researchers could draw conclusions on what input needed to be added to the health communication (Thomson & Hoffman-Goetz, 2011).

1.4. Health communication to newly arrived refugees in Skåne

In Skåne, Sweden, social orientation- and health communication (SHK) (Swedish translation, Samhälls- och Hälsokommunikatörer) were initiated by the County Administrative Board under the project Partnerskap Skåne (Carlzén, 2011) as a response to changes in the migration politics in 2009 that lead to an establishment reform in which education in social orientation was made obligatory to newly arrived refugees covered by the establishment (SOU 2010:16). Previous efforts in health communication in mother tongue by Region Skåne and Malmö community were developed with special focus on the health topics. The program contains 32 topics, out of which 13 are delegated to health. The communication method aims to be culture
sensitive and builds on interactive methods, and with visual complements for stimulating discussions. In addition to the linguistic method, the communicators have cultural competence and share the migration experiences with the target group. The groups are stratified based on language, and mixed regarding other characteristics. The communicators have opportunities to adapt the information to the participant’s needs and abilities, although the content follows a national standard (Carlzèn, 2011, Lanstyrelsen.se, SOU 2010:16). As a part of the project “HIV/STI-prevention with a migrant perspective”, education in the area of SRHR has been developed and included in the health communication since 2012. SRHR is covered through three themes; women’s health, men’s health, and HIV/STI. The three themes cover physical and psychosocial perspectives as well as discuss norms and attitudes in relation to SRHR, and are delivered based on the same methods as the other information (Lansstyrelsen, 2012a).

In order to design appropriate and effective health interventions it is essential to have an understanding of how information is perceived by the receivers (Kreps & Sparks, 2008). There is evidently a knowledge gap in research investigating newly arrived refugee’s perception of health communication in SRHR. There is also a knowledge gap regarding possible outcomes of health communication in terms of health literacy, provided to the same group. The purpose of this study is to explore how health communication efforts within the area of SRHR provided by social orientation- and health communicators (SHK) have been received among newly arrived female refugees in Skåne. As the information is obligatory for those covered by the establishment it is of utmost importance to take the perspective of those receiving such information into consideration. An increased understanding of how the information is received has the possibility to contribute with important insights that can be used for development and quality assurance of culture sensitive communication methods provided to this group.

The overall aim of the study is to gain a deeper understanding of how health communication in sexual and reproductive health and rights, provided by social orientation- and health communicators (SHK) to newly arrived female refugees, can contribute to improved health literacy in the area. The specific objective of the study is to explore the experiences of newly arrived female refugees with regard to exposure to health communication in sexual and reproductive health and rights, provided by social orientation- and health communicators (SHK).
The research question for the study is: *How is the information, provided by SHK within the area of sexual and reproductive health and rights, perceived among their female participants?*

2. Methods

2.1. Research design

A qualitative research method was used as the purpose was to gain a deeper understanding of how the female participants have received the health communication in SRHR. A qualitative study allows for a deeper insight in the informants way of reasoning in relation to the topic as it gives opportunity to freely explain feelings and reflections regarding their perception of health communication in SRHR, from the informant’s point of view (Creswell, 2007).

2.2. Study setting

In 2011 a total of 12 726 who applied for asylum received residence permit in Sweden under refugee status (migrationsverket, 2012a), out of which Skåne received 1572 persons and where 881 persons were above the age of 18. The largest groups in Skåne came from Afghanistan, Irak, Somalia, and Iran (migrationsverket, 2012b). Present study took place in Skåne, Sweden, where the SHK project is active and where a total of 750 persons received information from SHK in 2012. More specifically, the data collection took place in Lund, Helsingborg, and Kristianstad, which are the main junction points for the project and where newly arrived refugees living in different municipalities in Skåne go for receiving information from SHK. Present study investigates how health communication in SRHR provided by SHK has been experienced by female participants from the three largest language groups; Dari (spoken by people from Afghanistan and Iran), Arabic, and Somali. In the Somali group there is one male and one female communicator, in the Arabic and Dari group the communicators are male (Carlzén, 2011, Lansstyrelsen.se).

2.3. Sampling of participants

With regards to their often gatekeeping role to family health (Skolnik, 2008), and vulnerable position in relation to the migration process (Webber, 2007), the focus was on women for this
study. A purposive sampling strategy was used in order to get a variation in the sample but with shared attributes regarding gender, status as a newly arrived refugee, and with experiences of health communication in SRHR (Dahlgren et al, 2007). The inclusion criteria was women within the ages of 18 to 50 from three different language groups (Arabic, Dari, and Somali) who have been taking part in health communication in SRHR by SHK (Dahlgren et al, 2007).

2.4. Data collection
Semi-structured interviews were used as data collection method in order to capture the essence of the informants’ experiences, but to keep a focus on the topic aimed at being explored. Moreover, as there was a need for using an interpreter, semi-structured questions were considered more feasible (Kvale & Brinkmann, 2009). An interview guide (Figure 1, Appendix I) with suggested questions (Appendix II) was developed, with openness to changes in order and with room for follow-up questions and clarifications (Dahlgren et al, 2007). The interview guide aimed at capturing the experiences of receiving health communication in SRHR, and its possible consequences in terms of health literacy. It consisted of four broad topics, where the first aimed at uncovering the experience in the light of the informant’s life situation, comprising culture, previous experiences, and other aspects that may influence the perception. The other three topics covered different aspects belonging to the functional, interactive, and critical dimension of health literacy inspired by Nutbeam (2000). The questions were pre-tested on two Arabic women in order to control for appropriateness and clarity, and were mainly used as a support during the interviews. Prior to the data collection the researcher also had the opportunity to participate during some of the communication sessions as an observer.

The data collection period took place between 20th of March- 17th of April, and the settings for conducting the interviews were Lund, Helsingborg, and Kristianstad. The health communication in SRHR in the program is covered through the three themes; men’s health, women’s health, and STI/HIV. The program is ongoing and takes place during a four months period with one block per month. The three language groups had different schedules and the SRHR themes are covered in three different blocks. Potential informants would have to be finished with all three themes in order to be eligible. Due to the complexity of the program, some help was needed from SHK to identify potential informants. All participants eligible
according to the inclusion criteria, and still enrolled in the program at the time for data collection, were asked to participate in the study. SHK assisted in collecting contact information from interested participants, who were contacted by the researcher by telephone in easy Swedish, or with help from interpreter. The informants were given an oral description of the purpose of the study and asked to participate. In one case, the informant was asked in connection to an information session by the researcher with assistance from a person in the class who could interpret if needed. The informant was handed written information in her native language explaining the purpose of the study (Appendix III). After agreeing on participating, time was scheduled, interpreter was booked, and settings for conducting the interview were arranged by the researcher. The interviews were conducted in a familiar place for the informants, in a room where the door could be closed and discussions could be held in private. Before conducting the interview the informant was asked to sign a written informed consent provided in their native language (Appendix III).

When conducting cross-cultural interviews it is essential to be aware of perception of power relations, implicit language, and social factors that may affect the interaction. This is important if not to lose important meanings or to misunderstand cultural codes that may cause discomfort. When using an interpreter, it is important that he or she is accepted by the informant (Kvale & Brinkemann, 2009). During the interview an external interpreter hired from an interpreter service was used. The criteria for the interpreter were to be female, and have competence within this type interpretation situation. The interpreters were asked to sign a confidentiality consent (see Appendix IX), which content and meaning was explained to the informant. The interpreters were given clear instructions of how the interview must be performed. The importance of being careful with the translation was underlined in order to not change the format of the questions so that meaning or openness of the questions would be lost. The same was emphasized for the response. The procedure for the interview was as following; the researcher asked a question, which was directly translated by the interpreter to the informant, who replied, and the response was translated back to the researcher in the same manner.

Lessons learned from each interview was reflected upon and incorporated into the following interview (Dahlgren, 2007). Other aspects were explored more in depth as the interview guide was used with increased confidence and as the researchers understanding was enhanced. The interviews were audio recorded and the translations made by the interpreter were transcribed
verbatim and used as a basis for data analysis. The nine interviews lasted between 24 to 48 minutes.

2.6. Content analysis

The procedure for data analysis followed a content analysis based on Graneheim and Lundman (2004). According to this method, the analysis can either be made on the manifest and/or the latent level. Analyses that are made on the latent level imply higher levels of abstractions and allows for deeper interpretations of the underlying meaning of the data. The collected data from the interviews was determined to be rich so that both a manifest and latent analysis could be performed. The analysis follows steps starting from the raw text to increased levels of abstractions as the deeper underlying meaning is further explored.

The unit of analysis was decided to be each of the nine interviews, as there were important elements running through all of the transcriptions. The texts from the transcribed interviews were analyzed separately in the first steps where they were bracketed into smaller meaning units consisting of sentences or short paragraphs that was considered to share similar information. The meaning units were condensed, meaning that they were rewritten but still in close contact with the original structure of the meaning. Each condensed meaning units were interpreted separately, abstracted, and assessed with codes. The software program Open Code (ICT, 2009) was used for the coding process and the division into content areas, whereas the process of bracketing into meaning units, condensation, and creation of final sub-categories, categories and themes was done manually. The coding process was guided by the informant’s perceptions of the experience of receiving health communication in SRHR by SHK, and viewed in terms of potential outcomes of the information. An example of the process of moving from the raw text to condensed meaning units, codes, sub-categories, category, and themes can be seen in table 1.

By moving back and forth in the text during the coding process, finally a pattern started to emerge. Codes were clustered into broader preliminary content areas which consisted of; cultural influences on perception, influences of context, the role of SHK, new insights, functional, interactive, and critical health literacy. The content areas were further explored and codes were investigated as isolated units, and then viewed in the light of the context. The content analysis was taking place parallel with the data collection, so that a discovered pattern
could be further explored in the proceeding interviews. Codes were clustered and started to form preliminary sub-categories and categories, which were increasingly confirmed along with the continued data collection and the move towards saturation (Dahlgren et al, 2007). The final sub-categories, categories, and themes were formed after the last interview had been performed (Table 2).

2.7. Ethical Considerations

This study follows the ethical guidelines as stated by WHO in collaboration with Council for International Organizations of Medical Sciences (CIOMS) (CIOMS, 2008). There is an awareness concerning the sensitive nature of the topic as well as the vulnerable position as a newly arrived refugee. There is a risk that there will be a discomfort in their meeting with authorities and that the research situation may put the informants in a stressful position. There is also a possibility that the participants believe that they do not have the right to refuse to participate. In order to avoid the risk of putting the participants in a stressful situation it was of utmost importance that the participants were aware of their rights in relation to the research situation. They were asked to fill in a written informed consent provided in their native language. This explained the purpose of the study, their rights in relation to the study, and a confirmation of their confidentiality and anonymity, and that they have the right to withdraw at any time during the research process (Appendix III). Anonymity was secured by using codes to protect the informant’s identities (P1, P2, P3…Pn). All informants were contacted and asked by the researcher in order to avoid an experience of being unable to refuse to participate due to their relations with SHK. Great efforts were made to make it clear to the informants that their participation is voluntary and not directly connected to SHK. Moreover, it was made clear to the informants that they would not be asked to discuss their own, or any of their family members sexual health, but how they experienced to receive the information, which may not be regarded as sensitive to the same degree (CIOMS, 2008).

To be aware of health risks and have information to make sound health decisions is a human right. Thus, ways of improving this type of health education in order to reach vulnerable groups with important information should be justified according to the principle of beneficence (Dahlgren et al, 2007). This study was approved by the Ethical Review Board in Lund (EPN).
3. Findings

The final sample consisted of n= 9 women, where n=4 was from the Arabic group, n= 3 from the Dari group, and n=2 from the Somali group. Their ages varied between 24-38 years, and the education level varied between basic education (n= 4), medium (n= 2), and higher (n=3), time spent in Sweden varied between four months to one year and four months. A socio-demographic table is found in table 3, but due to the risk of identification the informants are presented together in respective language group.

The sub-categories represent different aspect of the experience of receiving health communication in SRHR by SHK, taking pre-and post-migration context into consideration, and these constitute the base for the eight categories, and the final two themes (Table 2). The sub-categories and categories represent the manifest level and the themes the latent level of analysis. The two themes that appeared from the data will lead the structure of the finding section; assumed homogeneity- failing to reach all, and planting a seed for future engagement. The theme, assumed homogeneity- failing to reach all consider the emotional ambivalence regarding the new context and the new culture. This in turn has implications for their engagement in health, influenced by differences in contextual demands between home country and new country. In addition to the practical consequences, the theme cover the meaning of meeting a new health culture, taking into account how traditional cultural norms and values are deeply incorporated in the informants way of; a. perceiving the information; b. their previous knowledge levels within the area; and c. ability to accept the new information. This is also integrated in the implications of using a culture sensitive approach by showing how the cultural and social norms are following the women into the classroom in Sweden.

The second theme planting a seed for future engagement represents what meaning the access of previously unavailable information has in their everyday life. It suggests consequences of the new knowledge in terms of starting a process within the individuals and their way of relating to the subject, where an increased awareness of the need for information contributes to that cultural norm are being questioned and viewed in a new light.

Following section will present the findings from the study. The section will start with describing each of the themes by showing how these have been founded on categories and
with belonging sub-categories. The themes will stand as headings, categories will be in **bold**, and sub-categories will be presented in *italics*. Quotations from the informants will bring life to the themes and will be referred to language group and interview code in order to protect the identities of the informants.

### 3.1. Assumed homogeneity- failing to reach all

What all women had in common was that they were all in the position of meeting a new context and culture, and to be **starting from zero in a new context**. The sub-category *ambivalent about new culture* characterizes the experience of meeting a new culture, carrying multiple meanings. It represents the feelings regarding coming to a foreign context, which on the one hand was perceived as positive and a relief, having been given an opportunity to start a new life. On the other hand, the new context meant to be leaving something behind and having to give up things that one have been working hard to achieve. To start over also meant new hinders that needs to be defeated.

"*in the beginning we were very happy that we had come here to a new country, but eventually we found out that there were hinders due to the language, it was very difficult when we couldn’t communicate, it felt like you were completely mute*” (IP7, Dari group)

Migrating to a new country meant a need for *learning to navigate in a new health system*. This showed to have implications for the engagement in information seeking behavior and action taking in relation to health, as contextual demands to a large degree seemed to determine the strategies for finding information about SRHR. Although constraints due to language difficulties were stated, information about sexual health in Sweden was easier to access contrary to the home country, where it had been more demanding due to its sensitive nature. Therefore less engagement was needed in finding information in Sweden.

“*Here you get direct information, and you can say that the information comes to you in a sense. There you have to wait, there is an age limit and things like that, and you have to look for this information*” (IP2, Arabic group)

Regardless of the easier access, the women expressed how the ability of using ones social network as source for information was consequently removed when leaving the home country.
This lead to that alternative source for information needed to be found. The importance of the information from SHK was therefore regarded as very useful for getting to know the new culture and how to navigate in the new health system. Internet was another source for information, where SHK also was stated as an important link to other sources of where they could find information provided in their native language.

”...in order to know how to manage when getting sick here, to know the system here, because it is completely different from the home country” (IP4, Arabic group)

“you get addresses for websites after the lecture and then afterwards I do it at home too, I go to the website and investigate more” (IP5, Dari group)

”Either I would ask any of the two teachers, you can ask this woman and this man. They would always answer your questions” (IP8, Somali group)

The category new information being tainted by existing norms and traditions represents how the shame and taboos ascribed to the subject had been hindered the women from access to information, and the knowledge gaps that has developed as a product of the restricted access in the home country. The sub-category norms strongly influenced by shame and taboo thus indicate how the women experienced various levels of cultural hinder and also had different levels of pre-knowledge, but it was well underlined by all women that shame was closely linked to the subject. Some had a more traditional background and a more conservative attitude to the subject than others, and also appeared to be less open to new perspectives. These women indirectly gave indications of how culture affected their perception, but without giving it too much consideration.

”They just say sometimes...since we are Muslims and it is just forbidden to meet a man and woman if they are not married, and some say”no, be careful with this disease”.. Only...not more than that...not open information (IP9, Somali group)

However there were also indications of more reflections on the influences of culture, especially when receiving this information in Sweden as the difference in views became more explicit.

“The problem is not the information, but it is the people, and the persons that listen to it. They are shy and it is embarrassing to listen to this kind of things in our home country” (IP4, Arabic group)
Knowledge gaps give rise to misconceptions and myths illustrate the knowledge gap that had emerged as a result of the inability to speak openly about sexual health and rights. This in turn was expressed as having contributed to the rise of myths and misconceptions. Therefore the access to correct information in Sweden was welcome by the women in order to challenge these myths and misconceptions, for example concerning how sexual diseases are transmitted and how condoms function.

“We have discussed previously together with friends that it is not secure, that it is not 100% that you can use a condom and that the woman won’t get pregnant, it is always high risks that the woman can get pregnant, because they mean that all condoms has a hole and that it leaks through. We haven’t learned about this” (IP3, Arabic group)

There were various perspectives presented regarding the structure of the groups and the approach. On the one hand it was described as contributing to a feeling of being censured by own culture also in Sweden. This was expressed by how the interplay within the group and with the communicator, being a part of the same culture, lead to the perception that information was censured in similar manner as in the home country.

” Since it is taboo in the home country, and here as well, it is the same people that are here in the classroom, I still think that it was not completely open information” (IP1, Dari group)

But what was a bit difficult for me was that since I am a woman who discuss, it is just my opinion, so it was difficult to be able to say something that others could understand better and not look down at me (IP4, Arabic group)

Requesting cultural sensitive approach to information reflects how the information provided by SHK was perceived as desired by all the women, but due to the way the information was provided, regarding the gender-mixed composition of the group, made them feel that the information was unavailable. In this sense it gave them access to information, but questions remained. This lead to that many were wishing for cultural appropriateness because it had left them with a feeling that they could have gotten more out of it if the course communicator was a female and it was gender separated groups.
“But because it was a male…and it was mixed with men, then you get information but you would like to also ask questions, and want answers to the questions, but you never get it, you can’t do it” (IP3, Arabic group)

The communicators needed to be sensitive to the individuals in the groups and their levels of readiness, both regarding the knowledge levels and the level of acceptability of the information in SRHR. This is represented in the category external and internal influences on perception of information, and includes the way it was required for SHK to adapt the information and the methods to the individual differences among the participants, demonstrated in the sub-category SHK balance between individual levels of readiness. This had implications in the way it involved the chance of only reaching those who could accept the information, while at the same time some persons would regard the information as being forced upon them. The women often expressed this from the eyes of the others, or as a wish for cultural appropriateness as described above.

“Generally people, not me, feel a bit ashamed since it was men and women together. But for me it was information that is obligatory, and that you need to know in life” (IP2, Arabic group)

“It was fantastic information, it was very easy to grasp and at the same time he was so careful not to cross the border. I think for me it was pretty good, I felt comfortable, but there were others that did not feel comfortable..” (IP6, Arabic group).

The category finding SHK a trustworthy source of important information reflect that regardless of the perceived sensitivity of the information, the women emphasized the importance of receiving correct information, which indicates a trust in the source. This was also expressed in an uncertainty concerning the information that they had received in the home country, or a lack of thereof. The knowledge levels varied a lot in the group, where some had received information previously in the home country, whereas for others this information was completely new. For those with previous knowledge it had provided a more in depth and detailed information about the subject. The importance and need of the information was stressed, and as the women experienced that they finally got access to previously unavailable information it was clear that the information had contributed to
increased knowledge in the area of SRHR. Many of the women also expressed a desire for more information.

“They haven’t got this information, not the newly arrived, it is very important that when they come to Sweden, that they have the chance to get the right information about health” (IP9, Somali group)

“I learned about diseases, female diseases for example..., and that you can easily can get contraceptives for example, this is something I did not know before, so it is better that you use this.. (IP5, Dari group)

“You got a totally different idea, knowledge, especially the way he informed. And then he would go in depth into how it was transmitted, how you treat the disease and everything. About AIDS, so you have gotten so much knowledge about this” (IP6, Arabic group)

The sub-category new information for future use refers to how the women expressed that they had not been taken action in response to the information yet, except for further information seeking, but they highlighted that the new knowledge was good for future needs. Moreover this also indicated how the conceptualization of sexual health referred mainly to diseases and reproduction, suggesting that the information one day would come in handy.

“In the future, if something happens, within the family, then you are informed” (IP6, Arabic group)

“Maybe not right now, but in the future, maybe something happens, maybe a question pops up, and then I have already been informed about it..“(IP7, Dari group)

Methods for facilitating the learning process, refers to the specific methods used by SHK and was highlighted by the women. The linguistic strategy and interactive activities were especially raised as important approaches for facilitating the transfer of the information, although not all of the women perceived that they were able to participate actively in the discussions due to the sensitivity of the topic. However, the discussions between the others in the group could be skilleed over to the rest and benefit also those with less confidence.
“It was through the discussions, because it was a woman who instructed in this… and so through the discussions of course…but we never participated in the discussions because it was a sensitive topic, but you also got a lot of information from, especially when they draw a lot on the board, and when they showed pictures through the computer and things like that… then we received a lot of information, but at the same time we could not communicate with the others, because it was very sensitive and we were very shy…” (IP3, Arabic group)

3.2. Planting a seed for future engagement

In addition to the new knowledge that the information had contributed with, the deeper meaning of the information was pronounced in the way it had **open doors to a new way of relating to Sexual Health and Rights**. The new knowledge had led to insights and opened up for new perspectives about the meaning of SRHR which had positive consequences in the women’s everyday life. *Information as an eye-opener* in this sense illustrates how the women discovered new possible ways to think regarding sexual health and new insights about the possibilities of communicating about this topic openly, without shame, something that was expressed with a new confidence.

“Before I could never mention in front of my husband that I had my period, but now after I have learned that it is a normal thing, that you can talk about it, so now when I have my period I go and tell my husband about it, and this information has led to something positive for me” (IP3, Arabic group).

*New insights about rights in relation to sexual health* indicate how the insights gained from the information had provided with new perspectives regarding the rights aspect in relation to sexual health, which was expressed with a feeling of relief. The women voiced how it was better here with special sexual and reproductive health care and easier access to contraceptives and information in comparison to their home countries. New insights regarding rights for people with AIDS were also emphasized, and stated with a bit surprise:

“…. that for example, here in Sweden you are a person, and you can live with AIDS, he will get medication, and he will get help, he will get the right information… you can also not infect others. This is a big difference […] in the home country if someone has this disease you run,
no one greets him, no one talks to him, no one sees him, he becomes very isolated..” (IP 8, Somali group)

Over all there were strong suggestions about how the information not only had provided with new knowledge, but also what the knowledge had meant for them in their lives. The access to this information was expressed with relief, which was and also shown in the way it had contributed to an enhanced confidence among the women. Moreover, the new knowledge and insights had inspired them and given rise to an increased motivation to learn more about the subject.

”...and now I have started to feel that I am very brave right now because I dare and I can receive information and so...so with time I think that I will be even more brave, and have more information, and dare” (IP3, Arabic group)

**Becoming aware of the need for adaption to new cultural norms** was expressed by those who revealed that they accepted and were open to the information regardless of the perceived cultural barriers. This suggests that the recognition of the need of information could cancel out the potential sources of discomfort. The women showed indications of a grown awareness concerning how the society needed for people to have this knowledge, and that it therefore should not be constrained by cultural norms. The information was underlined as important for all newly arrived in Sweden, since people from their home countries usually lacked this knowledge, which was stressed as needed in order to take control of their own health. This is represented in the sub-category *important information for empowerment*.

“I have gotten so much information now, so that I have become so positively impressed at the same time as I have all this new knowledge and information. We get so much new knowledge, they don’t know anything, they don’t know anything about what a good health is, nothing, a woman know before giving birth and after have given birth, that’s it. You have to get new knowledge, and this is new knowledge for these women, because they have never talked about it before, they don’t know what it means” (IP3, Arabic group)

The increased awareness of the importance of this knowledge for newly arrived refugees was expressed in the way that the women would question cultural norms that hindered them from access to the information, both in the home country and to a certain degree in Sweden. This
was reflected by stressing another view of the mixed gender groups. Instead of describing how the group compositions restricted the access to information, it was stated as having opened up for a new way of thinking about gender norms, and highlighted in how people from their home country needed to get used to the culture and invite a new way of relating to cultural norms and gender norms.

“Here I feel that the wall is falling. That the women are sitting together with men and receive the same information, it doesn’t occur often in our countries, so this was the best part” (IP2, Arabic group)

“There it was..., considering the culture and the women, so in that way it was good, it was appropriate, but here I think it was good and positive that it was a male teacher because you get used to it, the women get used to it, that it is normal and that everyone talks about it” (IP7, Dari group)

“It is not dangerous or embarrassing that you sit together and talk about this subject, it would be worse if we would sit and hide everything and don’t talk openly about the subject, I realize that it is an important subject” (IP6, Arabic group)

Expressing wish to spread new knowledge to others represents the consequences of how the increased awareness of the importance of the subject and the need for this information among other migrants, lead to an expressed will to reach out to others. “Spilling” over the new knowledge thus is a reflection of how the increased confidence after information within the area contributed to the will and also growing perceived ability to teach others. This was expressed by how the majority of the women voiced how they after having received the information had forwarded to friends and family members about what they had learned. A couple of the women also expressed an increased will to share knowledge to others outside their social network, indicating the start of a process towards community action.

“Before I came here and participated in this course I had little information, but now I have a lot more and I feel now that I can manage anything, anytime, and plus that I have the will to learn more and more and more” (IP4, Arabic group).
“I would like to start to educate others about what it means, right now I have a friend and her husband works, and she only attends SFI, and have not received this social orientation information, and every time I have learned something new I go to my friend and we sit down and talk about this, and I tell her that this is the symptom for this or this disease, and this and that, and she can inform about all this” (IP3, Arabic group)

“I have discussed a lot with my husband about this at home, it has been very interesting for me, even I consider the possibility of educate to the new generation about this, so that they will get better knowledge and better information, and it is my next step to actually consider this” (IP6, Arabic group)

4. Discussion

The objective of this study was to get a deeper insight in how newly arrived refugee women in Sweden had perceived information in sexual and reproductive health and rights (SRHR) that was provided to them by social orientation and health communicators (SHK) in Skåne, Sweden. The findings are covered under two main themes; assumed homogeneity- failing to reach all; and planting a seed for future engagement. The themes reveal how the women’s perception of the information was deeply influenced by cultural norms, which had hindered them from access to information in the home country, and continued to affect their perceived access to information in Sweden. This was expressed as a feeling of being censured by culture, but also in the way these cultural norms were questioned. To various degrees the information contributed to an increased knowledge, engagement, and motivation to learn more about SRHR topics.

Being faced with a new context and health culture without support from one’s usual social network made SHK a welcome source for information and constituted a link for getting to know to the new country. The information in SRHR was highlighted by the women as needed and important, however the perceived ability to receive the information varied. As described by Andrulis and Bracht (2007) information is always viewed through a cultural lens, and it was clear in this study how the topic was deeply influenced by cultural and religious norms in the way shame and taboo was ascribed to the topic. The cultural barriers to information had contributed to a knowledge gap, which was also affected by missed opportunities due to the migration process. This had given rise to misconceptions and myths influencing their way of
relating to the topic, in line with Flodström (2011). The knowledge gap caused by the migration process was more pronounced by some of the women who mainly had received information concerning sexual health from UN workers or NGOs, and which mostly concerned HIV/AIDS. This resulted in lack of knowledge about other topics covered in SRHR. The new insights about equal rights for people with AIDS were mostly stressed by those who came from a context with higher prevalence of HIV/AIDS, and where the fear of contracting the disease had given rise to a severe social stigma. By others, the rights aspect was emphasized concerning access to contraceptives and right to reproductive health care, and seemed to have opened up for a new way of relating to SRHR questions. Discussions regarding specific topics in relation to men’s health was rather absent, indicating a conceptualization of sexual and reproductive health that stands more in direct contact with them as women. Another possible interpretation is that men’s health is regarded as more shameful to discuss openly than women’s health. Nevertheless, the gained knowledge and insights expressed among the women underline the importance of the Cairo declaration, and the meaning this treaty has for people in the everyday life (Glasier et al, 2006).

Perception tainted by culture

The culture sensitive approach used by SHK could help to break down some of the barriers to information. According to Kreuter et al (2003) a linguistic method can benefit from being combined with a constituent-involving strategy. This means to provide information in the native language together with the communicator sharing certain characteristics with the target group. Emphasized by Zou and Parry (2012) is also the socio-cultural strategy, in which the conceptual meaning of a topic is adapted to the health message in order to make it comprehensive. In this study, the use of a linguistic strategy facilitated the transition of the information and together with a social-cultural strategy it further enabled SHK to bridge the gap between the contexts (home country/host country) by discussing differences in health systems and in perspectives for example regarding rights in relation to sexual and reproductive health. The interactive elements in the communication methods was shown to be beneficial for the learning process, also suggesting that the group dynamics provided a sense of cohesion in which commonalities found in language, backgrounds, and that they were all new in Sweden contributed to a free zone for sharing perspectives and opinions. This is in line with theories about multicultural communication (Saint-Jacques, 2012). Even though the interactive methods were less available in relation to the SRHR topics, it was expressed how
the discussions could stimulate knowledge-sharing in the group, regardless of levels of pre-
knowledge, or confidence.

The constituent-involving strategy as explained by Kreuter et al (2003) refers in this study to
how the communicator had similar cultural background and shared the migration process with
the women. However, the communicator was not matched regarding gender, something that in
relation to the information in SRHR was expressed with multiple meanings. One perspective
was that the cultural hinders was altered by the gender mixed groups and the fact that the
communicator shared cultural attributes with the women, leading to that the perceived access
to information was restricted. In this sense the information was constrained by the same
cultural attributes that was used for facilitating the health message. Contrary to Schiavo
(2007) an approach building on culture identification would not lead to increased access to
information, but rather contribute to the maintenance of structures hindering such access. On
the contrary, the gender mixed groups were by some of the women experienced as a way for
challenging cultural norms regarding the subject in particular, and gender norms in general.
This was done by stating that health should be of greatest concern, and by stressing a need for
adapting to the new culture. In this sense, the new heath culture in relation to SRHR was
perceived as beneficial for women and the importance of the information was underlined,
which has been underlined by Adanu and Johnson (2009). Therefore to stratify groups based
on gender was instead expressed as a way of accepting the prevailing structures hindering
women from access to information, which according to Webber (2007) contributes to unequal
opportunities for a good health for men and women.

Health literacy as an objective of health communication

The overall aim of this study was to gain a deeper understanding of how health
communication in SRHR provided to newly arrived female refugees, could contribute to
improved health literacy in the area. The possibilities for achieving enhanced health literacy
as a consequence of health communication should always be understood in the context in
which the information is provided, and in relation to what deeper meaning such information
have for the receivers (Papen, 2009). The way that the topics in SRHR was associated with
shame and taboo affected the women’s experience of receiving the information, both by how
it was sensitive to receive in mixed groups, but also how it opened doors to “hidden”
information. The vulnerable status as a newly arrived refugee woman and the fact that this
information is obligatory can be experienced as being forced upon, especially for those least open to the new views. This can give rise to a feeling that adaption to certain social norms is expected, which may clash with what one is used to (Papen, 2009). None of the informants expressed this view; rather it was discussed as possible reactions from others in the group, and seen in all language groups. However, a request for alternative ways of providing the information was voiced, but all perceived the information as important and needed, similar to the findings from Khoei and Richters (2008).

According to a public health perspective, the three health literacy dimensions; functional, interactive, and critical, is described by Nutbeam (2000) as a continuum moving from enhanced knowledge leading to increased autonomy and engagement in relation to health. Present study suggests that the culture sensitive health communication in SRHR indeed have potential for improved health literacy in the area of SRHR in all dimensions to various degrees. This was indicated in the way the women expressed that they achieved new knowledge, enhanced motivation and engagement in relation to SRHR topics, but which had not yet been put in practice. To draw conclusions of health literacy as an outcome to health communication efforts is complex and depends on the means for measuring such change (Baker, 2006). Regarding qualitative research, differences in ways of expressing engagement and communicating with others may be embedded in cultural behavior, and expressions may differ depending on the perception of the subject, something which needs to take into account when making interpretations (Andrulis & Bracht, 2007). Furthermore, within-group differences in baseline health literacy in relation to SRHR need to be taken into consideration in order to measure change. However, this study reveal indications based on the women’s expressed views both regarding pre-knowledge and post-outcomes in relation to the new knowledge and the meaning it have in their everyday lives. These types of interpretations of health literacy levels based on qualitative measures have been seen in other studies (Renkert & Nutbeam, 2001, Thomson and Hoffman-Goetz, 2011, Ellis et al, 2012).

Discussed in the light of the health literacy dimensions described by Nutbeam (2000), health literacy in these findings could be interpreted as the way the increased knowledge concerning SRHR topics, became further internalized, and finally led to more advanced skills to critically relate to the topic (the continuum and how it is interpreted in present study is illustrated in Figure 2 in Appendix X). The way the women described how they had gained new knowledge
in the area, as well as a grown awareness of how to navigate in the health system can be interpreted as improved functional health literacy. In another qualitative study the line between functional and interactive health literacy has been interpreted as how an increased understanding is combined with independent information seeking and actual action taking (Thomson and Hoffman-Goetz, 2011). This study suggest similar associations, manifested in how some of the women had used the internet sources that was provided to them for finding more information, and also how they expressed a greater general interest and engagement in health. This marker is also in line with Ellis et als (2012) differentiation between low and intermediate health literacy.

According to Nutbeam (2000), an enhanced engagement in health together with communicative abilities is connected to higher interactive health literacy. As these findings reveals, the information opened up for new perspectives and influenced the attitudes in relation to sexual health, which indicated a grown engagement and motivation to learn more about the topic. Moreover, the enhanced confidence in communicating about SRHR topics had implications for how the women felt that they could discuss with their partners and friends in a new way, leading to changes in their everyday lives. Reasons for not communicate with others was explained by the lack of social network due to the migration. These findings underline the social aspect of health literacy, and as a part of the everyday life (Nutbeam, 2008). The way the information was “spilled over” to friends and families, and along with an increased confidence the will to transfer it beyond the social network was voiced, can be interpreted in the light of the Nutbeams (2000) critical health literacy dimension. Moreover, an awareness of the social determinants of health was indicated in the way the information in SRHR was emphasized for this group, and by questioning cultural norms that constituted barriers for this type of health information. Although action had not yet been taken, this suggests that a seed was planted for future engagement. The will to share the new knowledge with others also highlights the women’s role as gatekeepers for family health (Skolnik, 2008).

The findings from this study implies an association between education levels and health literacy, where lower educational levels is linked with increased levels at the functional level, and higher education suggest links with the interactive and critical levels. The findings also indicate that for those not ready to start to question gender norms, the access to information
seemed to be more needed, and where challenging cultural norms may come secondary. The result is that these women may be trapped in between. To satisfy all needs is a challenge, which may also be outside the scope of the SHK project. To provide with tools for finding information independently and skills for analyzing it may therefore be a strategy for empowering the women to take control of their health, regardless of pre-knowledge and levels of readiness. This strategy has been stressed by Renkert and Nutbeam (2001) who underlines health literacy as an asset upon which new knowledge and skills can be built. Depending on the nature of the health message different cultural sensitive approaches may be to prefer (Kreuter, 2003). Considering that this topic is perceived as sensitive, these findings suggest that specific health information about SRHR are best delivered in same-sex groups, especially for those where the knowledge gap is larger, but that norms and values in relation to the topic can benefit from having gender mixed groups. In line with Thomson and Hoffman-Goetz (2011), for women that expressed increased motivation to learn more, referring to internet sources was shown to be a successful method, and where more discussions within the groups could further stimulate the critical reflections.

4.1. Methodological considerations

**Trustworthiness**

*Credibility* deals with the issue of truth value and refers the ability to reflect the different perspectives regarding the phenomenon in question (Dahlgren et al, 2007). In this study, the researcher had the chance to participate at some of the information sessions before the data collection, and could observe the group dynamics and methods that were used by the communicators. The suggested questions were controlled for appropriateness regarding the target group before the data collection by Arabic women, and the findings were peer debriefed with colleges. All of which may have contributed to the credibility of the findings. Great efforts were made for the informants to understand that the researcher was external to SHK, although some of them may still have perceived that their answers could influence SHKs work. The fact that it was a female researcher can have contributed to a more relaxed climate regarding the nature of the subject and the perceptions of power relations (Kvale & Brinkmann, 2009). It is crucial that the informants feel comfortable with the interpreter. In this study only female interpreters were used. However, as there were different interpreters at each occasion besides from one, there were fewer opportunities to work out a good method
for the interviews. The interpreter was given instructions on how the interviews needed to be performed and there were possibilities for clarifications during the interviews. Nevertheless, using an interpreter causes limitations in terms of fewer opportunities for conversations and to interpret tacit knowledge. There is also a risk of losing meaning in the translations as there are three different languages involved and where the Swedish language skills among the interpreters varied (Kvale & Brinkmann, 2009).

The **dependability** of the study refers to how the researcher dealt with the dynamic aspects of the research process, and the implications of the decisions made (Dahlgren et al, 2007). The data collection and analysis took place in parallel and notes were taken for capturing the reflections that were made. The nature of the semi-structured questions may invite for a certain kind of answers, although these were mainly used as support, and the order changed depending on where the interview would lead. Along with an increased confidence the thematic interview guide was used. The issue of dependability connects with that of **conformability**, which refers to the neutrality of the final results found in the data (Dahlgren et al, 2007). The data analysis followed a content analysis in which the data is analyzed by moving from isolated units to the whole. Keeping a neutral position to the data was also facilitated by bracketing the text into shorter meaning units.

**Transferability** means the extent to which the new knowledge is applicable to other context or persons. In this study all women eligible according to the inclusion criteria were asked to participate, this invites the chance of reaching those with more positive experiences since they may show a greater interest in participating. As the final sample mainly represent the views from younger women it fails to capture variations based on age, which may bias the results as traditional views and education levels may differ. However, the final findings do indicate variations in views and bring up both positive and negative perspectives. The patterns that appeared from the findings moved towards saturation but due to time constraints this was not reached. Nevertheless, the findings show similarities with that of other, and also brought something new. The discovered pattern in the women’s views indicates that these finding may be applicable in other context where this type of health communication is delivered, to newly arrived refugee women, provided in similar manner. More interviews, and with more variations among the informants could have further confirmed the pattern and strengthened the transferability of the findings (Dahlgren et al, 2007).
Conclusion

This study showed that culture sensitive health communication provided by SHK facilitated the transfer of information in SRHR to newly arrived refugee women, but how the perceived access was restricted due to cultural barriers. Nevertheless, the findings show possibilities for achieving increased health literacy in SRHR as an outcome to the health communication. To provide information in same sex groups would be especially important in order to reach women with limited knowledge in the area. Considering the compositions of the groups, to satisfy all needs is a challenge that may fall outside the scope of SHK. Instead, providing with tools for independent information seeking and learn how to act accordingly is a possible strategy for empowering these women to take care of their health, which also has the possibility to benefit others. The insights from this study can contribute to an increased knowledge in how to provide sensitive information in a culturally appropriate way. These insights can also contribute to an understanding of how health literacy can be improved in relation to other health topics, which can have implications for the development and design of health communication efforts targeting vulnerable migrant groups in the society. More research is needed for further exploring health literacy in relation to cultural diversities, and to investigate the link between health communication and potential outcomes in terms of health literacy.

Acknowledgement

I would like to thank various people for their contribution to this project; Maria Nilsson, Ziad Jomaa, Fadil Radi, Julaporn Kanyjuang, Mubarik Abdirahman, Dawud Negzad, Zahra Abdi Mohamed, Ashmadullah Turab, and Abdulbasit Jalal Taha for their friendliness and practical assistance, to Markus Larsson for assistance and support; special thanks to Anette Agardh for her professional supervision and encouragement; and Katarina Carlzén for have given me the opportunity. Finally thanks to friends and family for emotional support.
References


### Tables

**Table 1.** Table showing the process of moving from raw text to increased levels of interpretations

<table>
<thead>
<tr>
<th>Raw text</th>
<th>Condensed meaning units</th>
<th>Interpretations of CMU(codes)</th>
<th>Sub-categories</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;you have to obtain a lot of knowledge, and this is new knowledge for these women because they have never talked about it before, they don’t know what it means…&quot;</td>
<td>Women must obtain a lot of new knowledge because they have never talked about it before and don’t know what it means</td>
<td>-Important knowledge for women</td>
<td>-Important information for empowerment</td>
<td>Becoming aware of the need for adaptation to new cultural norms</td>
</tr>
</tbody>
</table>

**Table 2.** Table showing how the sub-categories (manifest) builds up the categories (manifest) and leads to final themes (latent).

<table>
<thead>
<tr>
<th>SUB-CATEGORIES</th>
<th>CATEGORIES</th>
<th>THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Ambivalent about new culture</td>
<td>Starting from zero in a new context</td>
<td></td>
</tr>
<tr>
<td>- Learning to navigate in a new health system</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Norms strongly influenced by shame and taboo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Knowledge gaps give rise to misconceptions and myths</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Being censured by own culture</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Access to information but questions remains</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Wishing for cultural appropriateness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- SHK balance between individuals levels of readiness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Access to previously unavailable information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- New knowledge for future use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Methods for facilitating the learning process</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Information as an eye opener</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- New insights about rights in relation to sexual health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Increased motivation to learn</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Important information for empowerment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Question cultural norms</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- “spilling” over the new knowledge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Increased confidence after information</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 3. Socio-demographic information of the informants

<table>
<thead>
<tr>
<th>Language group</th>
<th>Arabic</th>
<th>Dari</th>
<th>Somali</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age</td>
<td>24-38</td>
<td>24-27</td>
</tr>
<tr>
<td>Length of time in Sweden</td>
<td>4 months, 8 months, 15 months, 16 months</td>
<td>5 months, 6 months, 8 months</td>
<td>7 months, 8 months</td>
</tr>
<tr>
<td>Education (Basic: ≤9 y, Medium: ≤12 y, Higher: ≥15 y)</td>
<td>Basic (n=1) Higher (n=3)</td>
<td>Basic (n=1) Medium (n=2)</td>
<td>Basic (n=2)</td>
</tr>
<tr>
<td>Marital status</td>
<td>Yes (n=2) No (n=2)</td>
<td>No (n=3)</td>
<td>Yes (n=1) No (n=1)</td>
</tr>
<tr>
<td>Country of origin *</td>
<td>Syria (n=2) Jordan (n=1) Iraq (n=1)</td>
<td>Iran (n=2) Afghanistan/Iran (n=1)</td>
<td>Somalia (n=1) Somalia/Syria (n=1)</td>
</tr>
<tr>
<td>Religion</td>
<td>Christian (n=2) Muslim (n=2)</td>
<td>Muslim (n=3)</td>
<td>Muslim (n=2)</td>
</tr>
</tbody>
</table>

*If a person has lived in other country than home country for longer time, this is included in the table.
Appendix I

Interview guide with topics to be explored

**FUNCTIONAL**
How has the HC influenced the knowledge, awareness and attitudes regarding SRHR

**CRITICAL**
How has the information been reflected upon in relation to the status as newly arrived refugee/woman

**INTERACTIVE**
How has the HC influenced the Motivation and perceived self-efficacy in relation to SRHR

**PERCEPTION**
How is the information reflected upon in relation to cultural values and traditions

**Figure 1.** Figure showing the interview guide covering topics aimed at being explored during the interviews.
APPENDIX II

Suggested questions

Interview about the experience of receiving health communication by Community and health communicators (SHK) within the area of SRHR

The purpose of this study is to discuss how you experienced receiving information from SHK regarding the topics:

- men’s health
- women’s health
- STI/HIV

I would like to clarify that this interview is not about your own or any of your family members’ private health. I need your valuable thoughts about how you experienced receiving this information, in order to increase understanding about:

- how such information is perceived, and
- how it can benefit other women in the same situation.

Opening question:
I would like to start by asking you if you could tell me a little about yourself. Where are you from? How was your experience of coming to Sweden? You have received information from SHK related to your arrival in Sweden, and about different health topics. For example, you have received information concerning men’s health, women’s health and STI/HIV. I will now ask you some questions in relation to this information.

a. Could you tell me a little about how you experienced receiving this type of information?
- How did you experience receiving this information from SHK?
- How did you experience receiving the content of the information about:
  - men’s health?
  - women’s health?
  - STI / HIV?
- How did you experience the pedagogical approach the communicator used when informing about the topics; men’s health / women’s health / STI/HIV (the way they informed)?
- How did you feel when you listened to this information?

b. Was the information clear and easy to understand?

c. Is this information important to you?
   If yes,
   - In what way is the information important to you?
   - In what way might the information be important to other persons in the classroom?

d. Considering what you learned about these topics previously in your life, how was this information different?

e. Considering how you received this type of information previously in your home country, how was this different?

f. How would you prefer to be informed about these topics?

g. How do you think other persons in the classroom experienced receiving the information?

- How did you think it was perceived by the other women?
- How do you think it was perceived by the men?
- How do you think it was perceived by the older persons?
- How do you think it was perceived by the younger persons?
h. Could you please explain why you think that persons in the classroom have perceived the information regarding these topics differently?

1. a. Did you learn anything that you did not know before in relation to the topics men’s, health; women’s health; HIV/STI?

b. Please tell me if there is anything you think is missing from the information. Is there anything you would like to know more about regarding these topics?

c. How have you previously discussed these topics?

d. Is the way that you discuss these topics here in Sweden, through SHK, very different from what you have been used to from your home country?

e. If yes, how do you view/think regarding the new knowledge? Please clarify in what way?

(based on the previous question) Where you come from, the topics regarding men’s health, women’s health, or STI/HIV may be talked about in a certain way. Could you describe in what way your cultural background may influence the way you think and feel about the information provided in Sweden by SHK?

2. a. How do you think what you have learned about these topics could be useful?

b. Where would you turn (to whom) for more information now that you are here in Sweden?

c. Have you tried to find more information about these topics in other ways after been provided with information by SHK? How/what?

d. Have you applied the new knowledge in any real situation? (Example?)

e. (Based on previous question) Do you think you would have acted differently in your home country? Why?

f. Have you talked with anyone else about what you have learned from the information regarding these topics?

3. a. Considering that you have recently arrived in Sweden, do you think the circumstances of your migration have affected the way you think and feel about the information concerning men’s health, women’s health, HIV/STI? Please explain in what way?

b. Do you think that this information has been important to you? In what way?

• as a woman?
• as newly arrived?

If you would suggest any changes regarding the content or the provision, what would it be? Is there anything else you would like to add/bring up/ask?

Demographic information:

Age:
Education (groups): How many years in school?
Country of origin:
Length of stay in Sweden:
Marital status:
Appendix III.
Information letter in English (also available in Swedish, Arabic, Dari and Somali)

Interview about the experience of receiving health communication within the area of sexual and reproductive health and rights provided by Community and Health Communicators (SHK)

As a participant of social orientation and health communication, operated by Länsstyrelsen under the project Partnerskap Skåne, You have been asked to participate in the research project “improved health literacy within the area of sexual and reproductive health and rights: The role of Health communication”, in public health at Lund University. The study will focus on how female participants, who has received health communication by the community and health advisors (SHK) has experienced the information with regards to the topic sexual and reproductive health and rights (SRHR).

The interview that You will participate in will last between 30 minutes to one hour. I will ask questions about how You have experienced to take part of the information that concerns three themes: men’s health, women’s health, and HIV/STI. The questions will not be about your or any of your family members personal health, only about how you have experienced the provided information. The purpose of the study is to investigate the experience of being provided with this type of information among foreign-born women, who have recently arrived in Sweden.

The interview will be tape recorded and all the information that you leave will be confidential and treated according the rules for research. It will not be possible to connect your answers with you as a person, as your name and personal information will be removed directly after the interview. Your answers will be handled in a way that only I and my supervisor will be able to take part of them, and will only be used for research purposes. The interview with You will be part of my master thesis and the results will be published in international journals.

Your participation is voluntary and you can at any time choose to discontinue your participation, without giving any explanation. You can also choose not to answer the questions.

We thank you in advance for your effort.
Pia Svensson och Anette Agardh
Division för Socialmedicin och Global Hälsa, Lunds Universitet
Consent form

The researchers copy

Please tick the box if You agree to participate in the study? Ja [ ]

Name: ..........................................................................................................

Place and date: ............................................................................................

Tear here

Consent form

Participants copy

Please, tick the box if You agree to participate in the study? Yes [ ]

Name: ..........................................................................................................

Place and date: ............................................................................................

If you have any questions, you are welcome to contact me.

Pia Svensson
Email: Soc08psv@student.lu.se
Tel: 0702- 88 48 38

Supervisor and head of research: Anette Agardh
Email: anette.agardh@med.lu.se
APPENDIX IX

Confidentiality form, interpreter

INTERPRETER
CONFIDENTIALITY AGREEMENT

I ____________________________, as an interpreter assisting during the process of conducting research interviews within a project at Lund University, will take part of information.

Hereby I certify that:
I understand that all information that arise here is confidential and I assure my confidentiality in relation to the interpretive assignment.
I understand that I am not allowed to discuss or reveal any of the information from this interview to anyone, neither at the workplace nor outside.
I understand that this also applies after that the project has been finished.
By signing below, I hereby certify that I understand and agree on that I have confidentiality in relation to the interpreter assignment.

Date: ...........................................

Signature:....................................

Print name: ........................................
APPENDIX X

Figure of the health literacy dimensions

Figure 2. Figure showing how the different dimensions of health literacy are interpreted according to these findings, guided by Nutbeam (2000).