

# How Aboriginal young people in an urban setting access sexual health information, and the role technology can play

**Author:**

Gardner, Kristy

**Publication Date:**

2021

**DOI:**

<https://doi.org/10.26190/unsworks/1614>

**License:**

<https://creativecommons.org/licenses/by/4.0/>

Link to license to see what you are allowed to do with this resource.

Downloaded from <http://hdl.handle.net/1959.4/100014> in <https://unsworks.unsw.edu.au> on 2024-03-28

**How Aboriginal young people in an urban setting  
access sexual health information, and the role  
technology can play**

Kristy Gardner

A thesis in fulfilment of the requirements for the degree of Master  
of Arts

Centre for Social Research in Health

Faculty of Arts, Design and Architecture,  
University of New South Wales

2021

## Thesis submission for the degree of Master of Arts (Research)

Thesis Title and Abstract

Declarations

Inclusion of Publications  
Statement

Corrected Thesis and  
Responses

### ORIGINALITY STATEMENT

☒ I hereby declare that this submission is my own work and to the best of my knowledge it contains no materials previously published or written by another person, or substantial proportions of material which have been accepted for the award of any other degree or diploma at UNSW or any other educational institution, except where due acknowledgement is made in the thesis. Any contribution made to the research by others, with whom I have worked at UNSW or elsewhere, is explicitly acknowledged in the thesis. I also declare that the intellectual content of this thesis is the product of my own work, except to the extent that assistance from others in the project's design and conception or in style, presentation and linguistic expression is acknowledged.

### COPYRIGHT STATEMENT

☒ I hereby grant the University of New South Wales or its agents a non-exclusive licence to archive and to make available (including to members of the public) my thesis or dissertation in whole or part in the University libraries in all forms of media, now or here after known. I acknowledge that I retain all intellectual property rights which subsist in my thesis or dissertation, such as copyright and patent rights, subject to applicable law. I also retain the right to use all or part of my thesis or dissertation in future works (such as articles or books).

For any substantial portions of copyright material used in this thesis, written permission for use has been obtained, or the copyright material is removed from the final public version of the thesis.

### AUTHENTICITY STATEMENT

☒ I certify that the Library deposit digital copy is a direct equivalent of the final officially approved version of my thesis.

### Thesis submission for the degree of Master of Arts (Research)

[Thesis Title and Abstract](#)

[Declarations](#)

[Inclusion of Publications  
Statement](#)

[Corrected Thesis and  
Responses](#)

UNSW is supportive of candidates publishing their research results during their candidature as detailed in the UNSW Thesis Examination Procedure.

Publications can be used in the candidate's thesis in lieu of a Chapter provided:

- The candidate contributed **greater than 50%** of the content in the publication and are the "primary author", i.e. they were responsible primarily for the planning, execution and preparation of the work for publication.
- The candidate has obtained approval to include the publication in their thesis in lieu of a Chapter from their Supervisor and Postgraduate Coordinator.
- The publication is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in the thesis.

☒ The candidate has declared that **their thesis contains no publications, either published or submitted for publication.**

#### Candidate's Declaration



**I declare that I have complied with the Thesis Examination Procedure.**

## **Acknowledgements**

This thesis wouldn't have been possible without the people around me and their encouragement at all stages of my university journey. Thank you to my sister-in-law **Mandy** for getting me to university in the first place.

Thank you to **Wendy** for telling me to take this opportunity and stating that I would be able to undertake research. Your wisdom is appreciated.

I also need to thank my partner **Patrick** for his encouragement and support, and for taking care of the pets when I needed to write. Nothing could have stopped them from being present at Zoom meetings though.

I would like to thank my supervisors **A/Prof. Joanne Bryant, Prof. Reuben Bolt** and **Dr Michael Doyle** for their support, guidance and encouragement. Having never before had research experience, I have appreciated your patience in teaching me the required skills. This journey has been both rewarding and difficult at times, but I got incredibly lucky with my research team.

Finally, thank you to all the young people involved in this research either as peer researchers or participants. The project wouldn't have been possible without your knowledge, time and commitment.

## Contents

Acknowledgements .....	3
Abstract .....	8
Chapter 1: Introduction .....	9
1.1 Health, Sexual Health and Aboriginal Young People .....	9
1.2 The Existing Focus on a Deficit Approach .....	11
1.3 Giving a Voice to Aboriginal Young People in Urban Areas .....	12
1.4 This Research: Purpose and Significance .....	12
1.6 Research Questions .....	14
1.7 Overall Organisation of the Thesis .....	14
1.8 Positioning of Self .....	15
Chapter 2: Literature Review .....	21
2.2 Epidemiological and Behavioural Studies of Aboriginal Young People's Sexual Health .....	22
2.3 Women .....	23
2.3.1 Domestic Violence .....	24
2.3.2 Fertility .....	25
2.3.3 Motherhood .....	25
2.3.4 Antenatal Care .....	26
2.4 Men .....	27
2.4.1 Testing Rates .....	27
2.4.2 Social Expectations .....	27
2.5 General Issues Relating to Sexual Health .....	29
2.5.1 Poor Knowledge of Sexual Health Issues .....	29
2.5.2 Barriers to Accessing Sexual Health Services .....	30
2.5.3 The Focus on Clinical and Deficit-based Research .....	31

2.5.4	The Focus on Remote Communities as Research Subjects .....	32
2.5.5	Innovative Responses to the Provision of Sexual Health Services.....	33
2.6	Health Literacy among Aboriginal Populations .....	35
2.6.1	What is Health Literacy? .....	36
2.6.2	Historical Impacts on Health Literacy .....	36
2.6.3	World View: Why a Western Concept of Health Literacy Might not be Appropriate when Working with Aboriginal People .....	37
2.6.4	The Need for a Community Approach to Health Literacy .....	38
2.6.5	Improving Health Literacy is not a Quick Fix .....	39
2.6.6	How Gender Shapes Sexual Health Literacy.....	39
2.7	Technology and Promoting Sexual Health to Aboriginal Young People.....	41
2.7.1	Telephone Counselling .....	41
2.7.2	Email Counselling.....	42
2.7.3	Short Message Service (SMS) .....	44
2.7.4	Video Conferencing.....	45
2.7.5	Internet Forums, or Message Boards .....	46
2.7.6	Chat, or Instant Messaging .....	47
2.8	How Technology Can Have an Impact .....	48
2.9	Conclusion.....	49
Chapter 3:	Methodology .....	51
3.1	Research Questions and Objectives .....	51
3.2	Research Paradigm .....	52
3.2.1	Positioning of Self .....	52
3.3	Working with Aboriginal Communities.....	54
3.3.1	Spirit and Integrity .....	55
3.3.2	Cultural Continuity .....	55
3.3.3	Equity.....	56

3.3.4 Reciprocity.....	57
3.3.5 Respect.....	57
3.3.6 Responsibility .....	58
3.4 Ethical Considerations.....	58
3.4.1 Informed Consent .....	58
3.4.2. Data Management .....	59
3.4.3. Possible Adverse Effects on the Participants.....	59
3.4.4 Community Engagement and Sharing Findings .....	60
3.5 Methods .....	61
3.5.1 Research Design .....	61
3.5.2 Why Qualitative Peer Interviews? .....	62
3.5.3 Data Collection .....	63
3.5.4 Choice of Participants.....	66
3.6 Interview Questions.....	66
3.7 Interview Setting .....	67
3.8 Quality Control.....	67
3.9 Data Analysis .....	67
3.10 Introduction to the participants.....	69
3.11 Conclusion.....	70
Chapter 4: Findings and Discussion.....	72
4.1 Sources of Sexual Health Information: the Internet.....	73
4.1.1 Reasons for Using the Internet to Search for Sexual Health Information: Confidentiality and the Availability of Biomedical Information.....	75
4.2 Sources of Sexual Health Information: Family, Friends and Community .....	76
4.2.1 Parents.....	76
4.2.2 Grandparents .....	79
4.2.3 Other Family Members.....	81



4.2.4 Friends .....	82
4.2.5 Reasons for Consulting Family, Friends and Others for Sexual Health Information: the Importance of Knowledge Gained from Lived Experience.....	84
4.3 Sources of Sexual Health Information: Aboriginal Health Services, General Practitioners, Teachers and Counsellors .....	85
4.3.1 Doctors.....	85
4.3.2 The Local Aboriginal Medical Service.....	88
4.3.3 Schools and Teachers.....	90
4.3.4 Counsellors .....	92
4.3.5 Hierarchy of Trust, and Approachability.....	93
4.4 Summary .....	94
4.5 Limitations.....	96
Chapter 5: Conclusion.....	98
5.1 Areas in Which Technology Can be Used .....	98
5.2 Health Information Sharing.....	99
5.3 The Importance of Hearing Aboriginal Voices.....	100
5.4 The Importance and Significance of the Research .....	101
5.5 Areas for Future Research .....	102
5.6 Concluding Comments .....	104
References .....	106
Appendix 1: Interview Schedule.....	120

## **Abstract**

This study takes a deliberate strengths-based approach to identify the sources of sexual health information accessed by Aboriginal young people from one community in Western Sydney, and the role of technology in their information seeking. The research design draws on Aboriginal Ways of Knowing, Being and Doing (Martin & Mirraboopa, 2003) to position Aboriginal young people's knowledge and experiences as central to the research as participants, peer interviewers and ultimately peer researchers. The research methods were qualitative; peer-led interviews with 23 Aboriginal young people in Western Sydney were conducted. Peer interviewers were selected in consultation with members of a local Aboriginal community. Three male and five female interviewers were selected to ensure that cultural expectations were met regarding the need to discuss issues around sexual health with a person of the same gender.

The findings showed that participants used the internet to access information about physical symptoms because searching for information online allowed privacy. Participants then approached trusted sources, including those with whom they had formal relationships (doctors, teachers, counsellors) and informal relationships (family members, friends), to check that the information participants found online was correct and trustworthy. In this context young people used the internet as a triaging tool. The participants were also aware that their formal sources of help and advice, such as teachers, might have to undertake mandatory reporting if certain subject matter were discussed, although the parameters around this obligation and their understanding of which particular professionals were required to do so were not always clear. The research findings therefore have important implications for how sexual health education programs for Aboriginal young people living in urban areas should be targeted.

## **Chapter 1: Introduction**

The research project that forms the subject of this thesis used the peer-interviewing method and a strengths-based approach to identify the ways in which Aboriginal young people (aged 16 to 26) living in an urban community in Western Sydney accessed information regarding their sexual health. Qualitative interview data was used to identify the information sources that urban Aboriginal young people viewed as helpful in managing their sexual health, including what role technology played in this process.

This first chapter outlines the rationale, aims and significance of this study and highlights the importance of a strengths-based approach to examining how Aboriginal young people in urban areas access and check information in relation to their sexual health. Poor management of sexual encounters can have lasting implications for Aboriginal young people, including unintended pregnancy (and therefore fewer educational opportunities), unwanted consequences as a result of discrepancies in power and control (the potential to experience domestic violence), and sexually transmitted infections (which may have impacts on fertility in later life). The research was conducted in Western Sydney, which has the highest concentration of Aboriginal people in Australia (Strategic Communications and Engagement, 2016), yet most sexual health research with Aboriginal young people already undertaken has been conducted in remote settings (Senior & Chenhall, 2008; Shield et al., 2018). An urban setting like Western Sydney is therefore a new and ideal location in which to focus this important research.

### **1.1 Health, Sexual Health and Aboriginal Young People**

For Aboriginal and Torres Strait Islander Australians, good health is more than just the absence of disease or illness; it is a holistic concept that includes physical, social, emotional, cultural, spiritual and ecological wellbeing, for both the individual and the community (Aboriginal Community Controlled Health Organisations [ACCHOs], 2021). This concept of health emphasises the interconnectedness between these factors and recognises the impact that social and cultural determinants have on health (Commonwealth of Australia, 2013).

This is an important consideration because Aboriginal young people in Australia experience poorer sexual health outcomes, including significantly higher rates of sexually transmitted infections (STIs), than non-Aboriginal young people (Whiteside et al., 2012; Kirby Institute, 2018). Sexually transmitted infections – particularly chlamydia, gonorrhoea, infectious syphilis and blood-borne viruses such as HIV – and teen pregnancy are substantially more common among Aboriginal people than among non-Aboriginal people in Australia (Kirby Institute, 2018).

Sexual health testing rates among Aboriginal men are lower than among Aboriginal women. Aboriginal young people aged 16 to 19 years have the highest rates of STIs and are less likely to have a test compared to those aged 20 to 29 years (Kirby Institute, 2018). High testing rates are important because they increase the effectiveness of screening programs in targeted communities and populations (O'Connor et al., 2014). It is therefore self-evident that there is a need to identify and address the reasons for Aboriginal young people experiencing barriers to accessing sexual health services.

Information-seeking skills are important, as these give urban Aboriginal young people some control of their sexual wellbeing. Such skills allow them to find relevant information for themselves, to make informed decisions and to communicate effectively with medical personnel and others who can help.

Technology continues to play an increasing role in people's lives, especially in the lives of young people, and is becoming ever more normalised as a way to gather information. The Australian Bureau of Statistics reported that, in 2015, 99% of 15- to 17-year-olds were internet users, and the same age group spent an average of 18 hours each week online for personal use (Rice et al., 2016). The use of technology to deliver services to Aboriginal young people around sexual health may create a greater sense of confidentiality for young people and result in increased access to sexual health information. One online survey conducted with young people in Australia found that, of respondents aged 16 to 24, 63% would be willing to have a telephone consultation, and 29% a webcam consultation, regarding their sexual health (Garrett, 2011). Male respondents and those in same-sex relationships reported a higher rate of willingness to access an appointment over webcam (Garrett, 2011).

The use of technology is also aimed at breaking down some of the barriers that Aboriginal young people face to seeking support or information, including barriers to exploring issues around sexual health. These barriers include shame, limited awareness of services and what they offer, fears around lack of confidentiality, the taboo nature of discussion around sexuality, and fear that family members will become aware of a young person's sexual health problem (Price & Dalglish, 2013). The internet has enabled access to a large amount of information relatively easily. The success of some sexual health services that target Aboriginal young people in Australia could be strengthened by embracing technology and non-traditional modes of delivery that can appeal to young people and be more easily accessible. This could be through service provision, internet campaigns and interactive learning platforms that would allow Aboriginal young people to choose how they wish to access the information they are seeking.

## **1.2 The Existing Focus on a Deficit Approach**

The *deficit approach* to Indigenous health issues is quite common in existing literatures. This approach frames Aboriginal people's health practices in a narrative of lack and tends to highlight the negative aspects, weaknesses and shortfalls of a community or individual (Fforde et al., 2013). This way of thinking places the blame on the individual, rather than on systemic failures of healthcare systems (Foster & Spencer, 2011). The language that results when discussing Aboriginal young people's sexual health feeds into the stereotype that Aboriginal young people are incapable of helping themselves and others. My colleagues and I have published on this subject and suggested that the deficit approach be replaced by strengths-based research (Martin et al., 2020). This thesis is an attempt to do just that – to counteract the predominant deficit approach evident in the existing literature about sexual health and to encourage new approaches and more positive language based on young people's strengths.

Much of the health research undertaken in Aboriginal communities has been conducted by non-Aboriginal researchers with limited input from Aboriginal people themselves. The research conducted for this thesis purposely challenges the predominance of this approach in sexual health research. It is led by me, a Kamilaroi person, and supervised

by a team of Aboriginal and non-Aboriginal academics. It focuses on young people's strengths and what they do well to help themselves and those around them to maintain their sexual wellbeing. To further incorporate strengths-based research, data was collected using the peer interview method (see Section 3.5.4).

### **1.3 Giving a Voice to Aboriginal Young People in Urban Areas**

Most sexual health research carried out among Aboriginal people has until recently focused on remote Aboriginal communities (Fagan et al., 2015; Kildea & Bowden, 2000). This is despite the fact that 79% of Aboriginal people live in urban or regional areas of Australia (Australian Institute of Health and Welfare, 2017). Aboriginal communities across Australia vary in their beliefs, values and educational levels, and also in the particular barriers they face when it comes to sexual health. The body of research into Aboriginal sexual health has largely failed until now to consider whether or not the findings from studies of remote communities are consistent with those from urban communities. This thesis addresses this gap in the literature by focusing on Aboriginal young people located in an urban area, a group currently under-represented in the literature.

### **1.4 This Research: Purpose and Significance**

The research undertaken for this thesis has been developed as part of a broader Australian Research Council (ARC) funded linkage grant ("Fostering Aboriginal sexual well-being by building on strengths", no. LP170100190). It is being conducted by me, an Aboriginal researcher, and embeds an Aboriginal perspective rather than having an Aboriginal perspective added on as an afterthought, or objectified as part of a requirement.

The study is significant because it focuses on a large urban Aboriginal community and allows the experiences and values of this large population to be captured. As described earlier, its aim is to represent urban Aboriginal communities in the literature, given the previous overwhelming focus on remote and regional Aboriginal communities.

The other main significance of the study is that it embeds a strengths-based approach to identify what Aboriginal young people do well in relation to accessing sexual health services and information, and how services can tailor their approaches to better assist them. It also explores and reports on the different ways in which participants access, value and fact-check information for themselves and others in managing their sexual health. Apart from placing Aboriginal young people at the centre of the research, it creates a forum for them to lend their own voices to the discussion of issues and themes that are important to them within their communities.

The research focuses on the opinions, thoughts and feelings of participants and the experiences of individuals and the community (Blaikie, 2007), and used a peer interview method that involved training Aboriginal young people from a Western Sydney Aboriginal community to conduct interviews with their peers. As will be described in Chapter 3, of all interview methods the peer interview method most successfully gives voice to Aboriginal young people, so aligns well with the strengths-based approach adopted. In addition, the peer interview method provides young people with an opportunity to train as researchers and to experience employment, which will provide them with future employment opportunities in research. This upskilling of community members will hopefully ensure that the individuals involved as peer researchers have a positive and productive experience.

Other research argues that young people are often silenced, ignored or not consulted about matters central to their lives (Gomez & Ryan, 2016). To address this, the peer interviewer method places young people as both interviewer and interviewee, allowing them to guide the research themselves. In fact, the peer interviewers played a much more significant role in the sense that they were actually peer *researchers*, so will be referred to as such from this point forward.

Chapter 4 of this thesis, “Findings and Discussion”, reproduces direct quotes from the participants to ensure that their voices continue to be heard throughout all stages of as a result of taking part in the research.

## 1.6 Research Questions

The main goal of this research was to explore the ways in which Aboriginal young people in an urban setting access, value and fact-check sexual health information for themselves and others, and the role that online sources can play in this. The specific research questions were:

- 1) What sources of information are used by Aboriginal young people in urban areas to access sexual health information, including online sources, friends, families and health services?
- 2) What are the reasons for Aboriginal young people in urban areas accessing sexual health information from these sources?
- 3) How is technology being used by Aboriginal young people to support their information seeking around sexual health issues?
- 4) How could technology be used better or differently to support Aboriginal young people's information seeking around sexual health issues?

With a focus on these questions, the research sought to achieve the following objectives:

1. To give Aboriginal young people in urban communities a voice regarding the management of their sexual health and how they access and receive sexual health information; and
2. To identify in which settings technology can be used to increase urban Aboriginal young people's access to accurate and reliable sexual health information.

Each of the research objectives has been achieved and the research questions answered and reported on below.

## 1.7 Overall Organisation of the Thesis

This thesis is divided into five chapters. This chapter, **Chapter 1**, presents the rationale, aims and significance of the study, and positions the researcher within the research.

**Chapter 2** presents a review of the existing research literature on the subject of



Aboriginal sexual health and how technology has facilitated access to services. It shows that different modes of technology appealed to different members of the Aboriginal community, but that the need for privacy was a main factor. **Chapter 3** outlines the methodological framework used to conduct the research. It describes the study's strengths-based approach drawing on Indigenous Standpoint theories (Nakata, 2002; Martin, 2003) and qualitative peer interview methods. **Chapter 4** presents and discusses the findings arising from the research and addresses the limitations of the study. It identifies that participants used the internet to access information about physical symptoms because accessing information online gave them privacy. This information was then used to assess whether or not they needed to access medical treatment. Trusted sources, both formal and informal, were also approached to ensure that the information read online was correct and trustworthy. Thus, the internet was used as a triaging tool for young people to decide if their symptoms were normal or a cause for concern. **Chapter 5** presents some concluding points, identifies implications of the research for practice, and recommends pathways for future strengths-based research with Aboriginal communities. Research focused on Aboriginal communities needs to take a strengths-based approach and Aboriginal participants need to be given their own voices and to be seen as the experts.

## **1.8 Positioning of Self**

Seeking to position myself within my research, I was compelled to decide which aspects of my story I was willing to share with the reader, and which aspects I felt were important in shaping my path into academic research. As this was the first time I had undertaken such a task, I also needed to understand why this was important. During my reading I found a quote that stood out to me: "The ability to craft our own research stories, in our own voice, has the best chance of engaging with others" (Kovach, 2009). My own journey into research is an example of why I feel it is important for Aboriginal people to be involved in research. My story also details some of the obstacles I faced and had to overcome in order to attend university in the first place.

As a Kamilaroi woman and an Aboriginal researcher conducting research with Aboriginal people, I bring to this research my particular perspective as both an

Aboriginal person and a researcher in training. Throughout the various areas of my life I hold different roles, identities and positions that are all linked and embedded in the research process and the resulting thesis. In this chapter I will position my journey into research and the experiences that have helped to shape me. In the methods section (3.2.1 Positioning of Self) I will focus on the theoretical frameworks in relation to my position within the research. This will allow the reader to have a sense of who I am as an emerging researcher, both what has shaped how I interact with the data and how I have created a sense of self.

I grew up on Country in rural New South Wales before moving away when I was 18. My mother is Kamilaroi and has lived her entire life on Country. My father's ancestry is relatively unknown to me as I am not in contact with that side of my family. When I started writing my thesis I was living in Melbourne's outer suburbs (on the land of the Wurundjeri people). My partner and I then moved to Tasmania (the land of the Palawa people) to start a hobby farm, which is where I finished writing the thesis. On nice days I sat by the creek and wrote while enjoying the sounds of running water and watching the wildlife.

One of my strongest early childhood memories is of having my own toolbox, which had real tools in miniature. I'm surprised I never took off a thumb with my little axe. I was a *Daddy's girl*, proudly choosing to follow my dad around every chance I got and stating that I couldn't go shopping because I needed to help fix what he was working on at the time. I like to imagine that my form of helping did not add too much extra time to the job. Following my father's death when I was five, I would spend a lot of my time at the local swimming pool and at my Nan and Pop's place, just around the corner.

My mother entered a new relationship and we all eventually moved to a farm about two hours away, leaving all my family behind. Previously we had lived next door to my grandmother (my mother's father's mother) and just around the corner from Nan and Pop (my mother's parents). My mother's new relationship brought some excitement (I finally got a horse) and two new older brothers.

My stepfather was, to put it politely, old fashioned, holding very clear and antiquated ideas of gender roles and having low expectations of girls. We, my sister and I, were also told that we could no longer be Aboriginal, as he did not approve. It was not until I

was in high school that I felt able to challenge the new rule within the household. I clashed a lot with him while living in the house; he would often attempt to intimidate and was very authoritarian. Following my younger brother's birth (who again, in my stepfather's view, could not be Aboriginal, despite our mother being Aboriginal), the difference in the way he treated us, my sister and I, as opposed to both his sons by his first partner and our younger brother was more noticeable. I am not sure if this was because my brother was male or because we were not his children. This preferential treatment was also noticeable to a certain extent when my younger sister was allowed to undertake extracurricular school activities and go on excursions that I was not allowed to do.

I can't say that I was a dutiful student and I did not expect to go to university. One of my English teachers, however, suggested that I should consider it. Here I owe a huge thank-you to my sister-in-law, who took me on a trip to Sydney so we could visit the universities. I was shocked to be accepted into two bridging courses and chose to study at the University of Canberra, seeing it as a great way to escape a life that I was not enjoying.

I was the first person in my family to attend university (other than my stepfather's eldest son). When I was accepted, my stepfather and mother told me that the only way I would get there was if I caught the train. This was a daunting thought for someone who had never travelled alone before and was moving to a whole new place. Here again I owe thanks to my sister-in-law, who despite having just given birth, packed my belongings in her car and travelled down with me and my niece, ensuring that I had everything I needed and giving me advice and encouragement.

At university I was finally able to figure out who I was as a person and what I wanted to do. As a result, I changed courses several times during my undergraduate degree and was often the only Aboriginal person in the class. I eventually settled on a Bachelor of Arts and got my first degree. At this point I was often too shy to speak out about the disparaging comments both lecturers and students made about Aboriginal people. I did, however, speak out occasionally, seeing university as a space where people could start to use their own voice, either in their essays or in classes.

While studying my Master of Social Work, I attended three different universities in four different places. I left the first university because I was not enjoying the location or the casual assumption made by a supervisor made that, as an Aboriginal woman, I could only be interested in Aboriginal concerns and would want to work on a mission. Having a strong sense of my own identity, I had no desire to have others make assumptions about my motivations or interests based on their own flawed assumptions. My interest was actually in sexual health and its non-physical aspects: emotional health, education, and access to services. Resisting being pigeonholed as someone who was *Aboriginal-focused*, I undertook a placement working with people living with HIV. This also led me to further resist being pigeonholed as having an Aboriginal focus. The second university I attended also saw me move states, and therefore campuses, during my study. Before I could enrol in classes at the second campus I was required to attend a meeting with my course convenor, as he found it highly suspicious that any student would want to move states and transfer to another campus. During this meeting I was accused by the convenor of trying to steal an identity, what was my own identity, as no one would want to move during university. Eventually I was told that my request to change campuses could be granted, but that I would need to restart my degree. To this day I am still not sure exactly what made that convener question my identity and motives so forcefully or how they managed to become a convener. After deciding that I did not want to deal with issues like this for the rest of my degree, I moved to Griffith University, where I graduated. During this time I also volunteered at an HIV organisation, learning a lot and being in an environment I enjoyed.

After graduation I worked in an Aboriginal organisation while beginning a Master of Science in Medicine (HIV, STIs and Sexual Health) (Counselling). During this time a co-worker often sent me articles on what it was like to be Aboriginal, making comments that as a white woman I needed to justify why I wanted to work with Aboriginal children. I saw this as bullying behaviour and lateral violence. I felt that as I did not fit my co-worker's definition of what it was to be Aboriginal, I was expected to be silent and *white* or start conforming to her ideas. The idea of *blackness* is judged by both the Aboriginal and non-Aboriginal community, and often in a negative manner. I am Kamilaroi, I have my own way of being and I don't feel the need to fit a stereotype. Eventually I left the organisation due to long hours, stress and lack of support. This role

did, however, further highlight aspects of relationships and sexual health knowledge, held by both staff and clients of that was of great interest to me.

During my postgraduate degree, I started to address the comments and assumptions made in class about Aboriginal people. I often found myself rewriting my entire presentations the night before just so I could refute the claims other students made about Aboriginal people. I had decided that working professionals needed to know when they had false information and held dangerous assumptions. This resulted in an increased workload for me in a bid to ensure that Aboriginal clients of the future would receive a higher level of care. I was also faced with the same sorts of stereotypes, assumptions and harmful commentary from other classmates: “Why are Aboriginal people special? They don’t deserve their own health services”. I ended up gaining my Master of Science in Medicine (HIV, STIs and Sexual Health) (Counselling), a truly fancy title I can never remember.

Soon after, I saw an advertisement for expressions of interest to take part in a project titled, “Fostering the sexual well-being of Aboriginal young people by building on social, cultural and personal strengths”. Thinking that I would not have the relevant research experience, I did not apply even though I thought it would be an interesting project. At the time I was working in a stressful job redacting child-protection files for court, with very long hours and pressing deadlines. Months later a friend forwarded me the same advertisement and encouraged (told) me to apply. A few emails and phone conversations later and I was accepted into the degree Masters by Research at UNSW.

This is what led me to complete this thesis – but why the topic of sexual health? And why an interest in the use of technology?

When still in high school I was able to identify that sex education, as it was presented at the time, was not effective. There were a number of teen pregnancies in my year, which led me to question: ‘Why was this the case? What could schools, parents and the community have been doing better? Why were healthy relationships not talked about as well as sexually transmitted infections?’ I also started to identify unhealthy relationships among those I knew and the impacts these had on both those in the relationship and those around them. I knew that my mother’s relationship was not healthy, but why wasn’t it? And how would I have known that without positive role models? All my

work roles had shown that being in an unhealthy relationship could have devastating consequences for both parties involved, including children and surrounding family and friends. Achieving sexual health needed to take into account a broad array of issues, not just issues of physical health.

My interest in the technology aspect of this study came from my understanding of how difficult it could be to access services. Growing up on a farm and being forbidden to learn to drive, I was able to attend appointments only if I could fit them in before catching the school bus home. Being able to use technology to access services and support would have made my young life a lot easier.

Finally, as a light-skinned Aboriginal woman who had grown up in a predominantly white setting, I wanted to see more representation of people with backgrounds similar to mine. Following my experience of having my identity questioned and my blackness interrogated, the temptation was just to be silent. However, I felt that this only increased the belief that there was a *right way* to be Aboriginal. Research needed to reflect all experiences and opinions held by Aboriginal people. This firm belief led to my decision to focus on urban Aboriginal populations in my research, and I have had the privilege to work with an amazing group of young people who became involved in this research.

## **Chapter 2: Literature Review**

An integrative review was undertaken to determine the current knowledge around the issues impacting on Aboriginal young people's sexual health in Australia (Somekh & Lewin, 2011). Literature was found using two methods: 1) by searching online Library data bases including Medline, PubMed, CINAHL, ProQuest 2) by reviewing the reference lists of papers that were specifically relevant to the thesis topic. Through this process I found and read approximately 100 papers. The focus was on Australian studies with articles from other countries only included when a gap in the available Australian literature was identified. These gaps include health literacy and the use of telehealth in which international articles, predominantly from America were included. Each article was summarised using three-line annotation before being organised it in an excel worksheet, organised into themes, after which a paragraph on each articles theme was written. These themes identified within the literature were then categorised in a new analytical document that included the one paragraph article summary of each theme to be further analysed for the strongest themes. At each stage the themes were discussed during supervision and refined before a detailed document was drafted that formed the basis of this chapter.

Aboriginal young people in Australia experience higher rates of diagnosis with sexually transmitted infections (STIs) and poorer sexual health outcomes than non-Aboriginal young people (Whiteside et al., 2012). This chapter identifies some of the reasons for this as outlined in the research literature. The overall focus of this chapter is to understand the issues that impact Aboriginal young people's sexual health, both historical and current, and the strategies that are available to address these issues.

The research literature was examined with three distinct objectives:

- 1) to identify what issues impact Aboriginal young people's sexual health;
- 2) to identify the roles that information seeking and health literacy play in Aboriginal communities and their accessing of sexual health information; and
- 3) to identify how technology can be used to support Aboriginal young people in an urban area to access sexual health information.

A review of the literature relating to each of these three topics is presented below under distinct headings. The introduction to each section provides context before the subject is

discussed in more detail. The discussion is followed by a conclusion that highlights the main themes and any gaps in the current research.

There is a need for more research to take a strengths-based approach to suggest ways in which Aboriginal people can be supported in accessing sexual health services and sexual health education (Fforde et al., 2013). Current research takes a deficit approach, focusing on negative issues within Aboriginal communities and ignoring the positive changes that have been achieved by and within Aboriginal communities when they rely on their strengths.

The literature review reveals several main themes. These are that:

- 1) there is a deficit approach to research involving Aboriginal young people's sexual health;
- 2) many studies do not take a holistic approach to Aboriginal health;
- 3) most research is focused on remote communities rather than the experiences of Aboriginal young people in urban settings; and
- 4) there is a need to ensure community engagement.

## **2.2 Epidemiological and Behavioural Studies of Aboriginal Young People's Sexual Health**

The literature that reports the findings of epidemiological and behavioural studies of Aboriginal young people's sexual health indicates that there are high rates of diagnosis of STIs among Aboriginal young people compared to population size, and a high prevalence of high-risk behaviours, such as younger age of first sexual encounter, multiple sexual partners and inconsistent condom usage (Whiteside et al., 2012). For example, Aboriginal people of all ages, are 2.8 times more likely to be diagnosed with chlamydia, 5 times more likely to be diagnosed with syphilis and 7 times more likely to be diagnosed with gonorrhoea than their non-Indigenous counterparts (Kirby Institute, 2017). During the review of epidemiological and behavioural studies, a number of themes were identified, including: low testing rates among men; differing social expectations around sex and relationships depending on whether you were a man or a woman; the potential negative impact of domestic violence on women's sexual health; and issues concerning antenatal care, fertility and poor knowledge of and access to services. The review also revealed that the existing research was clinical focused and



problem focused and was largely concentrated on behaviour in remote, rather than urban, communities. This highlights the need for innovative responses to sexual health and for community engagement with the issue.

Since the issues experienced by men and women are often presented separately in the existing research, the following discussion is organised in the same way. Though this organisational approach has some limitations, it is also useful in that it highlights the specific and different issues facing young women and young men. Another limitation of the literature is the lack of representation of lesbian, gay, bisexual, transgender, queer, intersex plus (LGBTQI+) views and experiences. Also problematic is the presentation of important issues as the responsibility of one gender, for instance that domestic violence is just a women's issue, i.e. that it is women who must address the issue of domestic violence rather than male perpetrators themselves, who should in fact be encouraged to question their own actions. Such an approach also alienates those who have experienced domestic violence who are not women. Research that acknowledges only two genders discounts the experience of the LGBTQI+ community and places heterosexual relationships and experiences as the norm. There is also a lack of a whole-of-community understanding of the issues impacting sexual health.

### **2.3 Women**

My review of the literature revealed that Aboriginal women are among the most disadvantaged in Australian society on all social indicators. They are over-represented in the criminal justice system and victims of the actions of child protection agencies; they have high rates of teenage pregnancy, lower life expectancy and most often attract the attention of welfare services (Arabena, 2016). Much of the research in Aboriginal sexual health focuses on the experiences, knowledge and beliefs of one gender – women. The three themes identified below are drawn from studies involving Aboriginal women, though this is not to imply that these issues impact women only, or that it is Aboriginal women who should be responsible for and are required to address these issues. With much of the literature focusing on a deficit approach, the strengths and resourcefulness of Aboriginal women is often overlooked.

### 2.3.1 Domestic Violence

Domestic violence plays a significant role in leading to poor outcomes and negatively impacting people's sexual health and wellbeing. Aboriginal women experience higher rates of domestic violence than their non-Indigenous counterparts. They are 32 times more likely to be hospitalised as a result of domestic violence and twice as likely to die at the hands of a current or former partner than non-Aboriginal women (Australian Institute of Health and Welfare, 2018). When analysing these statistics it is important to remember that many Aboriginal women have non-Indigenous partners; one study found that 85% of Aboriginal women living in Melbourne had a non-Indigenous partner (Brown, 2016). Another national survey, which involved 2877 Aboriginal participants aged 16 to 29 years, found that only around half of the participants had a previous sexual partner who was Aboriginal (Ward et al., 2016). This highlights that the perpetrators of violence against Aboriginal women are often not Aboriginal men.

A study that took place in Townsville, Queensland, found that Aboriginal women over the age of 30 who were not experiencing domestic violence were less likely to be diagnosed with an STI (Panaretto et al., 2006), suggesting that domestic violence, including experiencing sexual assault reduces a women's ability to negotiate the use of safe sexual practices. As Stark & Hope (2007) point out, high rates of alcohol abuse, coercive sex and sexual abuse of Aboriginal women increase their risk of contracting STIs due to a lack of condom use and women's inability to negotiate their use. In another study among Aboriginal young people in remote parts of Australia, participants described violence as a normalised and accepted aspect of their sexual relationships (Senior et al., 2017). Despite this, talking about domestic violence was viewed as being shameful and disloyal (Senior et al., 2017). To address this issue, sexual health education needs to focus on all areas of health, just as Indigenous models of health do, and not simply on physical aspects of health. Good sexual health education includes discussion of topics such as domestic violence, consent, power imbalance and all forms of sexual violence and coercion, and should provide Aboriginal women and men with the skills to navigate discussion of sexual issues and to negotiate with their partners. These skills are part of what is taught in programs such as Strong Families (Duley et al., 2017) and Young Deadly Free (D'Costa et al., 2019), which have a holistic and community-based approach to improving sexual health outcomes for Aboriginal people

(Duley et al., 2017; D’Costa et al., 2019). These programs will be further discussed later in the chapter.

### 2.3.2 Fertility

Female fertility and child-bearing is valued in many Aboriginal communities. Research from Northern Australia shows that communities will shun a woman if she is thought to be unable to have children, but will not treat a man in the same way (Kildea & Bowden, 2000). In one Aboriginal community in Northern Australia, a high rate of infertility was found; it was determined that 26.3% of women between the ages of 20 and 45 were infertile (Kildea & Bowden, 2000). Despite the fact that these women valued their fertility, only 42% of those experiencing infertility sought medical intervention (Kildea & Bowden, 2000). Such reluctance to seek medical intervention needs to be understood to ensure that Aboriginal women who might want to seek treatment for infertility and other health concerns do not preclude themselves as a result of various barriers to coming forward for assistance.

### 2.3.3 Motherhood

Another study looked at the beliefs and behaviours of Aboriginal teenaged girls in remote Australia and found that they believed motherhood to be the point at which a girl became a woman, regardless of whether they were teenagers or older (Senior & Chenhall, 2008). The young women also viewed motherhood as a way to gain some independence and have some sense of control over their lives (Senior & Chenhall, 2008). Other studies have found that some women viewed pregnancy as a major concern and to be avoided, using various alternative methods of contraception when they felt that condom use could not easily be negotiated (Bell et al., 2020b). Being in a relationship was also associated with reduced condom use. Participants expected partners to trust each other not to have sex with others, so condoms were not used, increasing the need for other forms of contraception (Mooney-Somers et al., 2011). Women in also felt that they could pursue either a relationship and children, or employment, but not both (Senior et al., 2017).

There is no known literature reporting on the importance placed on fertility and child-bearing by Aboriginal women living in urban areas. If research found that Aboriginal women in urban areas placed a high value on fertility, then sexual health education and health promotion could be tailored to appeal to this value and improve outcomes relating to fertility.

#### 2.3.4 Antenatal Care

Pregnant Aboriginal women attending services for antenatal care in some regional Australian settings have been found to have high rates of STIs (Panaretto, 2006). A study conducted in Townsville over a three-year period found that of 456 Aboriginal women attending appointments at an Aboriginal health service, 14.4% tested positive for chlamydia, 6.1% for gonorrhoea, 7.2% for trichomoniasis and 2.5% for infectious syphilis (Panaretto et al., 2006). The study also found that among this group the risk of being diagnosed with an STI was higher in those aged under 20, those who were single at the time of their pregnancy, those who engaged in high levels of alcohol use, those experiencing their first pregnancy and those with unwanted pregnancy. Aboriginal women also experienced a high number of complications of pregnancy, with the risks to their babies of pre-term birth, low birth weight and prenatal mortality increasing in women diagnosed with an STI (Panaretto et al., 2006). Another study in northern Australia found that Aboriginal women in a remote community experienced a number of complications of pregnancy; 2.6% experienced an ectopic pregnancy, 1.8% a stillbirth, 14.3% a miscarriage and 12.3% the death of their newborn (Kildea & Bowden, 2000). Despite interventions already in place to improve outcomes, the rate of giving birth prematurely among Aboriginal women in 2008 was 13.3%, compared to 8.0% among non-Indigenous women (Kildea et al., 2019). Providing adequate antenatal care to Aboriginal women allows the opportunity to ensure that STIs are detected, treated and managed throughout pregnancy. Service provision should also take a holistic approach to ensure that women are engaged and supported throughout their pregnancy, and provided with education around sexual health, bodily autonomy and pregnancy.

## 2.4 Men

Few of the research studies reviewed for this chapter focused on Aboriginal men; the two themes below are drawn from the limited studies that *did* involve Aboriginal men. Aboriginal men in Australia have a lower life expectancy and experience higher rates of substance misuse and suicide compared to non-Aboriginal men. They are also over-represented in prison and other institutional settings (Brown & Blashki, 2005).

### 2.4.1 Testing Rates

Despite campaigns and increased awareness of the need for regular sexual health screening, Aboriginal men continue to have lower rates of testing than Aboriginal women. One study found that 15% of Aboriginal men in the study cohort had had a test for chlamydia compared to 25% of Aboriginal women (Goller et al., 2012). This same study reported that the rate of testing among Aboriginal men remained consistent, whereas it increased in other targeted populations (Goller et al., 2012). The low percentage of Aboriginal men undertaking sexual health screening is seen as problematic because it reduces the effectiveness of screening programs in targeted communities and populations (O'Connor et al., 2014). Another study found that Aboriginal young men were more likely to only seek sexual health screening when they experienced physical symptoms (Mooney-Somers et al., 2011). When interviewed, Aboriginal young men reported not being encouraged by their peers to seek testing. Sexual health testing was viewed as something to be avoided until they noticed physical symptoms (Mooney-Somers et al., 2011). This study suggests that Aboriginal young men are less willing to talk about sexual health than their female counterparts. Determining the reasons for an apparent aversion to testing and lack of awareness of sexual health issues among Aboriginal men is a gap in the current research that needs to be addressed.

### 2.4.2 Social Expectations

Studies have reported that Aboriginal young men are unlikely to make use of formal sexual health or general health services, and that Aboriginal men of all ages do not view

these services as an option due to the stigma around men being seen not to be able to handle general or sexual health issues on their own (Price & Dalglish, 2013). Young men also appear to have different peer support networks around them than young women, and their peers do not provide the same kind of support for sexual health as do young women's support networks (Mooney-Somers et al., 2011). However, one study conducted in the Northern Territory did find that the behaviour of participants' friends influenced their behaviour health-wise, and fatherhood especially was prized as part of their gender identity (Smith et al., 2020).

The reasons for men's reluctance to access formal health services requires further research. Given the low rates of sexual health testing and attendance at health services among Aboriginal men, research needs to identify the reasons for their non-engagement. One study that took place in the Northern Territory found that if an outreach program built trust and was engaging, participants were more likely to state that they would attend a health service for an issue related to sexual health (Smith et al., 2020). All studies reviewed identified that Aboriginal men were being tested at lower rates than their female counterparts (Goller et al., 2012; O'Connor et al., 2014). The findings also showed that Aboriginal men were usually expected to be responsible for using condoms during sexual intercourse and that Aboriginal women did not discuss condom use with their partners due to the stigma involved (Kildea & Bowden, 2000). This is consistent with the results of studies conducted among non-Aboriginal young people. When asked about condom use during their previous casual sexual encounter, a study of young Aboriginal men found that there was a 92% usage rate compared to 68% for women (Scott et al., 2015); both of these rates are quite high. The reasons for not using a condom included partner-related reasons (being in a committed relationship, partner not wanting to use condoms or other birth control being used), condoms not being available, drugs or alcohol being used at the time, and engaging in unplanned sexual intercourse (Scott et al., 2015). Young men were more likely than young women to carry condoms and would get them from their friends rather than from service providers, even if the condoms were free, because they worried about privacy and being recognised at the service (Bryant et al., 2011).

## **2.5 General Issues Relating to Sexual Health**

It was clear from the studies reviewed that various universal issues were impacting young men's and young women's sexual health: 1) poor knowledge of sexual health issues in the community in general; 2) a number of barriers to accessing sexual health services; 3) the dominance of clinical and deficit-focused research 4) a dominate focus and attitude within that health services that discounted the strengths within communities; 5) the focus of research being on remote communities, which has meant that Aboriginal people in urban areas are not being heard; and 6) a need for innovative responses to sexual health.

### **2.5.1 Poor Knowledge of Sexual Health Issues**

Existing research indicates that Aboriginal young people can have poor knowledge of STIs and blood-borne viruses (BBVs). For some, sex education that was insufficient or poorly targeted (compared to the quality of sex education given to their non-Indigenous counterparts) was associated with inconsistent condom use and having their first sexual encounter at a younger age (Whiteside et al., 2012). In their 2011–2013 study of Aboriginal and Torres Strait Islander people's sexual health and relationships and use of health services, Sexual health and relationships in young Aboriginal and Torres Strait Islander people: Results from the first national study assessing knowledge, risk practices and health service use in relation to sexually transmitted infections and blood borne viruses which surveyed almost 3000 Aboriginal and Torres Strait Islander people aged between 16 and 29 across all Australian, (Ward et al. 2014) found that levels of knowledge were good in most jurisdictions. Young people's level of knowledge was assessed in 12 questions, which included questions about the how STIs and BBVs could be transmitted and treated. Overall, 35% of participants answered at least 11 questions correctly, and the level of knowledge increased with the age of the participant. Of those under the age of 20 years, 26% responded correctly to at least 11 questions, while 46% of those aged 25 to 29 years responded correctly to the same number of questions (Ward et al., 2014).

In another study, Aboriginal young people identified that their lack of knowledge of sexual health was a result of their parents and role models not providing education on

the risks and unintended consequences of sexual activities and on how to prevent them (Mooney-Somers et al., 2011). They therefore lacked the skills and confidence to enforce the use of safe sexual practices and engage in difficult conversations with their partners (Mooney-Somers et al., 2011). From a strengths-based perspective this suggests that Aboriginal young people have identified areas of knowledge that they are lacking, and highlights that they see parents and role models as the obvious source of information and answers to questions. Current research does not examine why parents and other trusted adults are not comfortable, or confident, in discussing sexual health with their young people. Programs aimed at increasing Aboriginal knowledge of sexual health have shown that when provided with the opportunity, Aboriginal people embrace education (Duley et al, 2017). For example, Aboriginal men who took part in the Strong Family Program (delivered by Family Planning NSW) expressed the view that contraception was not the sole responsibility of women and that men were interested in learning more. The same program found that participants reported having improved knowledge and attitudes around rights and respectful relationships (Duley et al., 2017). Education programs such as Strong Family, which are culturally safe, have the potential to address many issues facing Aboriginal young people, including levels of knowledge about all aspects of sexual health matters.

### 2.5.2 Barriers to Accessing Sexual Health Services

The literature shows that Aboriginal people experience a number of barriers to accessing sexual health services. Apart from the fact that they are seen to be a mobile population, barriers include financial constraints, a belief in a lack of confidentiality in culturally inappropriate services, not enough Aboriginal staff or staff of the same gender in the service, and feelings of shame and embarrassment around discussion of sexual health issues (Biggs et al., 2016). Aboriginal young people have also reported that they are uncomfortable attending a sexual health clinic in which they may be seen by friends or family in the waiting room or by staff members who know them (Holmes et al., 2002). By working with the community to overcome these barriers, service providers should encourage more Aboriginal people to access sexual health services. The benefits of reducing barriers can be seen in the outcomes of the Deadly Liver Mob program in



Western Sydney, which reduced the stigma around sexual health by ensuring easy access and introducing participants to sexual health staff (Biggs et al., 2016). This approach resulted in an increase in the number of Aboriginal men over the age of 35 accessing the sexual health service (Biggs et al., 2016). This is a great outcome, but unfortunately Aboriginal people generally continue to experience stigma after entering a sexual health clinic. For example, the stigma around condom use has been reported as preventing individuals taking free condoms from the counters of sexual health clinics (Mooney-Somers et al., 2011). When deciding if they would visit a health service, Aboriginal young people considered various factors related to the risk of being seen. Locating a health service on a main road and the prevalence of accepting walk-in appointments, which reduced the ability for people to plan their attendance with accurate wait times resulting in them being more likely to be seen if required to wait for extended periods of time, are also barriers to young people attending (Bell et al., 2020a).

In the cases of both men and women, illicit drug use and alcohol consumption when engaging in sex increases the likelihood of being diagnosed with an STI (Wand et al., 2016). Shame associated with the use of drugs and/or alcohol can also be a barrier to some Aboriginal young people's accessing sexual health services. One study in NSW found that even young people accessing or thinking to access support around alcohol/drug use and sexual health from an Aboriginal Community Controlled Health Organisation experienced shame and guilt both when attending and at the thought of attending (Ward et al., 2013)

The research highlights the need for sexual health services to consult with the community to ensure that culturally appropriate services are provided in a manner that ensures the comfort of clients. Such consultation to identify the needs of the community would also allow service providers to take a more holistic approach to sexual health. When necessary, services could also promote reduction in drug and alcohol use alongside sexual health education to ensure better outcomes for their clients.

### 2.5.3 The Focus on Clinical and Deficit-based Research

The majority of research on Aboriginal sexual health focuses on clinical and epidemiological matters, and on problems related to sexual health, rather than on the

strengths of the Aboriginal young people and communities involved. There is a strong focus on the rates of diagnosis of STIs among the Aboriginal population and on the need for an increase in testing rates (Waling et al., 2019; Goller et al., 2012).

Consequently there is a gap in the current research around the actions that young people and communities are already taking to increase sexual wellbeing, sexual health education and knowledge, and to implement holistic approaches to sexual health.

A number of studies show that Aboriginal young people *have* acted to protect themselves and those around them, including through the sharing of condoms when friends are unable to access them from more public sources (Mooney-Somers et al., 2009). Sharing information about a potential partner's previous behaviour also allows young people to make more informed decisions regarding sexual partners (Mooney-Somers et al., 2011). Sharing their lived experience, knowledge and skills with family and friends also places some young people (especially women) in the position of educator (Mooney-Somers et al., 2011). Young people also have ideas around how they can be better supported to access services they are currently not making use of, including locating them in more private locations, increasing privacy in waiting rooms, having short wait times and placing supplies of free condoms in places where no adults are present (Bell et al., 2020a).

#### 2.5.4 The Focus on Remote Communities as Research Subjects

Research into Aboriginal sexual health has predominantly been conducted in remote communities despite the fact that 79% of Aboriginal people in Australia live in non-remote communities (Australian Institute of Health and Welfare, 2017). The vast majority of literature focused on Aboriginal people referenced throughout this chapter reports on studies undertaken in remote or regional Australia (e.g. the works of Bell et al., 2020b; Mooney-Somers et al., 2011; Ward et al., 2014; and Kildea & Bowden, 2000). Both qualitative and quantitative studies are represented. The work of Mooney-Somers et al. (2009) employed qualitative methods, conducting interviews with Aboriginal young people in Townsville. The Goanna Study, which surveyed 3000 young people across Western Australia, the Northern Territory, South Australia and New South Wales, was a quantitative study (Ward et al., 2020).

The current research into Aboriginal sexual health does not investigate whether the findings from remote communities can be applied to Aboriginal people living in urban settings. Much of the research assumes that Aboriginal communities across Australia are consistent in their beliefs, values and educational levels, and in the barriers they experience relating to sexual experiences and sexual health. This is problematic because Aboriginal communities across Australia are *not* a homogenous group and the strengths and challenges of a remote community are not necessarily the same as those of an urban community.

#### 2.5.5 Innovative Responses to the Provision of Sexual Health Services

Throughout Australia, a number of services and organisations have implemented innovative programs to respond to and better support Aboriginal young people's sexual health. Their responses have been developed as the result of community consultation to ensure that the specific needs of the clients are met (D'Costa et al., 2019; Duley et al., 2017). As mentioned previously, The Deadly Liver Mob implemented a program in Western Sydney that resulted in a ten-fold increase in the number of Aboriginal men attending the Western Sydney Sexual Health Clinic. This increase in attendance and subsequent testing rates was the result of removing the stigma of attending the service; clients were given a personal introduction to staff, a monetary incentive to encourage attendance, and education delivered by peers (Biggs et al., 2016). The Strong Family program was developed and delivered in various locations in NSW as a result of extensive consultation with Aboriginal communities, using the eight-way framework of Aboriginal pedagogy. This program The Strong Family program covers subjects including anatomy and physiology, puberty, sexuality, relationships, consent, family violence, safe sex, contraception, STIs (including HIV), pregnancy, and the use of drugs and alcohol. Following a three-year trial, it was found that, on completion of the program, participants' knowledge and attitude scores had improved (Duley et al., 2017). The Young Deadly Free program, which was run in 19 remote and very remote areas of South Australia, Western Australia, Queensland and the Northern Territory, is strengths-based with the aim to upskill and build the capacity of young people (D'Costa et al., 2019). It provided skills and training to young people so that they could deliver

sexual health education in their communities. On the website, there was information for parents, advising that their young people would want to talk to their parents to verify what they had learnt. The Yarning Quiet Ways website of the Western Australian Government also provides information to parents about talking to their young people about sexual health (Western Australian Government, *Yarning Quiet Ways*, 2015).

The research identifies a number of key features required for a sexual health program to be effective. The first is that consultation with stakeholders, including community Elders, young people and health professionals, is critical (Duley et al 2017).

Consultation is important to develop partnerships with the community and to ensure that services are designed and implemented in culturally appropriate ways. In addition, flexibility and adaptability are important in the delivery, design and implementation of services and programs. Adequate provision of appropriate staff, including staff of the appropriate gender, staff who are respected by the local community and staff who are accessible to young people, is also important for success (Duley et al., 2017). Some Aboriginal young people report that it is important for them to feel cared for as an individual, so being advised by an Aboriginal worker is essential to their willingness to attend the service (Mooney-Somers et al., 2009). It is also important to recognise that, in deciding whether to attend a particular service, Aboriginal young people are much more inclined to attend if the service has been recommended by family and friends who have shared their own experiences. (Mooney-Somers et al., 2009). A whole-of-community approach to delivering sexual health services is therefore essential. Young women, especially, appear to view themselves as educators, having the responsibility to share their awareness, experiences and skills with their peers (Mooney-Somers et al., 2011).

This has been a summary of the themes drawn from the literature focusing on epidemiological and behavioural aspects of Aboriginal young people's sexual health. It has highlighted that Aboriginal young people's sexual health is a complex and multilayered issue that must be addressed through careful and informed approaches. Also identified has been a number of gaps in the current research: a lack of strengths-based approaches; a lack of research undertaken in urban communities; studies being focused mainly on one gender, women; a lack of focus on gender-diverse and sexually diverse people; the lack of a whole-of-community understanding of sexual health; and

the view that Aboriginal communities are homogeneous, no matter whether they are remote or urban.

In my research I am particularly interested in how Aboriginal young people access, value and check sexual health information. For this reason, an examination of the literature on *health literacy* is relevant to determining how Aboriginal young people rate sources of information.

## **2.6 Health Literacy among Aboriginal Populations**

Inadequate health literacy among Aboriginal populations in Australia is directly related to poor health outcomes. An understanding of levels of sexual health literacy among Aboriginal people is therefore needed to better identify why this group experiences disproportionately poorer health outcomes than non-Indigenous Australians. The distinct lack of research focused on Aboriginal health literacy in the area of sexual health must be addressed.

This literature review found that the majority of studies focused on remote communities, and that health professionals in those communities were more involved in giving feedback than were Aboriginal community members. The existing literature that *does* focus on Aboriginal health literacy reveals that sexual health education based on a Western world view is often ineffective, and in some cases has even caused harm (Fforde et al., 2013). As reported in the literature, the differences in world view and understanding of health between Aboriginal and non-Indigenous Australians raise a number of issues that suggest the need for further research. These include whether or not health literature in its current form is appropriate when working with Aboriginal people, and whether or not our understanding of the health literacy of Aboriginal people in remote communities can also be assumed to apply to Aboriginal people in urban areas, who may in fact not understand health in the same way or share the same world view. A better understanding of these issues would allow health literacy to be more appropriately shaped to the target audience.

### 2.6.1 What is Health Literacy?

*Health literacy* can be described as the ability of individuals to access, understand and apply information. The Ottawa Charter for Health Promotion (1986) defines it as the extent to which health information is able to be obtained (from services, formal and informal sources), processed and understood in order to make appropriate health decisions (World Health Organization, 1986). Different authors apply different criteria, and Vass et al. (2011) contend that there are four key domains of health literacy: 1) fundamental literacy and numeracy; 2) science and technology literacy (a knowledge of basic health and scientific concepts, including an understanding that scientific knowledge is constantly changing, and an understanding of how to use basic technology); 3) community literacy (knowledge of information sources, awareness of other agendas, ability to engage in dialogue and make decisions); 4) cultural literacy (recognising and using collective beliefs and customs to interpret and act on health information). A commonly used definition in Australia, offered by Lakhan et al. (2017), is that *health literacy* is an individual's ability to access, understand, critically appraise and apply the information when making health-related decisions, managing illness, communicating with healthcare providers and navigating an increasingly complex and modern healthcare system.

The above definitions of health literacy suggest that it is applicable only at the level of the individual. None of these definitions consider health literacy as a community understanding and approach, which might be more relevant to Aboriginal communities given Indigenous concepts of health and wellbeing, and given how information, understanding and roles are shared within Aboriginal communities and family groups.

### 2.6.2 Historical Impacts on Health Literacy

Colonisation, dispossession of both Country and family, racism and intergenerational trauma have all impacted Aboriginal people, and each of these factors plays a role in Aboriginal people's having lower levels of health literacy. Aboriginal people's previous experiences inform their fear and mistrust of the medical system (Treloar et al., 2013). Fear and mistrust can lead many Aboriginal people to avoid hospitals or doctors' surgeries until their illnesses or symptoms have progressed to an advanced stage

(Treloar et al., 2013). Furthermore, some studies have shown that, when provided with a diagnosis, information or test results, Aboriginal patients report feeling that information is being withheld from them (Davies et al., 2014). The forced removal of Aboriginal children and subsequent impacts on family structures have resulted in parents not being able to pass health knowledge on to their children, so many Aboriginal children have not acquired skills and knowledge around health from their parents (Vujcich et al., 2018). This has a negative impact on Aboriginal people's health literacy today.

The introduction of Christian beliefs to Aboriginal communities and the consequent reinforcement that sex is sinful, and a taboo subject, have also had an impact on sexual health literacy (Vujcich et al., 2018). Discussion of and education about sex were often avoided, and the silence surrounding the subject continues. Indeed, many Aboriginal people feel shame and embarrassment when discussing sex. Social and economic disadvantage also contributes to lower levels of literacy among Aboriginal people. Future approaches to health literacy must be driven by Aboriginal people themselves, must address community mistrust, and must be informed by these issues around literacy.

### 2.6.3 World View: Why a Western Concept of Health Literacy Might not be Appropriate when Working with Aboriginal People

As some authors have identified, what is understood as health literacy has its foundation principally in the Western world view of risk (Vass et al., 2011). This is not always compatible with the traditional Aboriginal world view, in which Western concepts of health are less relevant (Shield et al., 2018). Aboriginal people view their health as being linked to their family and community, rather than as an individual experience. For many Aboriginal people, physical wellbeing and sickness are inseparable from human behaviour, social order and spiritual wellbeing (Vass et al., 2011). The lived experience of most Aboriginal people is cross-cultural, an understanding of aspects of both non-Aboriginal and Aboriginal world views. Therefore, an understanding of both Western and Aboriginal perspectives is needed to ensure that health messages are appropriate.

Taking an Aboriginal world view into account when providing health information is important in ensuring that messages are understood and resonate with the group.

Effective communication between healthcare professionals and Aboriginal communities is achieved by finding the middle ground between Western and Aboriginal world views. Employing an increasing number of Aboriginal people in the healthcare professions is also an effective way to challenge the Western world view, currently predominant in the fields of medicine and allied health.

#### 2.6.4 The Need for a Community Approach to Health Literacy

As described above, the current concept of health literacy in Western society is based on measuring the skills of the individual. This overlooks or discounts the community and collective approach to health literacy common among Aboriginal people and communities. Messages targeted at Aboriginal people are often simplistic and convey only very basic health information. They do not address the core areas of health literacy nor foster the empowerment of Aboriginal people to take control of their individual and communities health (Vass et al., 2011). Participants in one study, 16- to 25-year-old Aboriginal young people from the Northern Territory, Western Australia and South Australia, reported that the current approach to sex education missed the mark; participants said they couldn't relate to the available resources. For example, they believed that Condoman was a source of entertainment, television ads were corny, and that education sessions presented STIs as more serious than they actually were (Senior et al., 2014). Aboriginal young people need to be provided with the skills and understanding to navigate Western public health systems in a way that empowers them to have confidence in the services they attend (Vass et al., 2011). Past health literacy approaches have proved to be significantly more successful when they privileged Aboriginal history and culture and created a sense of pride and empowerment among the community (Vujcich et al., 2018).

*Current* concepts of health literacy, when applied to Aboriginal young people, fail to appreciate their knowledge and experience or to embed this knowledge and experience into targeted approaches. The national approach to health literacy also fails to consider the different world view of Aboriginal communities (Shield et al., 2018). Future health literacy campaigns need to address Aboriginal people's mistrust of mainstream services



and to incorporate Aboriginal traditional knowledge into their teachings.

#### 2.6.5 Improving Health Literacy is not a Quick Fix

The literature shows that campaigns and strategies aimed at raising levels of health literacy among Aboriginal young people need to ensure community engagement and, very importantly, be sustainable over the long term. Health messages must be reinforced, given that positive health outcomes can take up to a decade to be realised within a community (McEwan et al., 2013). Improving literacy in the area of sexual health requires lessening the taboo surrounding discussion of sex, which takes time and sustained effort. Community consultation and engagement during all phases of a campaign is vital for successful uptake within the community. The research literature shows that approaches to raising levels of sexual health literacy in communities are much more effective when implemented at multiple levels, using multiple strategies in multiple settings, and with sustained and adequate funding commitments (Fagan et al., 2015). This results in a holistic approach to increasing community awareness and action, each organisational approach supporting others within the community. Successful outcomes for communities require that they accept, maintain, update and pass on meaningful and relevant health literacy information to following generations to ensure that this information is neither lost nor becomes outdated (Shield et al., 2018).

Significant time and sustained investment is needed to increase health literacy in the area of sexual health, and this involves community-level changes (Fagan et al., 2015). One way this can occur is through the use of online methods of communication to raise levels of sexual health education, allowing information to be accessible to individuals of different ages within the community. This is a sustainable method that can adapt and change with the needs of the community. It also provides a level of anonymity, is affordable and more readily accessible than traditional face-to-face methods.

#### 2.6.6 How Gender Shapes Sexual Health Literacy

Central to spiritual belief systems, laws and cultural values among Aboriginal communities are roles, responsibilities and knowledges based on gender. This is

especially relevant in Aboriginal health. For example, Aboriginal cultures have the notion of *women's business* and *men's business*. These are gender-specific, which means that women and men discuss specific issues separately. With the need to maintain a clear balance between the sexual health knowledge of men and women, one study showed that Aboriginal men would travel hundreds of kilometres to see a male health worker or doctor and ignore promotional material that featured women in any form (Laws & Bradley, 2003). Not being able to see a healthcare professional of the same gender has been shown to be a major barrier to Aboriginal people's attending, or feeling comfortable in, health services (Davies et al., 2014). By agreeing to see only a healthcare professional of their own gender, Aboriginal people limit their potential access to health services, and this can have an impact on their health and even result in instances where individuals are unable to access services at all, or receive any information around health.

The lack of appropriate gender role models and cultural protocols have been identified as negatively impacting the sexual health of Aboriginal young people. For example, Aboriginal men experience high levels of incarceration, which impacts on their ability to play a role in their families and communities, and to pass on health knowledge and skills to their sons (Laws & Bradley, 2003). In one study, some Aboriginal carers reported feeling that, when no same-sex parental figure was available, cultural protocols needed to be relaxed or ignored to ensure that the young people they cared for had a good understanding of sexual health (Vujcich et al., 2018).

Health literacy is an important aspect of sexual health and requires that there is a level of understanding and knowledge around topics that impact both genders. For example, contraception is commonly seen as either the role of males (condoms) or the role of females (the pill, etc.) (Duley et al, 2017). However, both genders are impacted when contraception is not used. With increased health literacy, those participating in sexual activity are better able to negotiate terms that are mutually beneficial, i.e. protecting themselves from unwanted pregnancy and STIs. When taught appropriately to Aboriginal communities, sexual health education programs have been shown to have successful outcomes; groups *are* interested in learning information that is often viewed as the domain of one particular gender (Duley et al, 2017). For instance, Aboriginal men involved in the Strong Family program asked for more information around available

contraception, increasing their own health literacy around ways to avoid unplanned pregnancy (Duley et al., 2017). Sexual health education also needs to be holistic and not simply focus on aspects of physical health.

The literature finds that women who willingly engage in sex, even when in a relationship, are viewed negatively by both men and women, which places women at a disadvantage in their community. A study of Aboriginal young people in Western Australian, South Australia and the Northern Territory found that, regardless of their gender, participants viewed such women negatively and used slurs to describe them (Senior et al., 2020). This same study found that none of the participants viewed sex or desire in a positive manner (Senior et al., 2020). One way to address these issues is through the use of technology. As will be described in the following section, technology is playing an important role in how people access information regarding their health and subsequently make health decisions. It provides a level of privacy and accessibility that allows gendered responsibilities and knowledges to be preserved.

## **2.7 Technology and Promoting Sexual Health to Aboriginal Young People**

This section will provide a brief summary of the role technology has and can continue to play in providing sexual health information and services to Aboriginal young people. As technology plays an ever-increasing role in young people's lives, access to information comes from a variety of different sources. Health messages and ongoing service and support can therefore reach a large number of young people regardless of their location. The use of different forms of technology in general was reviewed in the existing literature, and some of the benefits and disadvantages of each were examined in light of the opportunities these technologies provide to impart sexual health information.

### **2.7.1 Telephone Counselling**

Telephone counselling has been used to provide real-time sexual health counselling and education across large geographical areas, and has been shown to deliver high-quality,

ethical, rights-based and gender-sensitive counselling that is anonymous and can provide personalised information on stigmatised topics (Flink et al., 2018).

Clients receiving telephone counselling for their sexual health needs reported that they felt less shame and stigma than they did when seeking services in person (Ippoliti & L'Engle, 2017). Having access to telephone counselling wherever they were at the time also removed the barrier of needing to travel to attend sessions (Hailey, 2005).

Telephone counselling was typically reported to be quicker, more accessible, more personal, more anonymous, more readily available and less complicated than face-to-face sessions (Price & Dalgliesh, 2013). A study undertaken in Australia with Aboriginal young people found that their limited access to private computer facilities was a likely contributor to their use of telephone services (Price & Dalgliesh, 2013). However, telephone counselling also presented some challenges for Aboriginal young people. For example, Aboriginal young people reported that they were uncomfortable not being able to see the person they were talking to on the phone, and feared they were more likely to be ridiculed after the session (Price & Dalgliesh, 2013). Intergenerational stigma regarding taboo subjects, and around seeking support outside the community, also resulted in young people being hesitant to access telephone counselling services (Price & Dalgliesh, 2013). However, since this study was undertaken in remote communities, it may not represent the feelings of urban Aboriginal young people.

Health professionals, on the other hand, reported that using telephone counselling allowed them to deliver specialised services without the need to relocate or travel (Hailey, 2005). This lessened the difficulties of hiring and retaining skilled staff to work in the relevant communities (Hailey, 2005). Professionals also needed to decide if services would be anonymous, or if appointments would be required to ensure that relevant personal information could be collected from the client. Anonymous telephone counselling could make it difficult or impossible to fulfil the mandatory reporting requirements if a disclosure happened to be made (Chester & Glass, 2006).

### 2.7.2 Email Counselling

Email counselling was another reported method of technology-based sexual health consultation. It allowed clients and professionals to be involved in the counselling

sessions at different times (Mishna et al., 2015) and also created a permanent and chronological record of the counselling sessions for both client and professional. Being able to easily reread the contents of a session may be beneficial for clients, allowing them to identify approaches that they had previously used. Rereading in a different frame of mind might also provide greater clarity and understanding (Dunn, 2012). However, this convenient record did create a greater risk of a breach of confidentiality, since emails left open on a client's shared computer might be read by others.

Clients receiving counselling via email reported the benefits as being the opportunity to receive support when they were not motivated to leave the house, when they were travelling or when it was difficult to fit counselling sessions into a busy schedule (Mishna et al., 2015). Counselling via email also allowed clients a greater sense of privacy and to feel more comfortable and less threatened when sharing sensitive or embarrassing information (Dunn, 2012). The use of a password on each Word document attached to the email went some way to addressing participants' privacy concerns (Dunn, 2012). Having to respond to an email also allowed them time to stop and think about their response and their reaction to the practitioner's messages, and users reported that this allowed them to remove their first reaction and emotions from their response before it was sent if they changed their mind (Dunn, 2012). This does raise questions about whether people are being honest in their responses or edited messages; sanitising them could hamper the quality of counselling. Some young people reported having a negative view of email support due to the extended response time that resulted, and the anxiety around waiting for the response (Shoveller et al., 2012).

Studies among non-Aboriginal communities have shown that practitioners providing counselling services via email can be frustrated by the limitations of the written medium, for example not being able to build a connection with clients and not being able to adequately express their emotions to clients (Mishna et al., 2015). Counsellors have expressed lower satisfaction with email consultations as they did not mimic natural conversation and it was difficult to engage with clients (Mishna et al., 2015). However, email counselling sessions did allow practitioners to respond to their clients at convenient times and to look after a greater number of clients at the same time (Dunn, 2012).

### 2.7.3 Short Message Service (SMS)

Short Message Service, more commonly referred to as SMS, or texting, has been commonly used in countries around the world to improve young people's sexual health knowledge and engagement with services (Ippoliti & L'Engle, 2017). It is a cost-effective, efficient and highly suitable communication channel for reaching large numbers of young people (Ippoliti & L'Engle, 2017). Health promotion messages sent via SMS can reach healthy individuals who are not regularly in contact with health services. And SMS also offers a confidential, non-confrontational means of communication when issues under discussion are socially sensitive (Gold et al., 2010), reducing shame and stigma for young people when accessing information and services (Ippoliti & L'Engle, 2017).

A study looking at Aboriginal young people in Australia found that men viewed counselling via SMS as less of a commitment and less daunting than other forms of counselling (Price & Dalgliesh, 2013). SMS interventions were found to be effective at creating short-term change in participants (Gold et al., 2010). While participants of an Australian study reported that receiving sexual health messages via SMS had no direct impact on their behaviour, it did reduce their apprehension and allow them to gain a better understanding of texting (Gold et al., 2010). Recipients had a preference for messages that were short, positive and relevant, and that covered a variety of topics (Gold et al., 2010).

Having professionals using SMS to provide sexual health education and services allows specific geographical areas to be targeted with relative ease (Ippoliti & L'Engle, 2017). The limitation of this approach is the lack of two-way communication, with recipients of educational messages generally unable to respond to seek further information or clarification (Gold et al., 2010). There was also a significant risk to confidentiality when some young people might be sharing phones (Ippoliti & L'Engle, 2017), an issue that has not really been addressed in past studies. SMS could also be used as a hook to get individuals thinking and discussing their sexual health with a service. The research suggests that the most effective sorts of text messages are funny, rhymed and/or tied into particular annual events (Gold et al., 2010), ensuring that they are remembered and

shared. Reaching a wide-enough audience and including sufficient educational content in an SMS, however, can be challenging for professionals.

#### 2.7.4 Video Conferencing

Video conferencing is a live visual and audio connection between two or more people in different locations. It allows services to be offered face to face without the traditional need for the client and practitioner to travel to the same location. The equipment and technology used for video conferencing can vary from sophisticated webcams to mobile phones, depending on resources available.

Clients of counselling via video conference have reported high satisfaction, with some individuals reporting that they preferred the medium to traditional face-to-face services (Winters & Winters, 2007). Since some Aboriginal people have reported that not being able to see the person from whom they are receiving counselling and support is a barrier to accessing services outside of their community (Martin et. al, 2017), the use of video-conferencing sessions might remove this barrier. In one study, in which internet services were supplied to remote Aboriginal communities in the Northern Territory, email and web browsing were embraced by the communities. However, participants' feedback was that they would prefer to see the person they were speaking to, and video-conferencing capabilities were requested as an alternative (Morrison, 2000).

A notable theme of the studies reviewed was a consistent call from Aboriginal communities to provide video-conferencing services as preferable to other distance media services such as email and telephone. For patients and their families, the availability of video-conferencing services results in reduced travel time, less time off work, reduced financial burden, reduced wait time, a better quality of life, increase consumer choice and an improved sense of privacy (Hailey, 2005). Communities that were unfamiliar with the technology were also been shown to have become familiar and comfortable with it in a short period of time (Eriks-Brophy et al., 2008).

Recruiting healthcare professionals in certain regions can be a lengthy process with a high turnover rate (Eriks-Brophy et al., 2008). By providing services via video conferencing, professionals can provide a form of face-to-face service without the need

to relocate or travel long distances (Eriks-Brophy et al., 2008). Professionals using video conferencing to work with clients have reported high levels of satisfaction with both the information being transmitted and the ability to connect with clients (Minichiello et al., 2013). When clients can see the person they're talking to, a connection is made with the community and this helps to build trust and give the professional a trusted presence in the community (Martin et al., 2017).

#### 2.7.5 Internet Forums, or Message Boards

An internet forum, also known as a *message board*, is an online discussion site that allows people to engage in group conversations by typing in messages. It differs from a chat room in that messages are generally longer and the discussion is archived, although the amount of archive time varies. The benefit of using an online forum to provide sexual health information to young people is that the online platform can reach a large number of people with very little effort (Korda & Itani, 2013). However, as with any forum in which peer-sourced information is shared, there is also the risk that any myths or misinformation around sexual health will be more easily spread (Minichiello et al., 2013). Practitioners need to be aware of this risk and work to ensure that these are addressed by giving young people information in a form that is easy to understand.

Another downside of a message board, if the forum is not sufficiently anonymised, is a lack of privacy for someone asking a question, since everyone taking part can see both question and response. Young people have reported fearing that their question could be traced back to them (Shoveller et al., 2012). One study exploring the perspectives of young people regarding online sexual health services found that while young people would read a forum, they were unlikely to actively participate (Shoveller et al., 2012). Privacy was a major concern of young people when asking questions to deal with sexual health. Fears about the reactions of their peers and families created a barrier to seeking support (Chester & Glass, 2006). Aboriginal young people appear to be particularly concerned with privacy and confidentiality, perhaps due to the history of government intervention in their communities. For example, they fear that their questions might elicit responses from child protection authorities (Price & Dalglish, 2013). Young people also report privacy concerns around the need to create an account and username



to participate in a forum; this was a hassle that further prevented them from engaging with the medium (Shoveller et al., 2012).

From the point of view of the practitioner, using an online forum to engage with clients can also create issues that need to be considered and addressed. Due to the anonymous nature of forums, the mandatory reporting requirements for professionals if a disclosure is made can be difficult or impossible to fulfil (Chester & Glass, 2006). Practitioners also need to ensure that they are upfront about the purpose of being on the forum, and to build trust and use language appropriate to the audience (Shoveller et al., 2012). The frequency with which participants come and go from forums also requires that practitioners remain up to date in their knowledge to reach the largest audience possible with information that is relevant (Korda & Itani, 2013). When an online forum has a large audience, practitioners also need to be aware that the laws and cultural and societal norms and beliefs of participants will be different depending on the country or state where they live (Chester & Glass, 2006). When practitioners are responding to questions or creating an informative thread to help participants make informed decisions, they need to be clear about where they themselves are located and also need to alert participants to the fact that the information may not be relevant in other places.

#### 2.7.6 Chat, or Instant Messaging

Chat, also known as instant messaging, is a written form of communication over the internet. Users can communicate in groups of two or more in real time by typing their message and hitting 'send', which then allows it to be read. Chat rooms, where the communication takes place, can be either private or public. Due to the instant nature of chat, written messages are typically short and abbreviation is often used to reduce response times.

Clients who access counselling and support via chat have reported a number of benefits of chat sessions, including convenience and accessibility. Not needing to book a session has been identified as a major advantage of counselling via chat. Clients can access support, without having to wait, when they are most motivated or currently in crisis (Rodda et al., 2013). Clients have also reported that they can talk more openly and honestly via text, without the fear of being overheard (Rodda et al., 2013). Disclosing

sensitive and embarrassing information in written form was also reported to be easier (Chester & Glass, 2006). As mentioned earlier, a study undertaken in Australia found that Aboriginal young people were uncomfortable not knowing whom they were talking to. Being unable to see the counsellor resulted in the individual's feeling that they would be judged and ridiculed by the counsellor after the session ended (Price & Dalgliesh, 2013). Further research is therefore required into the most comfortable way for Aboriginal young people to engage with services. Some clients of chat counselling have reported difficulties in understanding the meaning of the counsellor's messages because of literacy and language barriers and the speed of responses (Rodda et al., 2013). Young people have also reported that using chat allows them to hide, or control, the information they are giving to counsellors, because counsellors are unable to see the facial expressions and body movements that might give away their distress (Shoveller et al., 2012).

Counselling via chat has been associated with a decrease in clients' defensiveness, as the environment creates an illusion of privacy that reduces the perception of risk and allows the client to share more than they would in person (Chester & Glass, 2006). When working over chat, practitioners need to be aware of transference – the client transferring their emotions to the practitioner, as the result of being perceived as fantasy by the client. Practitioners need to be aware of when the need to refer their client to a new counsellor if this form of transference takes place (Chester & Glass, 2006). Due to the anonymous nature of chats and the possibility that clients may be taking place in a different state or country, practitioners need to be mindful of their legal and ethical obligations in providing support (Chester & Glass, 2006).

## **2.8 How Technology Can Have an Impact**

Many barriers face Aboriginal young people seeking services – shame, fear, intergenerational stigma, limited awareness of services and what they offer, fears around confidentiality, misunderstandings, fear of ramifications of contact with government (such as intervention by child protection services, etc.), ostracism by the community, fear of discussion of taboo subjects and of family members finding out what is discussed in a session (Price & Dalgliesh, 2013). Among Aboriginal young

people there is also concern that mainstream services lack understanding around the issues they face (Price & Dalglish, 2013). Breaking down the societal expectation that men should be tough and silent would allow Aboriginal young men to feel more comfortable seeking help, since many feel they need to *toughen up* rather than seek support (Duley et al, 2017). The use of technology to deliver services to Aboriginal young people may give a greater sense of confidentiality, which may result in increased access. It is clear that the decision to use any form of technology needs to take into account the confidentiality and privacy concerns of the group, weighed against the benefits of providing better access to services (Dunn, 2012).

Technology, always changing rapidly, is playing an ever-increasing role in people's lives and is also increasingly being used by services. Its use can break down some of the barriers young people experience to choosing to seek support or information.

## **2.9 Conclusion**

This chapter has focused on: 1) Aboriginal sexual health; 2) Aboriginal health literacy; and 3) the role of technology in improving access to services. A number of main themes have emerged. These include the main focus on deficit approaches in past research, the inadequate understanding of health literacy in Aboriginal communities, the continued taboo nature of sexual health issues and the shame associated with accessing services, power imbalances when negotiating sexual health within relationships, the need to find ways to better engage men, and the lack of representation of urban communities in Aboriginal research. In each case there is a gap in the current literature that I intend to address in my own research.

This chapter has: 1) identified the issues impacting on Aboriginal sexual health; 2) looked at the role health literacy plays in accessing information in Aboriginal communities; and 3) identified how technology can be used to support Aboriginal young people in an urban area to access sexual health information.

Because of the paucity of studies that focus on Aboriginal people living in urban areas, the experiences and needs of these Aboriginal young people have been overlooked. Further research is needed in urban areas to identify both the capabilities of these

communities and the issues and barriers they face when dealing with sexual health issues.

This literature review reveals that research undertaken in Aboriginal communities is often approached from a Western viewpoint. In fact, the concept of health literacy itself is heavily based on Western concepts. This fails to take into account the holistic nature of Aboriginal sexual health, the connections between the health of the family, community and individual. Mainstream approaches and programs provided for Aboriginal people have ignored their culture, history and need for empowerment. Western viewpoints have also often overlooked the existing achievements and skills in Aboriginal communities and the actions young people have already been taking to look after themselves and others. My research will be approached from the standpoint of a move away from the Western viewpoint of individualisation to embrace a holistic community approach to the sexual health of urban Aboriginal young people.

The literature review has shown that Aboriginal women are more engaged than Aboriginal men with research, services and community. Further research is needed to better understand why Aboriginal men are less involved with sexual health services and with the management of their sexual health. All participants engaging in sexual activities need to be responsible for their own, and their partners', health and wellbeing. The power disparity between genders needs to be understood to address the disadvantage Aboriginal women experience when attempting to negotiate safer sexual practices and their expectations of a relationship.

Another common theme that has emerged from the literature is that it is often others in the community or the authors of research projects who speak for Aboriginal young people. A better approach is to give Aboriginal young people the chance to share their own experiences and to shape the research themselves to ensure that it reflects their own experience. When parents and community members speak on behalf of Aboriginal young people about their sexual health needs, they bring the influence of their own values, experiences and ideas. A lack of Aboriginal young people's voices in research, and their lack of control over its direction, may also impact the effectiveness of programs and policies that have been implemented by the community to help them.

### **Chapter 3: Methodology**

This chapter gives an outline of the methodology of this research project. It provides information on the research questions and objectives, the Indigenous research paradigm, and the selected design, methods and method of data analysis. The procedures that were followed to involve the peer researchers in data collection are also described. Ethical issues and guidelines for working with Aboriginal communities are discussed. As an Aboriginal researcher, I will position myself in the research.

#### **3.1 Research Questions and Objectives**

The main goal of this research was to explore the ways in which Aboriginal young people in an urban setting access, value and fact-check sexual health information for themselves and others, and the role that online resources and information sources can play in this. The specific research questions were:

1. What sources of information are used by Aboriginal young people in urban areas to access sexual health information, including online sources, friends, families and health services?
2. What are the reasons for Aboriginal young people in urban areas accessing sexual health information from these sources?
3. How is technology being used by Aboriginal young people to support their information seeking around sexual health issues?
4. How could technology be used better or differently to support Aboriginal young people's information seeking around sexual health issues?

With a focus on these questions, the research sought to achieve the following objectives:

1. To give Aboriginal young people in urban communities a voice regarding the management of their sexual health and how they access and receive sexual health information; and

2. To identify in which settings technology can be used to increase urban Aboriginal young people's access to accurate and reliable sexual health information.

These research questions link to the gaps exposed by the literature review by ensuring that Aboriginal young people are given their own voices throughout the research. My research also views health literacy differently compared to the existing literature because I view it as a cultural and community issue by recognising that informal sources of sexual health information are viewed within culture as a valid and very important method of receiving education and knowledge. The community capabilities are seen within the rationale that the young people give for why they choose to access specific sources of information.

### **3.2 Research Paradigm**

The research paradigm followed in this study draws upon Martin Nakata's Cultural Interface Theory (2002) to position both myself and the participants. Cultural Interface refers to the way that me and the research participants, as Aboriginal people, navigate our everyday lives in two worlds: Western and Indigenous. Cultural Interface Theory helps me to understand the world view and experiences of the participants, which is essential to the choice of research questions and method of data analysis (Nakata, 2002). In addition, Martin & Mirraboopa (2003) help me to understand why peer-led interviews are the best choice for the collection of data, as they are similar to 'yarning', thereby allowing Aboriginal Ways of Doing to be a central part of the research.

#### 3.2.1 Positioning of Self

As an Indigenous researcher, it is important that I situate myself within the research. I am a Kamilaroi woman and grew up on Country in several predominantly white, small NSW towns, so have seen firsthand the impact that lack of access to health services can have on many people. This experience informed my decision to undertake a research degree and add to my previous university qualifications, namely a Bachelor of Arts, Master of Social Work, and Master of Science in Medicine (HIV, STIs and Sexual Health) (Counselling). My previous employment in community organisations,

government departments and Aboriginal community organisations also informed the decision to undertake further study.

I draw upon Martin Nakata's Cultural Interface Theory (2002) to position myself both as a researcher and in everyday life at:

“the intersection of the Western and Indigenous domain ... the place where we live and learn, the place that conditions our lives, the place that shapes our futures and more to the point the place where we are active agents in our own lives – where we make decisions – our lifeworlds.” (Nakata, 2002, p. 285).

This intersection of the Western and Indigenous domains has shaped my decisions to apply for and accept the jobs I have undertaken, as well as my decision to pursue further study, which has led to this research project. The focus is on how technology can be used within a *strengths* framework so that Aboriginal young people can make informed decisions for better sexual health outcomes.

I also draw upon the work of Martin & Mirraboopa (2003), which positions research as predominantly a Western practice and concludes that an entirely Aboriginal research framework is not possible. Aboriginal Ways of Knowing, Ways of Being and Ways of Doing can, however, be merged with aspects of Western qualitative research. This is evidenced in the research being conducted not *on* Aboriginal young people, but *with* Aboriginal young people. The priorities and strengths of Aboriginal young people can be privileged in their own voices.

“...as an Aboriginal researcher ... I actively use the strength of my Aboriginal heritage and do not position myself in a reactive stance of resisting or opposing western research frameworks and ideologies. Therefore, I research from the strength and position of being Aboriginal and viewing anything western as 'other', alongside and among western worldviews and realities” (Martin & Mirraboopa, 2003, p. 205).

When interacting with the data I draw on Aboriginal Ways of Being, Knowing, and Doing (Martin and Mirraboopa, 2003) as their familiarity is a strength to me as they are what I have done throughout my life. By drawing on Aboriginal Ways of Being, Knowing, and Doing I am able to use my reasoning, ethical values and cultural values to carry out research. This allows me to interact with the data by being my own self, in a

genuine and respectful way while remaining faithful to the stories told by the participants in this research. As an emerging Aboriginal researcher who is engaging with an Aboriginal community through research, I aim to give a platform for multiple voices, perspectives, ideas, thoughts, and truths to be heard through the stories told and the data collected.

My research paradigm was guided by a constructivist approach as defined by Blaikie (2007). Blaikie states that meaning is constructed as the result of the observer's engagement with it. There is no one reality or truth; it, meaning, is local and specific in its construction and is made up of a number of co-created realities. The paradigm argues that people create their own identities from interaction with the people around them and the depictions they are exposed to through the media, their community and society (Denzin & Lincoln, 2008). As a result, people view the world differently depending on their community and social settings. These realities are made either by individuals or groups. The constructivist paradigm assumes a relativist being, as there are multiple realities and a subjectivist knowing (only the individual can decide on what is true for themselves) (Blaikie, 2007). This research paradigm allows for the research to be shaped by the participants' cultural values and ways of living, appropriate to this study to ensure that Aboriginal young people were able to tell their own stories in their own words in a culturally safe setting to people who shared their world view and experiences. This approach also allowed the research to focus on the strengths of Aboriginal young people rather than on any deficits, which differentiates it from the more common deficits-based approach to research with Aboriginal people.

### **3.3 Working with Aboriginal Communities**

This research has adhered strictly to nationally recognised guidelines for ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities as set out by the National Health and Medical Research Council (NHMRC) (NHMRC, 2018). The guidelines clearly state that ethical research conducted with Aboriginal people should:

- 1) Improve the way researchers work with Aboriginal people and communities;



- 2) Provide Aboriginal people and communities the capacity to develop and strengthen their own research skills and capabilities; and
- 3) Enhance the rights of Aboriginal people to be researchers, partners in research, collaborators and participants in research.

This was achieved by adhering to the six core values of research, described in full below: 1) Spirit and Integrity; 2) Cultural Continuity; 3) Equity; 4) Reciprocity; 5) Respect; and 6) Responsibility.

### 3.3.1 Spirit and Integrity

*Spirit* refers to the ongoing connection and continuity between Aboriginal peoples' past, present and future generations. *Integrity* refers to the respectful and honourable behaviours that hold Aboriginal values and cultures together (NHMRC, 2018).

In my research I ensured that Spirit and Integrity were addressed by making that young people were asked about culture and Elders in their interviews to acknowledge that the older generations guided and influenced Aboriginal young people. The skills of Aboriginal young people were also highlighted to show how future generations could benefit from their skills and knowledge. In addition, expectations for Integrity were met by ensuring that members of the Aboriginal community were involved in all stages of the process. Integrity was also demonstrated by the research team in taking care to follow the NHMRC guidelines.

### 3.3.2 Cultural Continuity

*Cultural Continuity* promotes a resilient, shared and enduring identity for the individual and the collective. The bonds between people and the bonds with the environment are central to the preservation of culture (NHMRC, 2018).

Aboriginal people have historically experienced research as exploitative and deficit-focused with few positive outcomes for their communities (Fforde et al., 2013). Given my understanding of Aboriginal people's experiences and perception of research, the project was designed to ensure that the community was not exploited. The strengths-

based approach of this research aimed to highlight what Aboriginal young people did well when it came to sexual health, and the existing strengths within the community. Members of the local Aboriginal community were involved with the research, from the development of the research outline to the collection of data. The peer researchers were community members and assumed the role of identifying and interviewing the young participants to capture their experiences. And, in the process, the peer interviewers were able to gain useful work experience themselves

### 3.3.3 Equity

*Equity* refers to the commitment to ensuring that the Aboriginal community in which the research was undertaken receives a share of the distribution of benefits from the research (NHMRC, 2018).

As an Aboriginal researcher, it was absolutely paramount for me that this research that I designed and implemented, fit within the framework provided by the broader Australian Research Council (ARC) funded linkage grant (“Fostering Aboriginal sexual well-being by building on strengths”, no. LP170100190), closed the equity gap. Giving Aboriginal young people a voice in the research was empowering and counteracted the deficit discourse that has been so common in previous research. Peer researchers were employed to promote group voice and community efficacy, and to lessen structural disparities in the interview process. As subjects of research, young people are often silenced, ignored or not consulted about matters central to their lives (Gomez & Ryan, 2016). In this project, peer researchers had the opportunity to identify members of the community to interview, which reduced community gatekeepers who might have felt it their responsibility to protect young people from the research, and who are known often to draw in the same sample of the population, which results in a study having limited scope (Couch et al., 2014).

#### 3.3.4 Reciprocity

*Reciprocity* recognises the contribution of all research partners and ensures that the benefits from research outcomes are equitable and valuable for Aboriginal people and communities (NHMRC, 2018).

The broader ARC-funded research project is founded on the principle of reciprocity, and this has also translated to my Masters by Research project. During this research, members of the Aboriginal community were trained as peer researchers and had the opportunity to gain research and teamwork skills. Peer researchers also had the power to shape the interviews via the use of follow-up questioning where they felt more information or clarity was needed, to elicit knowledge which in their opinion could have the greatest impact on their friends and community. They also gained employment experience, learnt about research and advocacy, and were empowered to make change in their own community (Gomez & Ryan, 2016). I observed this personally. Several peer researchers decided to embark on university studies after they finished their HSC. During the research process they had learnt more about universities, including what university teaching was like and the sorts of opportunities that were available. This will provide benefits to Aboriginal communities way beyond future implementation of the research findings.

#### 3.3.5 Respect

Having *Respect* is having concern for the welfare, rights, knowledge, skills, beliefs, perceptions, customs and cultural heritage of Aboriginal people (NHMRC, 2018).

Showing respect was a key principle of my research. The trust, openness and engagement of young participants was increased by the use of peer researchers. The use of peers to conduct interviews allowed participants to be open in their responses while using language and jargon they were comfortable with and that was familiar to their peers (Price & Hawkins, 2002). Peer researchers and participants were also given the opportunity to express their views about issues of sexual health without the risk of being judged by an adult or authority figure.

### 3.3.6 Responsibility

According to the National Health and Medical Research Council (2018) the notion of *Responsibility* among Aboriginal people includes caring for Country, kinship bonds, caring for others and maintaining the harmony and balance between the physical and spiritual realms. An individual's responsibilities are not limited to themselves alone but also relate to both their family and community (NHMRC, 2018).

This important principle guided the conduct of this research. Members of the Aboriginal community were involved with the development of the research plan, determining the purpose of the study and the gathering of data. Peer researchers were provided with training and continued support throughout the data-collection period.

## **3.4 Ethical Considerations**

To ensure that this research met the NHMRC ethical guidelines, ethical consideration was given to the process of obtaining informed consent, methods of data management, the minimising of possible adverse effects, ways of community engagement and the dissemination of research findings. I will address each below. Ethics approval was obtained from the Aboriginal Health & Medical Research Council of NSW (AH&MRC). An ethics amendment was submitted to the AH&MRC Ethics Committee in February 2020 so that I could be added to the approved research team for the ARC-funded project titled "What we do well: Stories of love, sex and relationships" and be granted access to the data which formed the larger project that my own research is attached to. This was approved on February 17, 2020.

### 3.4.1 Informed Consent

For young people to be able to provide informed consent, participants are required to have ample information about the study process and appropriate levels of cognitive capacity to make informed decisions. They must also be free from coercion when making the decision whether or not to participate (Hildebrand et al., 2015).

All participants' written consent forms were collected by the peer researchers before first interview. Participants were given the opportunity to ask questions and clarify any points before signing the document. It was clearly explained to all participants that their participation was voluntary and that they could withdraw their consent at any time.

In the case of participants aged 16 and 17 years, no additional consent from a parent or guardian was required, as they were considered *mature minors* for the purpose of this research and the interviews did not require them to talk about their own personal sexual experiences (the peer researchers used a *third-person* interviewing technique). The *mature minor* concept in research states that young people of this age have the autonomy and decision-making capacity to choose for themselves whether or not to take part in research, and can understand and provide informed consent in a written form (Hildebrand et al., 2015).

#### 3.4.2. Data Management

All interviews (and debrief sessions) were recorded on a digital recorder, and these recordings were transferred to the University of New South Wales (UNSW) password-protected server as soon as possible. As soon as each recording had been transcribed into a Word file (by me, the principal researcher), the file was erased from the recording device. Each interview transcript was verified and de-identified, then stored on a secure, password-protected UNSW network drive. Access to all files was restricted to members of the research team.

#### 3.4.3. Possible Adverse Effects on the Participants

While every attempt was made to reduce risk, there was the possibility that a participant would become distressed when discussing personal matters around sex and relationships. Negative experiences for participants were avoided as much as possible by ensuring that the third-person interviewing technique (participants describe their views of the sexual experiences of "people like them" and were not permitted to tell personal stories or relate stories about individuals) was followed at all times. Also, interviews were designed to focus on positive experiences relating to sexual practice,

decision-making and relationships. Subject matter that may have been difficult for participants to discuss were off limits, including sexual assault, abuse and sex below the age of consent. A procedure was put in place in case any participant became distressed, which was to connect them with an appropriately trained Aboriginal member of staff who could ensure that they received the required support. However, this procedure was never needed; no distress was reported to the research team. Participants were also given a Participant Information Sheet with contact information for support services in case they wished to seek support on their own behalf.

Due to the unique data-collection method (i.e. peer researchers conducting interviews with individuals from their own personal networks) there was the risk of a breach of confidentiality. The four-day interviewer training included sessions on confidentiality to ensure that peer researchers were aware of the risks and consequences of any breach of confidentiality. Training was also provided to emphasise the importance of the third-person approach to interviews and the *no names* rule, such as no names of people, places or anything that could be identifiable.

#### 3.4.4 Community Engagement and Sharing Findings

An Indigenous Research Advisory Committee (IRAC) was specifically established as a component of the broader research study to review and endorse any publications or other research output, and to provide advice on issues of sensitivity to the Aboriginal community. In consideration of Indigenous people's right to self-determination, it is essential that Indigenous people have full and fair participation "in research projects that concern them, share an understanding of the aims and methods of the research, and share the results of the work" (AIATSIS, 2012). The project had several governance structures in place to ensure community control of the research. The investigating team involved seven Aboriginal people. The team oversaw the research processes, made all major decisions with regard to research and ensured that project milestones were met.

Members of the IRAC guided community safety and cultural appropriateness by reviewing all research materials, interviewer training materials and research output. All members of the IRAC who were not UNSW staff members were paid \$50 per hour for their time, including time spent in meetings and up to four hours of preparation time.

The committee was headed by Professor Reuben Bolt, an investigator on the larger project. Any findings that were to be presented at conferences or in journal publications would be sent to the IRAC for approval.

### **3.5 Methods**

#### **3.5.1 Research Design**

The research was designed to adopt a qualitative approach, using peer-led interviews with 24 Aboriginal young people in Western Sydney. Peer-led interviews allowed me, as the researcher, to gain a more in-depth understanding of the experiences of Aboriginal young people living in an urban setting. Qualitative interviews allowed for more in-depth responses by participants in their own voices, focused on what was important for them and their community. Qualitative research methods lend themselves to an Aboriginal way of doing research because of their similarities to *yarning* (Martin & Mirraboopa, 2003). The use of qualitative peer interviews in this research project was ideal and had four major benefits. Firstly, following the constructivist paradigm, qualitative methods focused on the opinions, thoughts and feelings of participants, thereby producing data that could show how people's experience was constructed (Blaikie, 2007). Secondly, qualitative methods allowed for a range of positions and perspectives to be examined (Grbich, 1999), allowed Aboriginal young peoples' experience to be identified and their sexual experiences and knowledge to be defined. Thirdly, participants were able freely to disclose their experiences, thoughts and feelings during interviews with the peer researchers, and there could be follow-up to encourage more in-depth answers (Denzin & Lincoln, 2008). And fourthly, each participant was able to frame their own life experiences, beliefs, values and behaviours, which, along with the people around them, influenced how they interpreted situations (Grbich, 1999). Their life experience then shaped how they viewed sexual health and access to services.

By applying Cultural Interface Theory, I was better able to understand the world view and experiences of the participants in my research (Nakata, 2002). Qualitative peer-interviewing methods allowed participants to highlight how they and their peers managed risks to their sexual health, supported each other and shared information about

their experiences, knowledge and contact with service providers, and contributed to the objective of ensuring that Aboriginal young people were given a voice in research.

### 3.5.2 Why Qualitative Peer Interviews?

One of the main strengths of the peer-interview method is that it gives young people a voice whether they are in the role of peer researcher or participant. When taking part in research projects, young people are often silenced, ignored or not consulted by adults and researchers about matters central to their lives (Gomez & Ryan, 2016). Adults often speak for the young people in their community, in their role either as parents, service providers or concerned community members. The use of the peer-interview method can empower participating young people by allowing them to voice opinions and experiences in an environment where any power imbalance between the researcher and themselves is minimised (Lushey & Munro, 2015). Minimising the power imbalance is thought to reduce bias and enhance the quality of the data collected (Lushey & Munro, 2015). Response rates among participants also increase, with participants being more willing to talk to their peers about particular subjects than they would be to adult researchers. Peer interviews can also produce more in-depth responses from participants (Gomez & Ryan, 2016). It is theorised that when young people are interviewed by an adult, they will give different accounts of social life and behaviour than they would to a peer. The higher level of trust and familiarity they experience talking to a peer allows them to open up more (Price & Dalglish, 2013). Peer researchers can therefore generate responses to questions on sensitive topics from hard-to-reach populations that adult interviewers are not able to (Bradbury-Jones & Taylor, 2015).

Another important strength of the peer-interview method is that it builds on existing trust within the community. Building trust and rapport with a community and participants is a key part of researching a group's social lives and experiences (Price & Hawkins, 2002). For researchers from outside a community, it can be a long and difficult process to gain trust (Isaacs et al., 2011). However, *insider researchers*, such as peer researchers previously known to the participants, provide a level of comfort and trust that researchers from outside the community cannot (Lushey & Munro, 2015). In addition, the use of peer-led interviews to collect data reduces embarrassment and



shame when participants are talking about subjects relating to sex (Lushey & Munro, 2015). Peer researchers are also more familiar with the language used by young people and the context of their experiences, allowing for a better understanding of what is said in the interviews (Elliott et al., 2002).

A peer researcher's ability to identify participants through their own networks allows for the collection of data from more diverse networks within a shorter period of time (Elliott et al., 2002). This is a *variation on snowballing*; rather than participants identifying individuals to take part in the study, peer researchers take on the role. This allows access to more young people in what can be a difficult-to-access population (Grbich, 1999). Working with peer researchers benefits both the researcher and the community by enabling more Aboriginal young people to shape the research that may have an impact on them.

One potential problem with the peer-interview approach is that there are often people in the community who take on the role of gatekeepers. These are community members who control the researchers' access to participants. If only a small number of community gatekeepers is approached to gain access to participants, this can result in the same sample of the community being used repeatedly as subjects for studies, which provides limited scope for new data to be collected (Couch et al., 2014). Adults in the role of gatekeepers, in this case identifying young people to become peer researchers, can also feel it their responsibility to protect young people from participating in research, a responsibility that can be taken very seriously in communities that have experienced past mistreatment from researchers (Couch et al., 2014).

Gatekeepers play an important role in protecting the community from research that may take advantage of the participants. Therefore researchers must work with these respected members of the community to identify that the choice of participants is appropriate.

### 3.5.3 Data Collection

Data for this research was collected in December 2019, as part of the larger ARC-funded project titled "What we do well: Stories of love, sex and relationships". For the

purposes of this thesis, a specific subset of data was used. While interviews covered the topics of sexual wellbeing, relationships, family, and community and cultural strengths, my thesis focuses on analysis of the data relating to young people's beliefs about and experiences with the use of technology in sexual health education and services.

Data was collected using the peer-interview method, as described above, specifically designed to be implemented with marginalised young people because it gives them a voice in their own future and the future of their community (Gomez & Ryan, 2016). Peer researchers were members of one of the local communities taking part in this research. Eight peer researchers were selected from differing family groups, and each had a different level of education and different experiences. They were selected in consultation with staff from the local Aboriginal health and social service organisation and were identified based on having an interest in the research topic and a wide range and variety of networks.

To ensure cultural expectations were met regarding the norm to discuss sexual health issues only with a person of the same gender, three male and five female peer researchers were selected. Peer researchers undertook four days of training before data collection began. Training involved learning about the practical and ethical aspects of research, including consent, voluntary participation, confidentiality and anonymity, secure data management, guidelines for selecting and approaching potential interviewees, qualitative interview skills, and the uses and purpose of qualitative data. Various activities aimed at learning about sexual health issues as a subject of research.

By joining the research team, the eight peer researchers gained research and teamwork skills and employment experience, and learnt about research and advocacy within their community (Gomez & Ryan, 2016). This adhered to the NHMRC ethical guidelines in research with Indigenous communities with regards to capacity building (NHMRC, 2018).

Peer researchers also had the chance to learn about the power dynamics between researchers and participants and the challenges this created, and helped to identify how the present power relationships could be better balanced to result in better outcomes for researchers, participants and the community (Bainbridge et al., 2013). Peer researchers

were paid as UNSW research assistants at a rate of \$30 per hour during all training sessions, and while conducting interviews and taking part in debriefing interviews.

Each peer researcher was interviewed by a member of the research team first, after which the peer researcher recruited three of their peers to become participants in the research. Three separate interview meetings took place between the peer researcher and each of the three participants during which the interview was digitally recorded. Each of the three interviews explored a different subject: 1) Resources for staying healthy – the cultural strengths, resources and ideas young people use in order to make positive sexual choices; 2) Sexual relationships – how sex and relationships are understood by young people, the choices they make, the significance attached to choices, and identification of the ways in which young people stay healthy, protect themselves and solve problems; and 3) Using health services and other health education/promotion to understand their views about, and experiences with, sexual health promotion and healthcare services and what services and approaches work well from their perspective. The third topic of interviews, which came from the ARC-funded project “What we do well: Stories of love, sex and relationships” was the focus of this Master’s research. Interviewees talked about the role of technology in providing access to sexual health services and how they had used forms of this technology themselves.

After each interview with a participant, the peer researcher who had conducted the interview took part in a recorded debriefing interview with a member of the research team. During this session the peer researcher and member of the research team listened to the recording of the interview so that clarification could be sought by the research team about emerging themes, and tips and feedback could be provided to the peer researcher about their interview technique and the content of the interviews.

Each debrief interview took place between peer interviewer and a member of the research team. Individual debrief interviews took place after each interview that the peer researcher conducted with a participant. All debrief sessions were audio recorded and involved listening to the audio recording of the interview between the peer researcher and participant. During the debrief session the member of the research team would pause the tape of the interview they were listening to in order to seek more information or clarification. This allowed the peer researchers to provide their own insights into the

interview and explain any topics within the interview that were not clear. This also ensured the peer interviewers were involved in the beginnings of identifying emerging themes (Price & Hawkins, 2002). All peer researchers were paid for their time in doing debrief interviews with the research team. These debrief recordings were then transcribed by the researcher and included in the data analysis.

Peer interviews were conducted at all times following a set of important rules: 1) peer researchers had to use the third-person interview technique, in which participants were asked to describe their views of the sexual experiences of “people like them” (and were not permitted to tell personal stories or relate stories about individuals); 2) no names nor other identifying information were permitted to be mentioned; and 3) subject matter that was deemed *off limits* within the interviews was not to be discussed, including, for example, sexual assault or sex that occurred below the age of consent. These rules ensured there was minimum risk to participants and interviewers with respect to confidentiality and emotional safety and wellbeing.

#### 3.5.4 Choice of Participants

All participants were aged between 16 and 26 years and recruited from the South Western Sydney area. Participants were recruited using the following eligibility criteria: a) they identified as Aboriginal; b) they were aged 16 to 26 years; and c) they lived in Western Sydney. Participants were drawn from a sample of young people with a range of family, educational and employment backgrounds.

### **3.6 Interview Questions**

Peer researchers were given a set of guiding questions to ask during the interview, questions on which they had already provided feedback during their training. It should be noted that, in some of the interviews, questions were asked in a different order or in some instances were missed entirely. Some peer researchers appeared to read straight from the script, while others asked the questions in their own way (see Appendix 1 for a copy of the guiding questions), which this method of peer interviewing allowed for. Peer researchers could ask questions in a way that was meaningful to them and that

reflected their world view, for example, their standpoint as Indigenous people (Nakata, 2002).

### **3.7 Interview Setting**

Interview settings were flexible; the time and location of the interview was organised between the peer researcher and the participant. As a result, the interviews occurred wherever those involved felt comfortable and able to talk. Examples of interview settings included homes, on the phone, at the Aboriginal community centre, at other community services and outside.

### **3.8 Quality Control**

A member of the research team met with each peer researcher individually, soon after they had conducted an interview, to have a debriefing session. Enough time was scheduled to listen to the content of the peer researcher's recording of the interview. This process allowed the research team to clarify sections of the interviews they were unsure of, while allowing the peer researcher to discuss their thoughts and any concerns about the interview.

This process worked well, but there were some issues. Some sections of the audio recordings were inaudible and, given that no one else was present at the interviews, it was not possible to fill in the gaps. Some of the interviews did not have enough depth and it was not possible to follow up on certain answers. This was particularly noticeable in the questions regarding the use of technology.

### **3.9 Data Analysis**

Data analysis occurred over an extended period of time due to the fact that I had limited research experience. Before beginning the process of data analysis, I read the academic literature extensively to examine the different approaches that could be taken to analysing the data. On the advice of my supervisors I read *Approaches to social enquiry* (Blaikie, 2007) and *Qualitative research in health* (Grbich, 1999). Following this, I

identified the approach that I felt was the best fit given the nature of this research, discussed this with my supervisors and settled on that approach. I used a thematic analysis, which is a method for identifying, analysing and interpreting patterns of meaning, or themes, within qualitative data (Clarke & Braun, 2017). This approach allows the researcher to move from broad themes to more focused themes within the data (Grbich, 1999). The aim of thematic analysis is to identify and interpret key features of the data, guided by the research questions, to produce rigorous and high-quality analysis (Clarke & Braun, 2017). Thematic analysis can identify patterns both within and across the data that relate to the participants' life experiences, opinions and viewpoints, as well as their behaviour and practices (Clarke & Braun, 2017). This is where my status as a Kamilaroi woman and the value of my lived experience played key roles, because they allowed me a deeper understanding of some of what was said around the frustrations of dealing with the healthcare system. Being a Kamilaroi woman, I am able to use Indigenous Standpoint Theory to draw upon my own experiences to critically analyse the disparity between the accepted positions regarding sexual health provision and what the participants in my research are telling us (Nakata, 2007).

As the key researcher, I transcribed the audio recordings and de-identified the transcripts. I then conducted a thorough and in-depth reading of the data transcripts to identify the “how”, “why” and “what ifs” present in the responses given by participants (Grbich, 1999). This involved reading through the transcribed interviews many times to become familiar with the data. Following this, the transcribed interviews were read again and the emerging themes categorized in a new analytical document. Each time a new analysis document version was created, and the old version saved. Different individuals expressed some of the same themes using distinctly different language. All coding was done in Microsoft Word, using colour-coding for different themes for easy reference. These themes were then discussed with my supervisors before they were refined and confirmed. There were six versions of the data-analysis document before it became the draft “Findings and Discussion” chapter.

Rigor was ensured by face validity, or member checks with regular member checking of the data that occurred during supervision (Grbich, 1999). This allowed for the interpretations of the data to be checked by presenting and discussing them in a group setting (Grbich, 1999). The supervision team held regular discussion about the emerging

themes and the researchers coding. All members of the supervision team read the coding reports and through discussion added detail to themes or combined themes with others.

### **3.10 Introduction to the participants**

Everyone involved in this research did so voluntarily, either as a peer researcher or a participant. For the purposes of data analysis and reporting, each individual was provided with a pseudonym. As had been determined at the beginning of the interview process, all had self-identified as Aboriginal and lived in the Western Sydney area. Some individuals were more open about their backgrounds than others, although some peer researchers did not ask participants about their background, so this information is missing in some cases.

These were the 24 participants:

**Ava**, aged 16 years, grew up in rural NSW and lived between there and Western Sydney often.

**Ben**, aged 18 years, was born in Western Sydney, played a lot of footy and was really into music.

**Charlotte**, aged 17 years, was involved in a number of sports.

**Dylan**, aged 19 years, grew up in Western Sydney and played football.

**Ellie**, aged 21 years, lived with her boyfriend and was working.

**Ethan**, aged 17 years, had lived in Western Sydney all his life and was heavily involved with a community organisation. He refereed footy matches.

**George**, aged 22 years, worked full time and lived with family.

**Grace**, aged 23 years, lived with her sibling and had previously lived overseas.

**Isabella**, aged 16 years, lived with three generations of her family and played sport.

**Julia**, aged 17 years, had lived in Western Sydney all her life and attended high school.

**Justin**, aged 20 years, did not introduce himself during earlier interviews

**Lily**, aged 16 years, lived with her parents and attended high school.

**Lucy**, aged 17 years, lived with family, attended high school and was working.

**Luke**, aged 19 years, worked in Mount Druitt, lived with family members and played in the Koori knock-outs.

**Matt**, aged 19 years, was working full time and living with family.

**Mia**, aged 17 years, was originally from Victoria but grew up around Penrith. She volunteered with a community organisation and used to dance.

**Olivia**, aged 26 years, did not introduce herself during earlier interviews.

**Piper**, aged 17 years, attended high school.

**Samantha**, aged 19 years, did not introduce herself during earlier interviews .

**Seb**, aged 18 years, recently graduated from high school and lived with family.

**Tyler**, aged 20 years, played football, was not working at the time, lived with family and volunteered at a community organisation.

**Violet**, aged 17 years, lived with family, attended high school and danced.

**Will**, aged 18 years, had lived in Western Sydney his whole life, but maintained a strong connection to Country and played footy.

**Zoe**, aged 19 years, lived with her boyfriend and his family and worked.

### **3.11 Conclusion**

The methodology for this research was guided at all levels by Aboriginal people and Aboriginal knowledge. The ethical issues and guidelines for working with Aboriginal communities were closely followed to ensure that participants and peer researchers gained from both the study and the work experience. Without the cooperation and expertise of the peer researchers, this study would not have been possible. For myself as an Aboriginal researcher, conducting research that involved Aboriginal people allowed me to both position myself in the research and learn from those around me.



The research was informed by Indigenous Standpoint Theory, which allowed for my existence in the tangled space of the Cultural Interface, both as a method of inquiry and a question of how I have my knowledge as an Aboriginal researcher (Nakata, 2007). It uses qualitative methods, which are similar to Aboriginal Ways of Being, in particular to yarning (Martin & Mirraboopa, 2003). The peer interviewing method used privileged the voices and perspectives of Aboriginal young people. Finally the research was led by me, an Aboriginal woman.

## **Chapter 4: Findings and Discussion**

This chapter presents a thematic analysis of the data generated in the peer interviews undertaken for this study. The results address the research questions, which were:

1. What sources of information are used by Aboriginal young people in urban areas to access sexual health information, including online sources, friends, families and health services?
2. What are the reasons for Aboriginal young people in urban areas accessing sexual health information from these sources?
3. How is technology being used by Aboriginal young people to support their information seeking around sexual health issues?
4. How could technology be used better or differently to support Aboriginal young people's information seeking around sexual health issues?

The findings and discussion show how Aboriginal young people have developed methods of using technology to access sexual health information and make informed decisions. Overall, the findings show that most participants used the internet as their primary source of sexual health information. They reported that searching the internet allowed them to check their concerns privately before deciding if they needed to speak to another person. They then consulted with trusted people around them to check facts and gather further information. The trusted people around them were both formal sources of information such as Aboriginal health services, general practitioners and teachers, and informal sources such as family members, friends and community. However, some participants sought information from trusted people first and then used technology to check the information. The findings also show that, after talking with a trusted source, participants would then be able to make an informed decision about whether or not to make a medical appointment. Privacy when accessing a medical service was a concern to them, with participants reporting that being known to staff members could be a barrier. They might also avoid mainstream services due to a perceived or real lack of cultural understanding and support.

#### **4.1 Sources of Sexual Health Information: the Internet**

Searching the internet was the first option for young people wanting to learn about their symptoms.

“[young people] could go to the Internet to see what the signs and symptoms are about it [sexual health issue] to give them, like, a, something brief to go off of. That would probably be my first option, seeing the Internet, seeing what was wrong with me. Typed it in there, seeing what came up” (Will, 18)

“the first, well, 100 per cent, the first thing they’d do, the internet, like ... If they have an STD or something, they’d go to the internet and search up the symptoms or something” (Ava, 16)

The participants used the internet as their first port of call and as a way to self-triage their symptoms. Internet access allowed young people to have more control over their health and helped them to decide when a matter required further help. It also allowed them maximum privacy while they took command of their own health. Participants described how the use of the internet reduced their feelings of shame, while providing quick and easy access to information. They also reported learning that not all physical changes were the result of a health issue that needed to be treated:

“I guess being around their phones, being able to answer questions, their being [in their] own environments by themselves, it’s a lot easier than being around other people” (Seb, 18)

“They might feel like, you know, shamed, and that sort of stuff, to tell other people, so they want to find out before they say anything. Sometimes they might not even have it, so they won’t have to say anything at all” (Will, 18)

The responses show that the internet is a way for young people to have some level of control over their situation when looking for sexual health information. They are able to identify and triage their symptoms before going to another person for advice.

Participants also searched the internet to find out about physical signs and symptoms that they were concerned about:

“Aww, I believe they’d go to Google if they notice something that they’ve never had happen before” (Justin, 20)

“they could go to the Internet to see what the signs and symptoms are about it, to give them, like, a, something brief to go off of” (Will, 18)

When discussing what sort of issues would make them do an internet search, participants mentioned emotional and social issues far less often than they mentioned physical issues. Having an unfamiliar symptom appeared to be the main push for seeking answers online. Participants also described how they sought information when they were in a state of distress and wanted quick reassurance or guidance on their situation:

“Yeah, so, a lot of kids go on there for panic as well, when they’re panicking” (Will, 18)

“Umm ... ah, maybe quicker replies from the actual service. Maybe if they give you a 24-hour talking service that would be pretty good” (Matt, 19)

The internet was seen to be useful because it was available at all hours to young people who did not want to wait for an answer.

Participants appeared very aware that not all sources of information on the internet were accurate, describing how information might be “fake” or “not accurate”:

“Umm, some of it’s fake, like you don’t know what’s real, and you could be reading something and it might not be true, so you have to be careful about what you read online ’cause it could, like, think it could make you, think you have something when you don’t have it” (Julia, 17)

“the information could be false or not accurate, yeah” (Tyler, 20)

“looking up the right websites and not grabbing the wrong information, the false information” (Violet, 17)

The data clearly showed that participants viewed the information they read on the internet with a level of mistrust and suspicion. They carefully considered what they were reading. They did not talk in detail about which internet sources they considered untrustworthy; instead they talked more generally about internet-based information being “fake”.

Participants describe how they verified information by checking in with the people around them, those they were most comfortable talking to, such as parents, friends and doctors and so forth:

“Most young people probably use the Internet just like, you know, search it up and to get advice or like... Google and things like that, yeah... that’s probably the main. But second option maybe they either get advice from a parent or like friend ” (Mia, 17)

“I’d probably look into it a fair bit. And, if everything matched up perfectly, then I’d take another step. Probably go, go see Mum or Dad and tell them that this happened. This is what’s happening and this is what I wanna do about it. I’ve done my research. Might not be 100 per cent true but everything’s lining up. Can we go see someone? And I think seeing someone would be the, the final stop after, after your parents” (Will, 18)

“I don’t know. Maybe not all of it’s true [*laughter*]. Maybe go see a professional about it” (Samantha, 19)

#### 4.1.1 Reasons for Using the Internet to Search for Sexual Health Information: Confidentiality and the Availability of Biomedical Information

The internet was seen by young people as a source of information that provided confidentiality. The sense of privacy and anonymity it gave allowed them to feel more comfortable about seeking information because they could do so without talking to another person:

“Because it’s private and, you know, just feels more comfortable keeping it to themselves” (Tyler, 20)

“... so it’s not a person ... not doing it that way face to face, so it’s more comfortable for them ... So, doing it on a screen because they feel more comfortable, because they’re not being, like, face to face with someone”  
(Julia, 17)

“privacy. No one else can look at it” (Ethan, 17)

The data clearly showed that the internet is shaping the way Aboriginal young people are seeking help and increasing their knowledge around sexual health. The National

Survey of Australian Secondary Students and Sexual Health (Fisher et al., 2019) found that websites were the most common source of sexual health information for young people. Participants in the current study mentioned using their phones as a way to access the internet and share information with peers. This is supported by other research (Ippoliti & L'Engle, 2017). When sharing a mobile phone with peers, the literature suggests that, among Aboriginal young people, gender norms play an important role; boys share with other boys and girls share with other girls. The same study shows that individuals appear to consider their phones an extension of themselves, and that sharing a phone is a sign of trust (Rice et al., 2016). That Aboriginal people's preferred method of accessing the internet is via their phones in general may well be because of a lack of home computers and internet access (Joint Select Committee on Cyber-Safety, 2013). The findings of this Parliamentary paper resonate with my study, also showing that Aboriginal young people accessed sexual health information on their phones for reasons of privacy, which was identified as a key factor in the report.

## **4.2 Sources of Sexual Health Information: Family, Friends and Community**

Participants identified a network of people around them with whom they were able to discuss issues of sexual health and relationships, including parents, grandparents and other older family members, and friends. Lived experience appeared to be valued when they were identifying a trusted person to approach; participants held in high regard those whom they felt had had similar experiences. Family members such as aunts and step-parents who had discussed sexual health matters with other young people were also valued as a source of information.

### **4.2.1 Parents**

Some participants identified parents as a safe, trustworthy and knowledgeable source of sexual health information:

“me, personally, I go straight to my mum because, like, mums know best, really”  
(Charlotte, 17)

“your parents, they're good support people” (Piper, 17)

“home... like parents” (Luke,19)

Others were more sceptical about seeking information from parents because they had not developed the kind of relationships that allowed for such conversations to take place. As Matt suggested:

“umm, just so it’s more closed up and they can probably just trust their parents a bit more and open up hopefully” (Matt, 19)

Among those who acknowledged parents as a source of help, mothers were mentioned more often than fathers, by both male and female participants:

“I’d go probably to my mum ’cause Mum would be the most, the most wise and, like, accepting towards it. Dad would be accepting as well but Mum would take that extra step into helping you. So, when it comes to family and, like, STDs or STIs, probably just your parents alone would be the best bet to know. At the end of the day, they’re your parents. They’re always gonna wanna help you through anything.” (Will, 18)

The Goanna Survey (a survey about sex and relationships among Australian Aboriginal young people) found that respondents aged 16 to 19 years were more likely to seek advice from family members than respondents aged 20 years and older (Ward et al., 2014). This suggests a need to provide support to family members to give them the confidence to broach the subject of sexual health with their teenagers. The findings of my research confirm the value in this, since participants identified their parents as their main source of support. An American study (Wisnieski et al., 2015) looked at the influence parents and family have on young people when it comes to sex and relationships and how the influence of parents shaped young people’s romantic and sexual behaviours. It reported several interesting findings: firstly, that a close relationship between a parent and young person increased the likelihood, but did not guarantee, that discussion about romantic and sexual subject matter would take place; secondly, that a close relationship between parents and children was not required for there to be discussion of romantic and sexual behaviour, something that appears to be a commonly held opinion among young people (Wisnieski et al., 2015).

For some participants, however, parents were not seen as a source of help. This was for a number of reasons, such as concern about how the parents might react, or the lack of

trust or of a close bond between them. Other participants identified parents as a source of help, but then explained that they themselves would not be comfortable approaching their *own* parents for information:

“Well, first of all, their parents ... it’s all about that trust and, umm, connection with them, the people, because, umm, it took, like, I didn’t tell my parents. I didn’t asked my parents” (Justin, 20)

“I don’t think, like, I could tell my parents stuff. They would have thought I had it, STIs” (Justin, 20)

“I don’t want her to, like, judge me. Like, she wouldn’t but, like, I just feel uncomfortable sort of ’cause, like, I feel, like, if I told her, like, about stuff, she’d, like, be really, like, mind-blown ... I don’t know. I just don’t really know how she’d really react and it makes me not really wanna talk to her about anything. It’s, like, sort of scary, ’cause sometimes I think about it but then I think, ‘Should I really say this? Like, what if she reacts like that?’ ”

(Isabelle, 16)

“ ’Cause, at the end of the day, they are, they are your family but it’s not their business to know what happens between you and your partner” (Will, 18)

This shows that participants had a number of reasons for not seeking information from their parents. They were able to identify and rationalise these reasons and seek information from sources with which they were more comfortable. Generational differences and the changing attitudes of society towards sex and relationships may also stop participants from seeking advice from their parents. In existing research with the general population, older people have been found to have less permissive attitudes towards sexuality (de Visser et al., 2014). Liberal attitudes among all age groups are associated with being female, speaking English at home, having a homosexual or bisexual identity, not being religious, and having higher levels of education and higher income (de Visser et al., 2014). Participants appeared to worry that their parent(s) would be judgemental if they were to approach them for help around sexual health, which could be related to a belief that their parents had less permissive attitudes to sex.



A past study has suggested that some Aboriginal young people report that their parents and role models are not providing education and advice on the risks to sexual health (Mooney-Somers et al., 2011). In this same study, conducted in Townsville, participants reported that their parents did not give information on how they could prevent the unintended consequences of sex (Mooney-Somers et al., 2011). However, the participants in this study did get advice and support from friends, peers, family members and trusted service providers. This makes it harder for Aboriginal young people to gain the skills and confidence to practise safe sex and to engage in difficult conversations with their sexual partners (Mooney-Somers et al., 2011).

Finally, the literature suggests that if there is no parent of the same gender in the family or household, young people may be even less inclined to view a parent as a source of help and information (Vujcich et al., 2018). One study has shown that, when no parental figure of the same gender is available, parents feel that cultural protocols need to be relaxed or ignored to ensure that their young people have a good understanding of sexual health (Vujcich et al., 2018). The responses of participants in my research suggest that, to approach a parent for information about sexual health issues, the young person must feel close to the parent. Some participants identified other young people would see their own parents as a source of sexual health information, while at the same time stating that they would not feel comfortable talking to their own parents. Those participants who reported that they would discuss their sexual health with a parent identified having an open and trusting relationship with that parent.

#### 4.2.2 Grandparents

Grandparents were identified by some participants as approachable, knowledgeable, trustworthy and honest in their advice due to their lived experience. During the interviews participants appeared to use the terms “grandparents” and “Elders” interchangeably:

“Yeah, yeah, like mostly, like, Elders, like, grandparents ...” (Julia, 17)

“... they’re pretty easy to talk to and they give you, like, the honest truth but the easy way ... Yeah, like, cause, like, most grandparents aren’t really rude to ya, like, they’re

different to your parents, like, and then they say because they've been through it, like, with your parents and they, like, explain it, like, what's happening, if they can, and just stuff, like, that I think they'd know, yeah"

(Julia, 17)

"I'd go maybe to, like, the Elders and stuff for advice" (Lily, 16)

Historically Aboriginal grandparents have played and continue to play a significant role in the lives of their grandchildren. Traditional Aboriginal ways and cultural expectations value and support the involvement of grandparents in the day-to-day lives of their grandchildren. Grandparents also play a vital role in passing down both their traditional knowledge and their lived experience. Aboriginal grandparents have the roles of both teacher and advisor when discussing issues of sexual health with their grandchildren. Participants reported that their grandparents were easy to talk to and, because they had answered all their own children's questions before, had added experience and expertise.

The comparatively young age of the Australian Aboriginal population may explain why grandparents were identified as a source of trusted information about sexual health. According to the Australian Institute of Family Studies, in 2018 only 4% of Indigenous Australians were aged 65 and over (Australian Institute of Health and Welfare, 2019). Statistics also show that Indigenous women in Australia have historically been younger when they have become mothers than non-Indigenous women. The median age for an Aboriginal woman to become a first-time mother in 2018 was 26 years, compared to the age of a non-Aboriginal women becoming a first-time mother, which was 30.5 years. Also an Aboriginal woman was eight times more likely to become a teenaged mother. The statistics, however, do show an upward trend in the age of Aboriginal women giving birth to their first child (Australian Institute of Health and Welfare, 2018). Between 1991 and 1993 the median age for an Aboriginal woman to become a first-time mother was 23.7 years, compared to 28.2 years for a non-Aboriginal woman (Plunkett, 1996). These statistics suggest that some of the participants had grandparents who were relatively young, which might have influenced young people's decisions to approach grandparents for advice. An American study that interviewed young women from various backgrounds found that participants who viewed a grandparent as a source

of stability, love and advice also viewed this grandparent as a trusted source of advice about romantic relationships (Wisniewski et al., 2015). This is confirmed by my research; some participants said that their grandparents were easy to approach and talk to and would be honest with them.

#### 4.2.3 Other Family Members

Other, typically older, family members were also identified as people whom participants would approach to ask questions:

“Maybe cousins, aunties, uncles, [Okay] grandparents, siblings” (Julia, 17)

“Yeah, cousins, mostly, I reckon ... My aunty has older daughters and, like, she’s gone through everything and my mum hasn’t ... or my step-mum, actually, ’cause she’s had an older daughter, and she’s, like, dealt with that all. So, like, she’d probably understand more. She knows what it’s like and, like, ’cause her daughter’s gone through this stuff before. And, yeah.” (Isabelle, 16)

“relatives, you know, just because they feel ... like, safe in talking to them about that kind of stuff” (Seb, 18)

“like, their aunty that they can trust” (Charlotte, 17)

Older family members were seen to be a good source of advice because they were thought to have lived experience and experience talking with other young people in the family, so were therefore able to “understand more”. Individuals who had previously been sources of information to others were also sought out for information.

Siblings, however, were usually not seen as people to approach for advice, though participants did not give any further explanation as to why this might be the case:

“I definitely wouldn’t go to my, [ahh,] brother” (Will, 18)

“if they have older sisters and that, and brothers. But I don’t really talk to my older siblings, so ...” (Isabelle, 16)

Participants identified older members of their families as sources of information regarding sexual health. The age of participants who identified family members as

sources of advice on sexual health, 16- to 19-year-olds, aligns with the findings of the Goanna Survey (Ward et al., 2014). A close connection with the family member was identified in the literature as necessary to make young women feel comfortable asking that person for advice (Wisniewski et al., 2015). Participants in my research also identified that it was important to have a sense of trust in the family member, who usually also had experience discussing sexual health with family members previously. Aboriginal young women appeared more likely than young men to make use of an intergenerational support network for both advice and support, such as having a trusted person attend a clinic with them (Bell et al., 2020a). This highlights both the importance of family connections and the likelihood that Aboriginal young men may require further support to build a supportive and informative network.

#### 4.2.4 Friends

Some participants saw trusted friends as an easy source of information, mostly because they felt comfortable with these friends. They and their friends listened to each other's advice:

“friends, if they also feel comfortable and they could also just give them advice as well” (Lily, 16)

“their friends really that would be it” (Grace, 23)

“’cause they’d be the easiest to talk to” (Will, 18)

“friends, like, it’s all about that trust and, umm, connection with them, the people” (Justin, 20)

“I wanted to get tested. I asked my mates because I saw my mates get tested – they weren’t even Aboriginal – but I said to them, I asked ‘em, ‘What do you do?’, and they were, like, you go there and that. Then I went, but I went by myself and I was that, and that was when I was nervous, like, I wish I took a mate” (Justin, 20)

“I think friends should be more on top of their other friends about it because that’s who they’re gonna listen to the most” (Ellie, 21)

Participants identified that a friend needed to be trustworthy, easy to talk to and able to deliver advice when needed. This shows that different friends play different roles in participants' understanding of sex and relationships.

Participants also acknowledged a number of concerns when discussing sensitive topics with their friends. A lack of privacy, worry about being embarrassed, and a fear that their friend would not be trustworthy were all reasons for participants not to approach a friend with their questions:

“Umm ... someone being embarrassed about it and somebody could judge someone, or yeah” (Tyler, 20)

“... umm as, where a lot of my friends, like, they don't really know, so they'll just be like, ahh, I don't know. They'll make shit up and then ... I guess it just depends like ... how trustworthy, I guess, your friends are to tell you the truth about whatever the question is. Something bad, they have to have the guts to tell it's something bad, I guess, and just not make stuff up” (Charlotte, 17)

“ 'cause your friend could just one day be sick of it and leave. But, then again, they've always got that, that knowledge about you. Then they could become a bad person and spread it, and it's happened before” (Will, 18)

If a friend was seen to lack the correct knowledge and not have the strength to discuss difficult information, they were not considered the *go to* person for advice. When it came to the sharing of sensitive issues, the possibility of a friendship ending after private information had been shared with the friend was also a concern for participants.

An ongoing survey of Australian high-school students (who are mostly non-Aboriginal) suggests that both male and female young people are more confident talking with female friends. Female friends were rated as one of the highest trusted sources of sexual health information (Fisher et al., 2019). Even among those young people who did not have access to friends and social networks friends were seen to play an important role in increasing sexual health knowledge, so young people with few friends would likely have lower levels of knowledge (Fisher et al., 2019). For LGBTQI+ young people, friends were reported to be particularly important and often their only source of information, as sexual health and relationship education in schools often failed to meet

their needs (Waling et al., 2019). While participants in my research identified that they had concerns about discussing sexual subject matter with friends, they also identified that their friends were the easiest people to talk to. In fact, a quote from Justin (see Section 4.2.4) clearly showed that his friends' positive attitude towards being tested for STIs was the reason he went and got a test.

#### 4.2.5 Reasons for Consulting Family, Friends and Others for Sexual Health Information: the Importance of Knowledge Gained from Lived Experience

It has been shown, above, that participants regarded trusted people who “have experience” and have “lived through it” as the best source of information and advice about sex and relationships. Participants also identified that being the first in a friendship group to become sexually active placed that individual in the position of being able to answer questions. Being older and being seen as “sexually experienced” was valued and made people appear more knowledgeable:

“Like, the friend that is probably the first to become sexually active and the first friend to have any problems and anything” (Charlotte, 17)

“Because they [grandparents] know more. They’ve been through it all, so yeah” (Julia, 17)

“... when I need advice, the, like, first person I’ll go to is my mum, only because she’s older. She’s had the experiences so she probably knows ...”  
(Charlotte, 17)

“Yeah, I think your parents could be, like, one of the best people to talk about it because they have a lot of experience, because they’re a lot older and how they did stuff, how they took care of their bodies” (Ellie, 21)

Participants appeared to place a high value on the lived experience of the people they approached for help and the knowledge these people had gained from their experiences and choices throughout their lives. This fits with Aboriginal Ways of Being, Knowing, and Doing, as yarning allows for knowledge to pass down to each new generation in the process of sharing one’s story (Martin & Mirraboopa, 2003). Because lived experience was so valued by participants, especially the experience of older adults who were

trusted and seen as honest and easy to talk to, there is potential for sexual health education aimed at giving adults the skills and knowledge to discuss sexual health and relationships with young people. For example, the Government of Western Australian has created *Yarning Quiet Ways* in response to a call from Aboriginal parents and carers (Government of Western Australian, 2015). This website is a resource for adults to gain skills and knowledge so that they can talk to Aboriginal kids and young people about a number of sexual health issues. The information on the website is divided according to suitability for various age ranges, which allows adults to choose age-appropriate subject matter and to feel more confident in engaging in an appropriate conversation around sexual health with their children, grandchildren and other young people. This helps to ensure that correct and current information is being passed on to all age groups. Research (e.g. Ward et al., 2014) shows that young Aboriginal people are more likely to approach a parent or family member for advice. This is supported by the responses of participants in this research with the lived experience and knowledge of older family members valued. My research shows that, because Aboriginal young people check up on their understanding of sexual health information by talking to the trusted older people around them, health literacy in Aboriginal communities requires a whole-of-community approach. All members of the community must be given correct and up-to-date sexual health information to ensure that correct and useful information is being passed on to the young people in the community.

#### **4.3 Sources of Sexual Health Information: Aboriginal Health Services, General Practitioners, Teachers and Counsellors**

Participants identified a number of professionals whom they believed could provide information and support to them regarding sexual health – GPs, teachers, counsellors and social workers.

##### **4.3.1 Doctors**

There was a range of views about doctors. In general, participants regarded doctors as a confidential and non-judgemental source of reliable and trusted information:

“Umm, doctors have confidentiality and won’t tell anyone. They aren’t judgemental”  
(Piper, 17)

Some participants reported that they felt comfortable sharing information with doctors as there was a less personal relationship:

“Umm ... they don’t know the person well enough, so, like, they feel more comfortable telling them those things. It’s confidential” (Lucy, 17)

Yet others felt that a longer-standing relationship was important:

“I would go to the doctor that I’ve grown up with ’cause he knows all my medical history, knows all my problems and everything. So he would understand more”  
(Charlotte, 17)

And then there were those who gave different reasons for going to the doctor:

“... they might go to the doctor’s because they might be a bit scared” (Julia, 17)

Feelings of embarrassment or judgement and past negative experiences of family members created a barrier for some participants when it came to attending a doctor’s surgery:

“... feeling embarrassed about it, not really wanting to talk about it” (Seb, 18)

Some of the participants felt strongly against mainstream doctors:

“They were fucking ripping our babies away and shit, these doctors at the hospitals and shit like that, you know. I think everyone who’s not us always thinks that’s, like, that was a long time ago, you know, when that thing, when that as [is] happening or, you know, treatment was being refused by doctors and things like that. People are, like, that, that happened such a long ... all it takes is for that nasty cunt at the front office to, like, at a fucking white doctor’s surgery or, like, a mainstream surgery and you’re just, like, fuck that”  
(Olivia, 26)

The cost associated with visiting mainstream doctors was a concern:

“they the fucked were fucking telling me that because I needed to get a second test and they were like this is going to cost you now and I was like fucking excuse me like what



the fuck like I, I can't afford this... Like if you's got it wrong the first time and you's need to well that's you fuck up, but for sure money for sure" (Olivia, 26)

Doctors and the medical profession were viewed with distrust and as unsafe by some participants because of the impact they could have on a family, either by refusing treatment or by getting child services involved. Nakata's Cultural Interface shows the reality of navigating through their two worlds for some of the participants when past experiences and trauma are involved (Nakata, 2002). For some of the participants mainstream doctors are not an option due to past negative experiences, both their own and family members (Mooney-Somers et al., 2009). For other participants mainstream doctors allowed them the sense of anonymity needed to access a service for sexual health needs (Mooney-Somers et al., 2009). Aboriginal people commonly view the medical system with fear and mistrust because of past experiences with the effects of government policies on their communities (Treloar et al., 2013). Colonisation, dispossession from Country and family, racism and intergenerational trauma have all impacted Aboriginal people, and still have ramifications when people are attempting to access health services (Ward et al., 2014). Distrust of medical systems is a shared world view for some Aboriginal people, but Indigenous Standpoint allows for each individual to have their own *truth* shaped by their experiences and social settings (Nakata, 2007). Power and control over Aboriginal people's sexuality has also been an aspect of the government's approach (Sherwood, 2013). For example, during South Australia's Protection Era, in place from 1910 until the 1960s, Aboriginal women could be removed from their homes and forced to undergo sexual health examinations and treatments. Police were used to target, survey and detain women, while ignoring the actions of their non-Indigenous partners (Kelly & Luxford, 2007). Experiences such as these still influence the way Aboriginal people view sexual and other health services. Continuing mistrust, fear and anger mean that some Aboriginal people will avoid attending a mainstream doctor's office. Some of the participants in this study reported a lack of trust in attending mainstream medical services with the negative experiences of older family being recounted as a reason for this. To ensure that Aboriginal young people feel comfortable accessing the mainstream medical system, local health services need to develop a relationship with the community. Respectful and trustworthy relationships between medical staff, their patients and the community are needed for

sexual health programs to be culturally acceptable, effective, safe and meaningful (Kelly & Luxford, 2007). Strategies must be put in place both at the individual and community levels to address the systemic issues that are negatively impacting Aboriginal people's sexual health.

#### 4.3.2 The Local Aboriginal Medical Service

The local Aboriginal Medical Service was seen by some participants as being in some ways like family and having an understanding of culture, and therefore as the most comfortable and trusted place to seek help:

“they are close to ya, like family, yep” (George, 22)

“Umm, because they're like, umm, founded around Indigenous people, they'd have more of an understanding, umm, with us, umm, and would probably be able to communicate and give better advice to us Indigenous people rather than just a non-Indigenous medical centre” (Lily, 16)

“like, if they're more brought up, like, culturally, like, how we are, then they'll go there 'cause they know they have a cultural understanding, but I think most young people would just go straight to their local doctor's” (Charlotte, 17)

“I think it's the only place we've had – the AMS – really” (Olivia, 26)

Participants identified that the local Aboriginal Medical Service was created for Indigenous people and therefore had a better understanding of their health needs and experiences. That the service had cultural understanding and its workers were generally viewed to have been raised culturally was also a reason for participants feeling more comfortable attending an AMS. This suggests that for some participants in this research an area that they find it difficult to navigate the Cultural Interface is around medical issues (Nakata, 2002). By also looking at what was discussed by participants in the previous section 4.3.1 Doctors it suggests that medical and health services are one of the main areas in which Aboriginal young people must navigate the Cultural Interface. Individuals, families, and communities are required to bring both their individual and collective experiences and knowledge together to try to find the best health care for themselves, including sexual health care. These responses also highlight the importance of Aboriginal Medical Services and the option they provide when needing to address

medical concerns (Ward et al., 2020). A national survey of Australian Aboriginal young people (Ward et al., 2020) found that 45% of respondents reported that the AMS was the first place they would seek advice on matters of sexual health and STIs, with men being more likely to access an AMS than women. An earlier study that looked at the use of health services by Aboriginal young people in NSW to get advice about STIs also found that Aboriginal Community Controlled Health Services (ACCHOs) were the most commonly accessed services by Aboriginal young people for treatment (Kelly & Luxford, 2007). However, trans and gender-diverse respondents were less likely to go to an AMS (Ward et al., 2020), suggesting that the AMS was not seen as trustworthy by all gender-diverse Aboriginal young people.

For some participants, on the other hand, the sense of familiarity with the local AMS was a barrier to accessing the health service because of the perceived risk of gossip being spread within the community and the fear of subsequent embarrassment to the participant:

“I don’t know. It’s different now. It’s like, yeah, you go to the AMS but it’s, like, you see fucking 12 people there and before you know it it’s on Facebook that you went to the AMS, like, and all of a sudden you’re fucking on Facebook having a baby announcement from someone ‘cause they seen you” (Olivia, 26)

“Yep, so I guess, umm, you, I guess, those [AMS] could be a good thing or a bad thing. Like, they’re good because they’re your – you know, family members are involved in that community and in that workplace and they have that sort of knowledge, but then, I guess, it could be embarrassing, hey, because, umm, their family could be sort of embarrassing talking to your parents about sex and relationships” (Ethan, 17)

When family members, and maybe the partners of family members, worked at the service or were well known to staff, this became a barrier to accessing services for some participants because of a sense of embarrassment. Despite these worries, however, the participants in this research project stated in general that the AMS was a valuable source of information for young Aboriginal people when seeking information around sexual health, and the literature confirmed this.

The literature suggests that young Aboriginal men are more likely to access sexual health screening at an AMS than at another form of health service (Ward et al., 2013). A

study undertaken in Townsville also reported that participants (Aboriginal young people) had a high level of trust in their AMS (Scott et al., 2015) and did not voice any distrust of workers. Rather their concerns were about the potential of seeing other community members in the waiting areas. For Aboriginal young people who identified as LGBTQI+, accessing an AMS can still be difficult, and this is perhaps due to the fact that gender-diverse people are excluded from Men's and Women's business, which can have a significant impact on an individual's wellbeing (Scott et al., 2015). In the current study, it was clear that participants had thought carefully through the pros and cons of accessing an AMS for sexual health services. Attending an AMS was mostly viewed positively but did have some risks. Because of young people's mixed feelings about consulting an AMS for help with their sexual health, it is important that Aboriginal young people have a range of options for seek assistance.

#### 4.3.3 Schools and Teachers

Teachers, when considered trustworthy and approachable, were seen by participants as a good source of information around safe sex and what young people could do to protect themselves:

"... they can, like, receive, like, really good inside information, like, not just, like, what they need to do and what's okay ... and what's not okay and have, how to protect themselves" (Zoe, 19)

"school, with teachers and stuff, some, some kids might be, umm, closer to their teachers" (Justin, 20)

"Umm ... with the teachers, like, you need to have a good teacher that's not gonna make it uncomfortable or just all about the science stuff. You need someone who can at least joke around a little bit or, you know, not make it awkward" (Ellie, 21)

For some participants, having a teacher who was not seen as supportive, or who might have to report conversations, was a barrier to discussions around sexual health:

"They're not really ... like, they're not really supportive. They just teach you, like, consent and STIs and, like, chlamydia, just stuff like that. They just teach the basics. Like what could happen if you have sex." (Ben, 18)

“teachers have to report stuff. They have to mandatory report if they hear stuff that is unsafe or, I think, they’re under age. They might be afraid to approach them but sometimes them teachers understand and they – but they go through their reports because they have to ... it could be a good thing but also a bad thing for people who brings judgement. It brings judgement between people, I reckon” (Justin, 20)

Participants felt that the focus placed on safe sex in schools and the need for teachers to mandatorily report in some cases were reasons for some young participants not being comfortable to approach a teacher.

A synthesis of qualitative studies from a number of countries that investigated what young people thought about their sex and relationship education in schools found that these subjects needed to be addressed in a different way to other subjects (Pound et al., 2016). Students reported feeling vulnerable, with young men being anxious to conceal any ignorance around sexual matters and young women being afraid of being sexually harassed. These became barriers to participation. Having a teacher taking these subjects was also seen as inappropriate, as this broke down the boundary of the student–teacher relationship and created an environment in which students felt uncomfortable asking questions (Waling et al., 2020). Students also reported that these subjects needed to foster positive views of sex and reduce the amount of gendering and heterosexual focus (Uink et al., 2020). It is clear that when teaching sex education in schools, specialists should be involved in the delivery.

Another way to approach this might be through the use of technology, which might allow students to ask questions anonymously. Their concerns could then be addressed without their having to feel judged by their peers or worried that they might be reported. While participants in this research found that teachers could be a support in some cases, the majority of responses indicated that teachers would not be approached for advice on sexual health or relationship issues.

#### 4.3.4 Counsellors

Confidentiality and a sense of privacy were valued by participants, and most young people in this study felt comfortable and confident in discussing their concerns with a counsellor:

“counsellors, if they wanted to be, like, umm, like, private and they still needed advice but were too scared to go to a medical practitioner of [or] something like that” (Lily, 16)

“... like, a counsellor has to stay secret. It’s their job ... they give you that, that freedom of speech to talk about anything you want, even if it’s sexual, non-sexual. And, like, relationship counselling; there’s always that one person. You could go with someone. Figure it out together as opposed to going alone and trying to figure it out. If you go with someone, you’re both on the same page ...” (Will, 18)

“Umm, I think the good [thing] is you feel like it’s definitely going to stay between the two of you” (Matt, 19)

Participants appeared to place a high value on confidentiality when discussing sexual health matters with counsellors. However, these young people may not have realised that counsellors also come from a variety of professional backgrounds and have differing codes of ethics, personal values and reporting requirements. It is clear that the extent to which specific professionals are perceived to guarantee confidentiality is seen as very important by some of the participants, and that an assurance of confidentiality leads to trust and a well-developed rapport between young people and the health professional. This leads to the question of mandatory reporting. Are young people aware that anyone can make a report and are they assigning the blame to the wrong professional when a mandatory report takes place destroying any rapport that has been developed.

“umm, the bad thing, you might be a little bit embarrassed and not open up as much but, umm, yeah, I guess you just gotta trust them and, umm, go with their word” (Matt, 19)

Participants’ mistaken belief that all aspects of a counselling session were private might have led young people to discuss more with a counsellor than they would with other professionals in their lives.

#### 4.3.5 Hierarchy of Trust, and Approachability

Some of the responses suggest that there is an informal hierarchy of trust associated with these professionals that originates from young people's incomplete understanding of mandatory reporting. Although participants knew that teachers were mandated to report their concerns, many felt that what they discussed with other professionals, such as counsellors, was guaranteed to remain confidential. They did not always view other professionals as mandatory reporters, seeming to feel that the confidentiality of their discussions with these professionals was binding in all instances. The danger of this understanding of mandatory reporting is that relationships with professionals could be damaged if a report was required to be made:

“teachers have to report stuff. They have to mandatory report if they hear stuff that is unsafe or, I think, they're under age. They might be afraid to approach them but sometimes them teachers understand and they, but they go through their reports because they have to ... it could be a good thing but also a bad thing for people who brings judgement, it brings judgement between people I reckon” (Justin, 20)

Will provides an explanation for some professionals being trusted more than others:

“well, I think the bad thing about sort of talking to teachers is they have to report it. Umm, it won't stay secret like a counsellor, like, a counsellor has to stay secret. It's their job” (Will, 18)

This notion of “staying secret cause it's their job” is also suggested by Piper:

“Umm, doctors have confidentiality and won't tell anyone. They aren't judgemental” (Piper, 17)

Participants appeared to have a level of understanding around mandatory reporting that informed their decisions regarding which professionals they would turn to for help. Teachers appeared to be the least trusted, with participants stating that teachers were required to report anything considered unsafe. Doctors and counsellors were viewed as providing confidentiality; no mention was made of their role as mandatory reporters. Aboriginal young people appeared to be particularly concerned with privacy and confidentiality, perhaps, as already discussed, because of the history of government intervention. Their concern included the fear that their questioning might result in the

involvement of child protection services (Price & Dalglish, 2013). It would be interesting to conduct further research into whether non-Aboriginal young people had the same understanding of the teacher's role as a mandatory reporter and what impacts this would have on non-Aboriginal young people and their families.

Professionals were seen to play a different role in educating about sexual health issues than the young people's informal sources of information. In order for a young person to approach a professional, a sense of trust, privacy and confidentiality was needed, allowing the young person to overcome the worry that reporting could take place and that there could be unwanted consequences as a result.

The findings of this study show that Aboriginal young people need access to both professional and informal sources of information about sexual health to ensure the best outcomes. These young people first seek information from the internet in privacy, check it for accuracy with a trusted person and then, if required, go on to discuss it with a professional.

#### **4.4 Summary**

Participants actively seek information online and then check in with people they trust. They make careful decisions about who is trustworthy and who is not. This is how they actively manage their sexual health and solve the problems that arise with respect to sexual health and relationships. They see the internet as an anonymous and confidential source of information, often the starting point from which to build their own knowledge about any physical symptoms they are experiencing. Participants are also able to identify that some of the people who could be sources of information would, by law, be mandated to report any concerns, and therefore deem these people to be less approachable and less trustworthy as a result. Aboriginal young people *are* able to identify and assess the trustworthiness of people around them when they are looking for adults with whom to discuss their sexual health issues.

The participants in this research identified one form of technology – the internet – as their principal source of information on sexual health. Other forms of technology that were incorporated into service provision, for example the use of interactive forums,



instant chats and video chats (see Section 2.7), were not discussed. They appear to use the internet only to check up on their physical symptoms and physical concerns. None of the participants spoke about using the internet to access information about relationships. Their main use of the internet was to determine if they needed to be concerned by their symptoms and seek further information. Information that was found on the internet was checked with trusted sources around them, both formal and informal.

Young people were also concerned that personal information they shared with their informal sources of information could be spread in the community by means of gossip. As a result, they were more likely to have conversations around sexual activity and sexual health in person rather than via text message to avoid the risk of messages being shared. Participants shared their knowledge with each other when they trusted their friends, and could also be influenced to get an STI test by the attitudes of those around them. Participants were aware of the requirement for formal sources to undertake mandatory reporting, although the roles and parameters of this obligation were not always clear. This has led participants to create a hierarchy of confidentiality when it comes to trusting their various sources of information, and this was relatively consistent in their discussions. Participants who were concerned about approaching a potential mandatory reporter appeared to weigh up the impact this would have on themselves and others against the fear of being judged if they were to approach an informal source of information, such as a family member or friend.

The experiences of participants accessing mainstream and Aboriginal health services in an urban area of Western Sydney are in line with the experiences of other Aboriginal young people previously identified in the literature, and the barriers to access are similar. Worry about the spread of gossip, the financial cost of tests, feelings of shame and embarrassment and concern about a lack of Aboriginal staff members (or Aboriginal staff members of their own gender) at mainstream services were mentioned by participants as a reason for not choosing to access services. The literature states that Aboriginal young men reported not being encouraged by their peers to seek testing (Vass et al., 2011), but in this study a male participant reported how he was encouraged to be tested by his peers, who also informed him of the best place to go to and what was involved.

As a counterpoint to the majority of existing research that is deficit-focused – that is, focused on the problems that Aboriginal young people have with sexual health and not on how they manage and solve their own problems – my study shows how Aboriginal young people have developed a proficiency in collecting information from multiple sources and found ways to ensure they are able to fact-check information and make informed decisions. They are proactive in accessing the knowledge found in their communities, through both trusted family members and others, including local professionals.

Remote Aboriginal communities have often been the sites for research into Aboriginal sexual health. This results in the experiences of urban Aboriginal people not being captured or reported in research allows a focus on issues that may not be important to them and means that service providers may not be focusing on what is important to urban communities. The fact that research is being undertaken predominantly in remote communities also overlooks the fact that the majority of Aboriginal people now live in metropolitan settings. Despite the vast differences in lifestyles between Aboriginal people in remote and urban communities, the bias of past research has meant that certain beliefs around sexual health practices of Aboriginal young people in remote communities have been applied across the board. It is time that the voices of urban Aboriginal young people are also heard.

#### **4.5 Limitations**

This study has several limitations:

Several of the peer researchers appeared to struggle with understanding the meaning of some of the questions. This was noted when the participant they were interviewing would ask for clarification of the question and the peer researcher and participant would then agree that they did not know what the question was asking. They would then skip the question or the participant would attempt to answer their own interpretation of the question, which may not have been correct. In future it may be beneficial during training to give the peer researchers more time to explain the questions in their own words. This would help to ensure that the questions were written in appropriate ways

that better reflected the perspectives of Aboriginal young people, as per the Indigenous Standpoint approach that guides this thesis (Nakata, 2002).

None of the interviews nor debrief interviews were conducted by the researcher. This was due to a number of factors: 1) the research method chosen and the decision to place Aboriginal young people as the experts, which resulted in the researcher's not being able to ask follow-up questions that may have further expanded the data, and not being able to clarify any confusion around the meaning of the questions; 2) the researcher's not being a member of the community under study and not falling within the age requirements to be a peer researcher; 3) travel constraints on the researcher at the time the debrief interviews were being scheduled. All data analysis was conducted by the researcher, however, which ensured familiarity with the findings.

There were also limitations relating to the fact that no peer researchers nor participants who did not identify as LGBTQI+ who identified as LGBTQI+ were involved in the data collection. Participants were not asked any questions about their sexual identity, behaviour or orientation. As a result, this research is unable to speak for the experiences of Aboriginal young people who identify as LGBTQI+. Other research has shown that young LGBTQI+ people access sexual health information over the internet more often than heterosexual young people (Vass et al., 2011). Aboriginal LGBTQI+ young people deserve to have their experiences and voices heard in research studies; the ways in which they are accessing information and advice around sexual health is important. It is *so* important that young people have medically accurate information about gender identity and sexual orientation; are aware of positive role models of LGBTQI+ individuals, romantic relationships and families; learn about the need for protection during sex for all people no matter their sexual orientation, and have common myths and stereotypes about behaviour and identity addressed. It is also important that their exposure to homophobia, transphobia and biphobia within communities and mainstream Australia, and any experiences of racism felt by Aboriginal people who identify as LGBTQI+ and its impact on how individuals seek help need to be understood in order to be addressed.

## **Chapter 5: Conclusion**

This research found that Aboriginal young people consulted trusted people around them to check up on the sexual health information they found on the internet. By going to the internet as the first port of call in their search for sexual health information, the participants were able to determine if they should be concerned about any physical symptoms. Participants saw the internet as an anonymous source of information that allowed them to build knowledge about their physical symptoms before approaching another person. The people they subsequently approached for further information or to check what they had found on the internet included both those with whom they had an informal relationship, such as a parent, friend or family member, and a formal relationship, including a teacher, a GP, a counsellor and staff at the local Aboriginal Medical Service.

### **5.1 Areas in Which Technology Can be Used**

This study focused on how Indigenous young people obtained sexual health information and the role technology could play. When the participants were asked which technology they used to search for information about their sexual health, their replies focused mostly on the internet. The reasons they gave for using the internet to access information included: quick and easy access to information; more privacy; feeling less shame; and having control over their own health decisions. These key findings suggests that Aboriginal youth in urban areas would be more open to non-face-to-face methods of service provision. This is because telephone, email, SMS, instant messaging and video conferencing can all be accessed from a young person's personal device (such as a smart phone), and in a manner that would likely reduce waiting times for getting answers. Young people's concerns around maintaining confidentiality and not wanting to be seen at a sexual health service would also be addressed with the use of telehealth (consultation over the phone), provided that they had access to a personal device and private space for such a session to occur. Young people can continue to go to their trusted sources to check up on information given by a telehealth professional without needing to state that they are using telehealth.

The findings also show that Aboriginal young people used the internet to triage their physical symptoms and to determine whether or not they should be concerned. This ability to triage symptoms was not mentioned in any of the literature reviewed for this study (see Chapter 2). This finding demonstrates that participants actively participated in managing their own sexual health in ways not necessarily reported in previous research (such behaviour does not fall under the definition of the concept of health literacy, as described in Chapter 2). Findings show that the young people in this study managed their health by finding information for themselves, but used the people around them to verify and expand on their knowledge. This reveals a variety of ways in which technology can be implemented to support Aboriginal young people to access information and support.

## **5.2 Health Information Sharing**

Aboriginal people see health not as an individual experience, but rather as linked to a person's family and community, and in some cases their connection to Country (see Section 2.6.3). This is evident in how the participants in this study accessed sexual health information privately, but then used the support networks they had in place to determine the accuracy and trustworthiness of the information. The lived experiences of trusted individuals in the community was valued as an important source of knowledge and advice. This is in line with Martin & Mirraboopa's (2003) work on Aboriginal Ways of Being, Knowing and Doing. Thus, the acquisition of health information happens on both the individual and community levels. The concept of *health literacy*, as described in Chapter 2, does not capture this important aspect of Aboriginal young people's health because it focuses on the skills and ability of the *individual*, suggesting that health literacy is a skill separate from the community (Lakhan et al., 2017; Nikkelen et al., 2020). Definitions of health literacy and strategies to improve it based on a Western approach have been shown to be ineffective, and sometimes even harmful, among some Aboriginal people and communities (Fforde et al., 2013). This needs to be addressed in the provision of services, education and health campaigns. Vass et al. (2011) argue for the term *community literacy*, defined as having knowledge of the

sources of information as a community, and a knowledge of agendas and how to interpret them, that enables people to engage in discussion and decision-making. This concept of community literacy is evident in the fact that the participants of this study were aware of the different sources of sexual health information, could identify that some sources were mandatory reporters and were confident about what they could safely share.

### **5.3 The Importance of Hearing Aboriginal Voices**

This research adhered to the nationally recognised guidelines for ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities as set out by the National Health and Medical Research Council (NHMRC, 2018). This upheld the rights of Aboriginal people to be researchers, partners in research, collaborators and participants as a way to enhance the research outcomes, and also allowed Aboriginal voices to be heard.

The responses from the Aboriginal young people within this research have shown how they, as Aboriginal people, navigate their everyday lives in two worlds: Western and Indigenous (Nakata, 2002). It is important to show how being able to navigate the Cultural Interface is a strength for these young people who are able to recognise the way in which they interact with, are shaped by and treated by both of their worlds. By also being an Aboriginal researcher who is also navigating everyday life in two worlds I am able to use this shared lens to interact with the data.

This research was undertaken by an Aboriginal researcher, with a supervision team that also included Aboriginal people. This meant that as an emerging researcher I was able to be supported in all aspects of my research, as well as being able to involve Aboriginal people at every stage of the project. I was also able to use my own experience to assist in interpretation of the data, evidence of how Indigenous Standpoint Theory has formed the foundation of my research (Nakata, 2007).

During the project, Aboriginal young people were given multiple platforms from which to have their voices heard. The research could not have been undertaken without

employing them as peer researchers – to recruit participants and organise and conduct interviews. They gave feedback at several stages of the research, and through the debrief interview process were able to provide valuable insight and clarification about emerging topics and themes referred to by participants in their interviews. The method allowed participants to feel comfortable being interviewed by a person known to them; they could speak freely about their experiences in their community and their strengths.

The use of peer researchers was also important in ensuring that Aboriginal voices were prioritised in the research; it allowed the project to be guided and conducted by the group being studied. The interviews were not only conducted by a peer, but also in familiar language. The data was analysed by an Aboriginal researcher with extensive experience working with Aboriginal young people. This is, to the best of the author's and supervisory team's knowledge, the first time that such an approach has been used to undertake research in an urban Australian Aboriginal community.

#### **5.4 The Importance and Significance of the Research**

This research was significant in a number of ways. The use of a strengths-based approach meant that the project did not start from the common assumption of deficit – from the starting point that Aboriginal young people did not know how to manage their sexual health and that they needed adult and/or professional help. It is important to avoid a deficit approach, which perpetuates the stereotype that Aboriginal people are incapable of being healthy and solving the problems within their community.

Researchers who adopt a deficit approach ignore the systemic failures of the healthcare system in favour of placing the blame and justification for ill health on the individual. By taking a strengths-based approach, on the other hand, this research project was able to identify the ways that young people, and their families and communities, helped themselves by fact-checking and filtering information, and to show that they made rational decisions based on the information they received from multiple sources (Foster & Spencer, 2011).

This research project placed the young people in the position of expert and gave them a forum to have their own voice on issues that concerned them. This happened in their

roles both as peer researchers and participants. The use of peer researchers was what made the data in this research so important. The young people employed in this role gained skills, research experience, training and the opportunity to be involved in future research; some have since been employed as peer researchers on other research projects. The use of peer researchers to conduct interviews reduced embarrassment and shame for participants when sexual subject matter was discussed, and therefore allowed more data to be collected (Lushey & Munro, 2015). The peer researchers and participants in this research were already known to each other, and of similar ages. This redressed the power imbalance that exists when a participant must talk to an older person previously unknown to them. For example, Justin (see Section 4.2.4, “Friends”) is comfortable enough during his interview to talk about his own experience of getting an STI test. Olivia (see Section 4.3.1, “Doctors”) is comfortable enough to show anger and swear when talking about the experiences of her family. Peer researchers were also familiar with the language used by the young people in their interviews and the context of their experiences, allowing for a better understanding of the interviews, which was evident in the debriefing interviews.

## **5.5 Areas for Future Research**

This research has revealed several areas in which it would be beneficial to undertake further research that is strengths-based and Aboriginal-led. These are as follows:

- 1) Further research should be undertaken that takes a strengths-based approach to find out what young people already do well to keep themselves healthy.
- 2) Further research should be led by Aboriginal researchers. All levels of research, especially when it is focused on Aboriginal people, need to involve Aboriginal people. This allows for the values of Aboriginal people to be followed and therefore has a direct benefit for both the participants and their communities. This would allow Aboriginal researchers to play a leadership role in research projects, rather than being used merely as cultural advisors. Aboriginal researchers could then determine research subjects, making sure they mattered to Aboriginal communities, and decide on the best way to answer research questions, as outlined in the nationally recognised guidelines for ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities



(NHMRC, 2018), and adhering to the six core values of: a) Spirit and Integrity; b) Cultural Continuity; c) Equity; d) Reciprocity; e) Respect; and f) Responsibility.

3) It is important that more research be undertaken into how Aboriginal young people in an urban area feel about the use of telehealth. Important research questions could be, for example: Has the recent acceleration in the number of health services offering telehealth because of COVID-19 led to an increased uptake in Aboriginal young people's use of sexual health services (via the more anonymous telehealth)? Have there been changes in the way people understand and view telehealth? Does telehealth also perhaps allow for discussion, and the promotion of education, on the subjects of relationships and other non-physical issues?

4) More research is needed into the levels of understanding of Aboriginal young people in an urban setting with regard to the requirements of mandatory reporting and which professionals are bound by them. For example, do some Aboriginal young people not seek help or advice because of concerns about mandatory reporting? And if a young person has sought help without understanding that the professional they've consulted is bound by the requirements of mandatory reporting, has this then resulted in negative consequences for themselves and/or their family, or mistrust of other professionals?

5) More research is also needed to identify how Aboriginal young people feel about cultural expectations surrounding sexuality, and sexual health education in schools. The design and implementation of sexual health programs need to reflect the needs and requirements of Aboriginal young people.

6) Given that a limitation of this research was the lack of voices of Aboriginal young LGBTQI+ people, it would be valuable to undertake more research into the strengths of young LGBTQI+ people in the community, and how they share sexual health information and their experiences.

7) Research into the importance that is placed on fertility and childbearing on Aboriginal women living in an urban area could be beneficial. What are the experiences of Aboriginal young women that have decided to have children at an older age? This could also look at the experiences of women who have chosen to be childfree or have issues regarding fertility. The research could also look at whether women feel they have to choose between raising a family and having a career.

## 5.6 Concluding Comments

The sexual health needs of Aboriginal young people have to be viewed holistically. This research has shown that there need to be multiple sources of accessible and accurate sexual health information so that Aboriginal young people can make informed decisions regarding their own health. Information resources should be accessible on the internet to enable young people to conduct their own research. Aboriginal young people's use of both formal sources (GPs, teachers, counsellors) and informal sources (family members, friends, trusted Elders) in their communities to verify this information also needs to be taken into account, and confirms that more resources such as the *Yarning Quiet Ways* site (Government of Western Australia, 2015) should be made available to help community members. Sexual health information also needs to be expanded beyond just the physical and biological aspects of sexual health to allow for more conversations between young people and trusted sources around sexual consent, healthy relationships and other non-physical sexual health issues. When dealing with issues around sexual health, all aspects of the individual need to be addressed, including issues such as family, peer and community relationships, and bullying and poor self-esteem. A holistic approach is essential to ensure that Aboriginal ways of understanding health and wellbeing are fully addressed.

Because Aboriginal young people use multiple informal sources for information sharing and fact-checking, educational programs and health initiatives need to address the whole community to ensure better outcomes. These programs and initiatives need to teach parents and members of the community how to talk about sexual health with young people, in the way that *Yarning Quiet Ways* does (Government of Western Australia, 2015). This would help to normalise conversations about sexual health, so that conversations about sexuality might no longer be viewed as taboo or shameful.

There need to be sustained efforts towards providing up-to-date sexual health information to decrease the taboo nature of discussions around sexual health and ensure that correct information is shared at all levels. It has been shown that for approaches to sexual health to be effective they need to be implemented at multiple levels, using multiple strategies in multiple settings and fields with sustained and adequate funding commitments (Fagan et al., 2015). It is evident that the participants in this research used

the knowledge of those around them to make informed decisions regarding their sexual health. Strategies need to target not only young people, but also their trusted sources of information. To ensure a successful outcome for Aboriginal young people, communities need to accept, maintain, update and pass on to the next generation health information that is meaningful and relevant to them. This would ensure that this information is not lost and remains up to date (Shield, 2018). With young people having been shown to value the lived experience of those they turn to for advice, it is vital that a whole-of-community approach be taken to ensure that up-to-date and culturally appropriate information is available.

## References

- Arabena, K. (2016). Addressing structural challenges for the sexual health and well-being of Indigenous women in Australia. *Sexually Transmitted Infections*, 92(2), 88–89. <http://dx.doi.org/10.1136/sextrans-2015-052412>
- Australian Government Department of Health. (2013). *National Aboriginal and Torres Strait Islander health plan 2013–2023*. Commonwealth of Australia. <https://www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-health-plan-2013-2023>
- Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS). (2012). *Guidelines for Ethical Research in Australian Indigenous Studies*, AIATSIS. <http://aiatsis.gov.au/sites/default/files/docs/research-and-guides/ethics/gerais.pdf>
- Australian Institute of Family Studies (AIFS). (2018). *Digital technology use in the child, youth and family sector*. Child Family Community Australia fact sheet, AIFS. <https://aifs.gov.au/cfca/publications/digital-technology-use-child-youth-and-family-sector>
- Australian Institute of Health and Welfare (AIHW). (2017). *Australia's welfare 2017: In brief*. AIHW. [https://www.aihw.gov.au/getmedia/5c7b48ba-f5a2-46a6-96bd-2bbac02a5139/AIHW-AUS215-AW17\\_inbrief.pdf.aspx?inline=true](https://www.aihw.gov.au/getmedia/5c7b48ba-f5a2-46a6-96bd-2bbac02a5139/AIHW-AUS215-AW17_inbrief.pdf.aspx?inline=true)
- Australian Institute of Health and Welfare (AIHW). (2018). *Family, domestic and sexual violence in Australia*. AIHW. doi:[10.25816/5ebcc837fa7ea](https://doi.org/10.25816/5ebcc837fa7ea)
- Australian Institute of Health and Welfare (AIHW). (2019). *Profile of Indigenous Australians*. AIHW. <https://www.aihw.gov.au/reports/australias-welfare/profile-of-indigenous-australians>
- Australian Institute of Health and Welfare (AIHW). (2020). *Australia's mothers and babies 2018: in brief*. Perinatal statistics series no. 36. AIHW. <https://www.aihw.gov.au/getmedia/aa54e74a-bda7-4497-93ce-e0010cb66231/aihw-per-108.pdf.aspx?inline=true>
- Bainbridge, R., Whiteside, M., & McCalman, J. (2013). Being, knowing, and doing: A phronetic approach to constructing grounded theory with Aboriginal Australian

partners. *Qualitative Health Research*, 23(2), 275–288.

<https://doi.org/10.1177/1049732312467853>

Bell, S., Aggleton, P., Ward, J., Murray, W., Silver, B., Lockyer, A., Ferguson, T., Fairley, C., Whiley, D., Ryder, N., Donovan, B., Guy, R., Kaldor, J., & Maher, L. (2020a). Young Aboriginal people's engagement with STI testing in the Northern Territory, Australia. *BMC Public Health*, 20, Article 459.

<https://doi.org/10.1186/s12889-020-08565-0>

Bell, S., Ward, J., Aggleton, P., Murray, W., Silver, B., Lockyer, A., Ferguson, T., Fairley, C., Whiley, D., Ryder, N., Donovan, B., Guy, R., Kaldor, J., & Maher, L. (2020b). Young Aboriginal people's sexual health risk reduction strategies: A qualitative study in remote Australia. *Sexual Health*, 17(4), 303–310.

<https://doi.org/10.1071/SH19204>

Biggs, K., Walsh, J., & Ooi, C. (2016). Deadly Liver Mob: Opening the door – improving sexual health pathways for Aboriginal people in Western Sydney. *Sexual Health*, 13(5), 457–464. <https://doi.org/10.1071/SH15176>

Blaikie, N. W. (2007). *Approaches to social enquiry*. Polity Press.

Bourne, C., Lam, M., Selvey, C., Guy, R., & Callander, D. (2018). Changing pattern of sexually transmissible infections and HIV diagnosed in public sexual health services compared with other locations in New South Wales, 2010–14. *Sexual Health*, 15(4), 366–369. <https://doi.org/10.1071/SH17183>

Bradbury-Jones, C., & Taylor, J. (2015). Engaging with children as co-researchers: Challenges, counter-challenges and solutions. *International Journal of Social Research Methodology*, 18(2), 161–173. <https://doi.org/10.1080/13645579.2013.864589>

Brown, A., & Blashki, G. (2005). Indigenous male health disadvantage: Linking the heart and mind. *Australian Family Physician*, 34(10), 813–819.

<https://www.racgp.org.au/afpbackissues/2005/200510/200510brown.pdf>

Brown, L. (2016, November 25). Why we need to educate journalists about Aboriginal women's experience of family violence. *The Conversation*.

<https://theconversation.com/why-we-need-to-educate-journalists-about-aboriginal-womens-experience-of-family-violence-65789>

Bryant, J., Ward, J., Worth, H., Hull, P., Solar, S., & Bailey, S. (2011). Safer sex and condom use: A convenience sample of Aboriginal young people in New South Wales. *Sexual Health*, 8(3), 378–383. doi:[10.1071/SH10138](https://doi.org/10.1071/SH10138)

Chester, A., & Glass, C. A. (2006). Online counselling: A descriptive analysis of therapy services on the Internet. *British Journal of Guidance & Counselling*, 34(2), 145–160. <https://doi.org/10.1080/03069880600583170>

Clarke, V., & Braun, V. (2017). Thematic analysis. *Journal of Positive Psychology*, 12(3), 297–298. <https://doi.org/10.1080/17439760.2016.1262613>

Commonwealth of Australia. (2013). *National Aboriginal and Torres Strait Islander health plan 2013–2023*. Commonwealth of Australia. <https://www.health.gov.au/sites/default/files/documents/2021/02/national-aboriginal-and-torres-strait-islander-health-plan-2013-2023.pdf>

Couch, J., Durant, B., & Hill, J. (2014). Uncovering marginalised knowledges: Undertaking research with hard-to-reach young people. *International Journal of Multiple Research Approaches*, 8(1), 15–23. <https://doi.org/10.5172/mra.2014.8.1.15>

Davies, J., Bukulatjpi, S., Sharma, S., Davis, J., & Johnston, V. (2014). “Only your blood can tell the story”: A qualitative research study using semi-structured interviews to explore the hepatitis B related knowledge, perceptions and experiences of remote dwelling Indigenous Australians and their health care providers in northern Australia. *BMC Public Health*, 14, Article 1233. <https://doi.org/10.1186/1471-2458-14-1233>

D’Costa, B., Lobo, R., Thomas, J., & Ward, J. S. (2019). Evaluation of the Young Deadly Free peer education training program: Early results, methodological challenges, and learnings for future evaluations. *Frontiers in Public Health*, 7. <https://doi.org/10.3389/fpubh.2019.00074>

Denzin, N. K., & Lincoln, Y. S. (2008). *The SAGE handbook of qualitative research* (5th ed.). Sage Publishing.

de Visser, R. O., Badcock, P. B., Simpson, J. M., Grulich, A. E., Smith, A. M. A., Richters, J., & Rissel, C. (2014). Attitudes toward sex and relationships: The Second Australian Study of Health and Relationships. *Sexual Health*, 11(5), 397–405. <https://doi.org/10.1071/SH14099>

Duley, P., Botfield, J. R., Ritter, T., Wicks, J., & Brassil, A. (2017). The Strong Family Program: An innovative model to engage Aboriginal and Torres Strait Islander youth and Elders with reproductive and sexual health community education. *Health Promotion Journal of Australia*, 28(2), 132–138. doi: [10.1071/HE16015](https://doi.org/10.1071/HE16015)

Dunn, K. (2012). A qualitative investigation into the online counselling relationship: To meet or not to meet, that is the question. *Counselling and Psychotherapy Research*, 12(4), 316–326. <https://doi.org/10.1080/14733145.2012.669772>

Elliott, E., Watson, A. J., & Harries, U. (2002). Harnessing expertise: Involving peer interviewers in qualitative research with hard-to-reach populations. *Health Expectations*, 5(2), 172–178. doi:[10.1046/j.1369-6513.2002.00158](https://doi.org/10.1046/j.1369-6513.2002.00158)

Eriks-Brophy, A., Quittenbaum, J., Anderson, D., & Nelson, T. (2008). Part of the problem or part of the solution? Communication assessments of Aboriginal children residing in remote communities using videoconferencing. *Clinical Linguistics & Phonetics*, 22(8), 589–609. doi:[10.1080/02699200802221737](https://doi.org/10.1080/02699200802221737)

Fagan, P. S., Robertson, H. K., Pedrana, A. E., Raulli, A., & Crouch, A. A. (2015). Successes in sexual health communications development, programmatic implementation and evaluation in the Torres Strait region 2006 to 2012. *Australian and New Zealand Journal of Public Health*, 39(3), 270–276. doi: [10.1111/1753-6405.12356](https://doi.org/10.1111/1753-6405.12356)

Fforde, C., Bamblett, L., Lovett, R., Gorringer, S., & Fogarty, B. (2013). Discourse, deficit and identity: Aboriginality, the race paradigm and the language of representation in contemporary Australia. *Media International Australia*, 149(1), 162–173. <https://doi.org/10.1177/1329878X1314900117>

Fisher, C. M., Waling, A., Kerr, L., Bellamy, R., Ezer, P., Mikołajczak, G., Brown, G., Carman, M, & Lucke, J. (2019). *6th National Survey of Australian Secondary Students and Sexual Health 2018*. (ARCSHS Monograph Series No. 113). Australian Research Centre in Sex, Health & Society, La Trobe University. doi: [10.26181/5c80777f6c35e](https://doi.org/10.26181/5c80777f6c35e)

Flink, I. J. E., Mbaye, S. M. O., Diouf, S. R. B., Baumgartner, S., & Okur, P. (2018). Collaboration between a child telephone helpline and sexual and reproductive health and rights organisations in Senegal: Lessons learned. *Sex Education: Sexuality, Society and Learning*, 18(1), 32–46. <https://doi.org/10.1080/14681811.2017.1376276>

Foster, K. R., & Spencer, D. (2011). At risk of what? Possibilities over probabilities in the study of young lives. *Journal of Youth Studies*, 14(1), 125–143.

<https://doi.org/10.1080/13676261.2010.506527>

Garrett, C. C., Hocking, J., Chen, M. Y., Fairley, C. K., & Kirkman, M. (2011). Young people's views on the potential use of telemedicine consultations for sexual health: Results of a national survey. *BMC Infectious Diseases*, 11, Article 285.

<https://doi.org/10.1186/1471-2334-11-285>

Gold, J., Lim, M. S. C., Hellard, M. E., Hocking, J. S., & Keogh, L. (2010). What's in a message? Delivering sexual health promotion to young people in Australia via text messaging. *BMC Public Health*, 10, Article 792. <https://doi.org/10.1186/1471-2458-10-792>

Goller, J. L., Ward, J., Saunders, M., Couzos, S., Kaldor, J., & Hellard, M. A. (2012). Chlamydia sentinel surveillance in Aboriginal Community Controlled Health Services finds higher testing and positivity rates among younger people. *Australian and New Zealand Journal of Public Health*, 36(6), 577–581. doi: [10.1111/j.1753-6405.2012.00929.x](https://doi.org/10.1111/j.1753-6405.2012.00929.x)

Gomez, R. J., & Ryan, T. N. (2016). Speaking out: Youth led research as a methodology used with homeless youth. *Child and Adolescent Social Work Journal*, 33(2), 185–193. <https://doi.org/10.1007/s10560-015-0414-4>

Government of Western Australia. (2016) *Yarning Quiet Ways: Teaching kids to have strong, safe and healthy relationships*. Sexual Health and Blood-borne Virus Program, Department of Health. <https://gdhr.wa.gov.au/web/yarning-quiet-ways>

Grbich, C. (1999). *Qualitative research in health: An introduction*. Sage Publications.

Hailey, D. (2005). Technology and managed care: Is telemedicine the right tool for rural communities? *Journal of Postgraduate Medicine*, 51(4), 275–278.

<https://www.jpogmonline.com/text.asp?2005/51/4/275/19240>

Hildebrand, J., Maycock, B., Comfort, J., Burns, S., Adams, E., & Howat, P. (2015). Ethical considerations in investigating youth alcohol norms and behaviours: A case for mature minor consent. *Health Promotion Journal of Australia*, 26(3), 241–245.

<https://doi.org/10.1071/HE14101>



Holmes, W., Stewart, P., Garrow, A., Anderson, I., & Thorpe, L. (2002). Researching Aboriginal health: Experience from a study of urban young people's health and well-being. *Social Science & Medicine*, 54(8), 1267–1279. doi:[10.1016/s0277-9536\(01\)00095-8](https://doi.org/10.1016/s0277-9536(01)00095-8)

Ippoliti, N. B., & L'Engle, K. (2017). Meet us on the phone: Mobile phone programs for adolescent sexual and reproductive health in low-to-middle income countries. *Reproductive Health*, 14(1), 11. doi:[10.1186/s12978-016-0276-z](https://doi.org/10.1186/s12978-016-0276-z)

Isaacs, A., Pepper, H., Pyett, P., Gruis, H., Waples-Crowe, P., & Oakley Browne, M. (2011). “What you do is important but how you do it is more important”. *Qualitative Research Journal*, 11(1), 51–61. doi: [10.3316/QRJ1101051](https://doi.org/10.3316/QRJ1101051)

Joint Select Committee on Cyber-Safety. (2013). *Issues surrounding cyber-safety for Indigenous Australians*. Issue 244 of Parliamentary paper. Parliament of the Commonwealth of Australia.  
[https://www.aph.gov.au/Parliamentary\\_Business/Committees/House\\_of\\_Representatives\\_Committees?url=jssc/indigenous\\_australians/report.htm](https://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=jssc/indigenous_australians/report.htm)

Kelly, J., & Luxford, Y. (2007). Yaitya tirka madlanna warratinna [Culture nothing without language]: Exploring what sexual health nurses need to know and do in order to meet the sexual health needs of young Aboriginal women in Adelaide. *Collegian*, 14(3), 15–20. [https://doi.org/10.1016/S1322-7696\(08\)60560-0](https://doi.org/10.1016/S1322-7696(08)60560-0)

Kildea, S., & Bowden, F. (2000). Reproductive health, infertility and sexually transmitted infections in Indigenous women in a remote community in the Northern Territory. *Australian and New Zealand Journal of Public Health*, 24(4), 382–386.  
<https://doi.org/10.1111/j.1467-842X.2000.tb01598.x>

Kildea, S., Gao, Y., Hickey, S., Kruske, S., Nelson, C., Blackman, R., Tracy, S., Hurst, C., Williamson, D., & Roe, Y. (2019). Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: A prospective cohort study, Brisbane, Australia. *EClinicalMedicine*, 12, 43–51. doi: [10.1016/j.eclinm.2019.06.001](https://doi.org/10.1016/j.eclinm.2019.06.001)

Kirby Institute. (2017). Bloodborne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander people: Annual surveillance report 2017. Kirby Institute, University of New South Wales.

Kirby Institute. (2018). Bloodborne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander people: Annual surveillance report 2018. Kirby Institute, University of New South Wales.

Korda, H., & Itani, Z. (2013). Harnessing social media for health promotion and behavior change. *Health Promotion Practice, 14*(1), 15–23.  
doi:[10.1177/1524839911405850](https://doi.org/10.1177/1524839911405850)

Kovach, M. (2009). Indigenous methodologies: Characteristics, conversations and contexts. University of Toronto Press.

Lakhan, P., Askew, D., Harris, M. F., Kirk, C., & Hayman, N. (2017). Understanding health talk in an urban Aboriginal and Torres Strait Islander primary healthcare service: A cross-sectional study. *Australian Journal of Primary Health, 23*(4), 335–341.  
doi:[10.1071/PY16162](https://doi.org/10.1071/PY16162)

Laws, T. A., & Bradley, H. (2003). Transmission of health knowledge and health practices from men to boys among Aboriginal communities and non-Indigenous Australians: Searching for evidence. *Contemporary Nurse, 15*(3), 249–261.  
doi:[10.5172/conu.15.3.249](https://doi.org/10.5172/conu.15.3.249)

Lushey, C. J., & Munro, E. R. (2015). Participatory peer research methodology: An effective method for obtaining young people’s perspectives on transitions from care to adulthood? *Qualitative Social Work, 14*(4), 522–537.  
<https://doi.org/10.1177/1473325014559282>

Martin, K., Dono, J., Rigney, N., Rayner, J., Sparrow, A., Miller, C., Mckivett, A., O’Dea, K., Roder, D., & Bowden, J. (2017). Barriers and facilitators for health professionals referring Aboriginal and Torres Strait Islander tobacco smokers to the Quitline. *Australian and New Zealand Journal of Public Health, 41*(6), 631–634.  
doi:[10.1111/1753-6405.12727](https://doi.org/10.1111/1753-6405.12727)

Martin, K., Gardner, K., Bryant, J., Bolt, R., Doyle, M., Murphy, D., Graham, S., & Beadman, M. (2020). “What we do well”: Strengths-based research about Aboriginal young people’s sexual wellbeing in Western Sydney. Australian Federation of Aids Organisation. <https://www.afao.org.au/wp-content/uploads/2020/11/What-We-Do-Well-ReviewFinalTemplateversion-.pdf>

- Martin, K., & Mirraoopa, B. (2003). Ways of knowing, being and doing: A theoretical framework and methods for Indigenous and Indigenist re-search. *Journal of Australian Studies*, 27(76), 203–214. doi:[10.1080/14443050309387838](https://doi.org/10.1080/14443050309387838)
- McEwan, A., Crouch, A., Robertson, H., & Fagan, P. (2013). The Torres Indigenous Hip Hop Project: Evaluating the use of performing arts as a medium for sexual health promotion. *Health Promotion Journal of Australia*, 24(2), 132–136. doi:[10.1071/HE12924](https://doi.org/10.1071/HE12924)
- Minichiello, V., Rahman, S., Dune, T., Scott, J., & Dowsett, G. (2013). E-health: Potential benefits and challenges in providing and accessing sexual health services. *BMC Public Health*, 13, Article 790. doi:[10.1186/1471-2458-13-790](https://doi.org/10.1186/1471-2458-13-790)
- Mishna, F., Bogo, M., & Sawyer, J.-L. (2015). Cyber counseling: Illuminating benefits and challenges. *Clinical Social Work Journal*, 43(2), 169–178. <https://doi.org/10.1007/s10615-013-0470-1>
- Mooney-Somers, J., Erick, W., Scott, R., Akee, A., Kaldor, J., & Maher, L. (2009). Enhancing Aboriginal and Torres Strait Islander young people's resilience to blood-borne and sexually transmitted infections: Findings from a community-based participatory research project. *Health Promotion Journal of Australia*, 20(3), 195–201. doi:[10.1071/he09195](https://doi.org/10.1071/he09195)
- Mooney-Somers, J., Olsen, A., Erick, W., Scott, R., Akee, A., Kaldor, J., & Maher, L. (2011). Learning from the past: Young Indigenous people's accounts of blood-borne viral and sexually transmitted infections as resilience narratives. *Culture, Health & Sexuality*, 13(2), 173–186. doi:[10.1080/13691058.2010.520742](https://doi.org/10.1080/13691058.2010.520742)
- Mooney-Somers, J., Olsen, A., Erick, W., Scott, R., Akee, A., & Maher, L. (2012). Young Indigenous Australians' Sexually Transmitted Infection Prevention Practices: A Community-based Participatory Research Project: Young Indigenous Australian's sexually transmitted infection prevention practices. *Journal of Community & Applied Social Psychology*, 22(6), 519–532. <https://doi.org/10.1002/casp.1134> [This does not appear to be cited in the text. Does this matter?]

- Morrison, P. (2000). A pilot implementation of internet access for remote Aboriginal communities in the “top end” of Australia. *Urban Studies*, 37(10), 1781–1792. <https://doi.org/10.1080/00420980020080401>
- NACCHO. (2021). Aboriginal Community Controlled Health Organisations (ACCHOs). <https://www.naccho.org.au/>
- Nakata, M. (2002). Indigenous Knowledge and the Cultural Interface: Underlying issues at the intersection of knowledge and information systems. *IFLA Journal*, 28(5–6), 218–221. <https://doi.org/10.1177/034003520202800513>
- Nakata, M. (2007). *Disciplining the savages: Savaging the disciplines*. Aboriginal Studies Press, AIATSIS.
- National Health and Medical Research Council (NHMRC). (2018). Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders. Commonwealth of Australia. [www.nhmrc.gov.au/guidelines-publications/ind2](http://www.nhmrc.gov.au/guidelines-publications/ind2)
- Nikkelen, S. W. C., van Oosten, J. M. F., & van den Borne, M. M. J. J. (2020). Sexuality education in the digital era: Intrinsic and extrinsic predictors of online sexual information seeking among youth. *Journal of Sex Research*, 57(2), 189–199. <https://doi.org/10.1080/00224499.2019.1612830>
- NSW Department of Communities & Justice. (2020). Who are mandatory reporters? NSW Government. <https://www.facs.nsw.gov.au/families/Protecting-kids/mandatory-reporters/about>
- O’Connor, C. C., Ali, H., Guy, R. J., Templeton, D. J., Fairley, C. K., Chen, M. Y., Dickson, B. M., Marshall, L. J., Grulich, A. E., Hellard, M. E., Kaldor, J. M., Donovan, B., & Ward, J. S. (2014). High chlamydia positivity rates in Indigenous people attending Australian sexual health services. *Medical Journal of Australia*, 200(10), 595–598. doi: [10.5694/mja13.10875](https://doi.org/10.5694/mja13.10875)
- Panaretto, K. S., Lee, H. M., Mitchell, M. R., Larkins, S. L., Manassis, V., Buettner, P. G., & Watson, D. (2006). Prevalence of sexually transmitted infections in pregnant urban Aboriginal and Torres Strait Islander women in northern Australia. *Australian*

and *New Zealand Journal of Obstetrics and Gynaecology*, 46(3), 217–224.  
doi:[10.1111/j.1479-828X.2006.00577.x](https://doi.org/10.1111/j.1479-828X.2006.00577.x)

Plunkett, A. L. P. (1996). *Indigenous mothers and their babies Australia 1991–1993*. National Perinatal Statistics Unit, Australian Institute of Health and Welfare.

Pound, P., Langford, R., & Campbell, R. (2016). What do young people think about their school-based sex and relationship education? A qualitative synthesis of young people's views and experiences. *BMJ Open*, 6, e011329. doi:[10.1136/bmjopen-2016-011329](https://doi.org/10.1136/bmjopen-2016-011329)

Price, M., & Dalglish, J. (2013). Help-seeking among Indigenous Australian adolescents: Exploring attitudes, behaviours and barriers. *Youth Studies Australia*, 32(1), 10–18.

Price, N., & Hawkins, K. (2002). Researching sexual and reproductive behaviour: A peer ethnographic approach. *Social Science & Medicine*, 55(8), 1325–1336.  
doi:[10.1016/s0277-9536\(01\)00277-5](https://doi.org/10.1016/s0277-9536(01)00277-5)

Rice, E. S., Haynes, E., Royce, P., & Thompson, S. C. (2016). Social media and digital technology use among Indigenous young people in Australia: A literature review. *International Journal for Equity in Health*, 15, Article 81. doi:[10.1186/s12939-016-0366-0](https://doi.org/10.1186/s12939-016-0366-0)

Rodda, S. N., Lubman, D. I., Dowling, N. A., & McCann, T. V. (2013). Reasons for using web-based counselling among family and friends impacted by problem gambling. *Asian Journal of Gambling Issues and Public Health*, 3, Article 12.  
<https://doi.org/10.1186/2195-3007-3-12>

Scott, R., Foster, R., Oliver, L. N., Olsen, A., Mooney-Somers, J., Mathers, B., Micallef, J. M., Kaldor, J., & Maher, L. (2015). Sexual risk and healthcare seeking behaviour in young Aboriginal and Torres Strait Islander people in North Queensland. *Sexual Health*, 12(3), 194–199. doi:[10.1071/SH14092](https://doi.org/10.1071/SH14092)

Senior, K. A., & Chenhall, R. D. (2008). “Walkin’ about at night”: The background to teenage pregnancy in a remote Aboriginal community. *Journal of Youth Studies*, 11(3), 269–281. <https://doi.org/10.1080/13676260801946449>

Senior, K., Chenhall, R., & Helmer, J. (2020). “Boys mostly just want to have sex”: Young Indigenous people talk about relationships and sexual intimacy in remote, rural and regional Australia. *Sexualities*, 23(8), 1457–1479.

<https://doi.org/10.1177/1363460720902018>

Senior, K., Helmer, J., & Chenhall, R. (2017). “As long as he’s coming home to me”: Vulnerability, jealousy and violence in young people’s relationships in remote, rural and regional Australia. *Health Sociology Review*, 26(2), 204–218.

<https://doi.org/10.1080/14461242.2016.1157697>

Senior, K., Helmer, J., Chenhall, R., & Burbank, V. (2014). “Young clean and safe?” Young people’s perceptions of risk from sexually transmitted infections in regional, rural and remote Australia. *Culture, Health & Sexuality*, 16(4), 453–466.

<https://doi.org/10.1080/13691058.2014.888096>

Sherwood, J. (2013). Colonisation – it’s bad for your health: The context of Aboriginal health. *Contemporary Nurse*, 46(1), 28–40. doi:[10.5172/conu.2013.46.1.28](https://doi.org/10.5172/conu.2013.46.1.28)

Shield, J. M., Kearns, T. M., Garngulkpuy, J., Walpulay, L., Gundjirryirr, R., Bundhala, L., Djarpanbuluwuy, V., Andrews, R. M., & Judd, J. (2018). Cross-cultural, Aboriginal language, discovery education for health literacy and informed consent in a remote Aboriginal community in the Northern Territory, Australia. *Tropical Medicine and Infectious Disease*, 3(1), 15. doi:[10.3390/tropicalmed3010015](https://doi.org/10.3390/tropicalmed3010015)

Shoveller, J., Knight, R., Davis, W., Gilbert, M., & Ogilvie, G. (2012). Online sexual health services: Examining youth’s perspectives. *Canadian Journal of Public Health*, 103(1), 14–18. doi:[10.1007/BF03404062](https://doi.org/10.1007/BF03404062)

Smith, J. A., Merlino, A., Christie, B., Adams, M., Bonson, J., Osborne, R., Judd, B., Drummond, M., Aanundsen, D., & Fleay, J. (2020). “Dudes are meant to be tough as nails”: The complex nexus between masculinities, culture and health literacy from the perspective of young Aboriginal and Torres Strait Islander males: Implications for policy and practice. *American Journal of Men’s Health*, 14(3).

<https://doi.org/10.1177/1557988320936121>

Somekh, B & Lewin, C. (2011). *Theory and Method in Social Research* (Second Edition). Sage Publications.

Stark, A. M., & Hope, A. (2007). Aboriginal women's stories of sexually transmissible infection transmission and condom use in remote central Australia. *Sexual Health*, 4(4), 237–242. <https://doi.org/10.1071/SH07009>

Strategic Relations and Communications Branch, NSW Ministry of Health. (2016). *NSW Health Annual Report 2015–16*. Government of NSW.

Treloar, C., Gray, R., Brener, L., Jackson, C., Saunders, V., Johnson, P., Harris, M., Butow, P., & Newman, C. (2013). Health literacy in relation to cancer: Addressing the silence about and absence of cancer discussion among Aboriginal people, communities and health services. *Health & Social Care in the Community*, 21(6), 655–664. doi:[10.1111/hsc.12054](https://doi.org/10.1111/hsc.12054)

Uink, B., Liddelow-Hunt, S., Daglas, K., & Ducasse, D. (2020). The time for inclusive care for Aboriginal and Torres Strait Islander LGBTQ+ young people is now. *Medical Journal of Australia*, 213(5), 201–204.e1. doi:[10.5694/mja2.50718](https://doi.org/10.5694/mja2.50718)

Vass, A., Mitchell, A., & Dhurrkay, Y. (2011). Health literacy and Australian Indigenous peoples: An analysis of the role of language and worldview. *Health Promotion Journal of Australia*, 22(1), 33–37. doi:[10.1071/HE11033](https://doi.org/10.1071/HE11033)

Vujcich, D., Lyford, M., Bellottie, C., Bessarab, D., & Thompson, S. (2018). Yarning quiet ways: Aboriginal carers' views on talking to youth about sexuality and relationships. *Health Promotion Journal of Australia*, 29(1), 39–45. <https://doi.org/10.1002/hpja.14>

Waling, A., Bellamy, R., Ezer, P., Kerr, L., Lucke, J., & Fisher, C. (2020). “It’s kinda bad, honestly”: Australian students’ experiences of relationships and sexuality education. *Health Education Research*, 35(6), 538–552. doi:[10.1093/her/cyaa032](https://doi.org/10.1093/her/cyaa032)

Waling, A., Kerr, L., Fraser, S., Bourne, A., & Carman, M. (2019). Young people, sexual literacy, and sources of knowledge: A review (ARCSHS Monograph series No. 119). Australian Research Centre in Sex, Health and Society, La Trobe University. DOI: [10.26181/5d9ea9a96d8e0](https://doi.org/10.26181/5d9ea9a96d8e0)

Wand, H., Ward, J., Bryant, J., Delaney-Thiele, D., Worth, H., Pitts, M., & Kaldor, J. M. (2016). Individual and population level impacts of illicit drug use, sexual risk behaviours on sexually transmitted infections among young Aboriginal and Torres Strait Islander people: Results from the GOANNA survey. *BMC Public Health*, 16(1), Article 600. <https://doi.org/10.1186/s12889-016-3195-6>

Ward, J., Bryant, J., Wand, H., Pitts, M., Smith, A., Delaney-Thiele, D., Worth, H., Kaldor, J. (2014). Sexual health and relationships in young Aboriginal and Torres Strait Islander people: Results from the first national study assessing knowledge, risk practices and health service use in relation to sexually transmitted infections and blood borne viruses. Baker IDI Heart & Diabetes Institute.

Ward, J., Bryant, J., Worth, H., Hull, P., Solar, S., & Bailey, S. (2013). Use of health services for sexually transmitted and blood-borne viral infections by young Aboriginal people in New South Wales. *Australian Journal of Primary Health*, 19(1), 81–86. doi:[10.1071/PY11032](https://doi.org/10.1071/PY11032)

Ward, J., Elliott, S., Bryant, J., Donovan, B., Pitts, M., Wand, H., & Kaldor, J. (2020). The GOANNA Survey 2. Results of the second Australian survey of knowledge, relationships, behaviour and health service access relating to sexually transmissible infections (STIs) and blood borne viruses (BBVs) among Aboriginal and Torres Strait Islander young people. South Australian Health and Medical Research Institute (SAHMRI). <https://youngdeadlyfree.org.au/wp-content/uploads/2021/01/GoannaSurvey2-FINAL.pdf>

Ward, J., Wand, H., Bryant, J., Delaney-Thiele, D., Worth, H., Pitts, M., Byron, K., Moore, E., Donovan, B., & Kaldor, J. M. (2016). Prevalence and correlates of a diagnosis of sexually transmitted infection among young Aboriginal and Torres Strait Islander people: A national survey. *Sexually Transmitted Diseases*, 43(3), 177–184. doi:[10.1097/OLQ.0000000000000417](https://doi.org/10.1097/OLQ.0000000000000417)

Whiteside, M., Tsey, K., Crouch, A., & Fagan, P. (2012). Youth and Relationship Networks (YARNS): Mobilising communities for sexual health. *Health Promotion Journal of Australia*, 23(3), 226–230. <https://doi.org/10.1071/HE12226>



Winters, J. M., & Winters, J. M. (2007). Videoconferencing and telehealth technologies can provide a reliable approach to remote assessment and teaching without compromising quality. *Journal of Cardiovascular Nursing*, 22(1), 51–57.  
[doi:10.1097/00005082-200701000-00008](https://doi.org/10.1097/00005082-200701000-00008)

Wisnieski, D., Sieving, R., & Garwick, A. (2015). Parent and family influences on young women's romantic and sexual decisions. *Sex education*, 15(2), 144–157.  
<https://doi.org/10.1080/14681811.2014.986798>

World Health Organization. (1986). *Ottawa Charter for Health Promotion: First International Conference on Health Promotion, Ottawa, 21 November 1986*.  
[https://www.healthpromotion.org.au/images/ottawa\\_charter\\_hp.pdf](https://www.healthpromotion.org.au/images/ottawa_charter_hp.pdf)

## Appendix 1: Interview Schedule

1. What do parent, elders and other adults in our community think are the best places for our community to get help for our health?
  - a. Follow-up:
  - b. Why are these thought to be the best places?
2. Where do young people think is *the best place* to get help for issues about sex and sexual relationships?
  - a. Follow-up:
  - b. What makes these places good for young people?
3. Apart from this 'best place' what other places do young people get help for sex and relationships? What are the good and bad experiences for young people at those places?
  - a. Follow-up:
  - b. Which places do young people get condoms? Where's the best place to get them?
  - c. Which places do young people go to get tested? What are young people's good or bad experiences with testing at these places?
  - d. Which places do young people go if they are pregnant? What are young people's experiences with these places?

4. What sort of cultural sensitivities do young people face when learning about health (and sexual health in mainstream environments)?
5. If you were designing posters or programs about sexual health for our community/families, what do you think would be important to include?
  - a. Follow-up:
  - b. What sort of health messages work the best, do you think?
  - c. What's the best way to deliver health messages to young people?
6. Can you think of examples of technology that people are comfortable using to answer questions they have around sex?
7. What do you think are some of the challenges when trying to find sexual health information over the internet?
8. What do you think can be done to fix the challenges?