Aboriginal and Torres Strait Islander adolescents and their attitudes and behaviours around relationships, contraception and pregnancy: lessons for policy and practice

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Abstract

Aims: The "U Mob Yarn Up" project emerged from expressed needs of young Indigenous mothers at Townsville Aboriginal and Islander Health Service (TAIHS), and investigated attitudes and behaviours of young Indigenous people around relationships and pregnancy.

Method: An innovative consultative methodology and participatory action techniques were used. A Young Mums' Group functioned as project designers, key participants and peer interviewers, and as a social support group. A multi-method design involved semi-structured interviews (individual and small-group) and a multimedia self-administered survey with peer assistance. 186 Indigenous students from 3 high schools and a homeless youth shelter, and 10 further young mothers took part.

Results: Key results from young mothers and never-pregnant young people will be summarised. These highlight the extremely disadvantaged backgrounds of the young women prior to pregnancy and the transformative effect of motherhood in terms of providing purpose for their lives and impetus for change (contingent upon adequate professional and psychosocial support). In addition, the educational aspirations and attitudes and behaviours around sexual relationships and contraceptive use of these young people will be discussed.

Implications: However, the main focus of this paper will be on the implications of the findings in terms of clinical practice for primary health care providers, and policy around sexual and reproductive health care and education for this population.

For health care providers these include: the importance of providing sensitive and non-judgemental antenatal and postnatal health care; linking with local Young Mums' Groups; facilitating access to the category of "good mothers"; increasing access for young Indigenous people to contraception, STI testing and abortion; and providing adequate and realistic family planning information for young people.

For policy makers priorities include: the provision of broadly based and culturally appropriate sexuality education (through schools and other networks); further training and support for young mothers; programs to prevent violence and abuse within Indigenous families; and reinforcing broader pedagogical initiatives to increase the range of educational and vocational options for Indigenous young people.

Introduction

Adolescence is a time when many young people experiment and start to engage in sexual activity. Individual psychological factors[1, 2], peer norms[3], family structure[4], neighbourhood factors[5], poverty, school engagement[6] and cultural values regarding sexuality may all exert powerful influences on a teenager's decisions (or lack of decisions) around sex.[7]

The high teenage fertility rate of Indigenous women of 69/1000, reflected in the Mums and Babies section of Townsville Aboriginal and Islander Health Service[8], is more than 4 times that of all teenage women.[9] Teenage pregnancy rates are also much higher in rural and remote communities in Australia with worse obstetric outcomes.[10, 11] Indigenous young people are considered a priority group for sexually transmitted infection (STI) strategies[12] and teenage pregnancy programs[13], and have lower rates of contraceptive use.[14] Indigenous adolescents deal with youth transitions and sexual maturation in a society that is often hostile[15]. They face socio-economic and educational disadvantage while working through tasks integral to Indigenous cultural identity formation.[16] Gender relations and family and cultural norms around sexual behaviour may differ in Indigenous communities, and a pattern of earlier transitions and parenthood may be encouraged.[17]

Teenage pregnancy tends to be problematised in non-Indigenous Australian society[18, 19], under prominent public discourses stressing the importance of education and ongoing employment. It is important that we, as health care providers and policy makers do not contribute to ongoing discrimination and harassment that further hinders young parents (often already vulnerable through poor self-esteem and poverty) from seeking assistance with education, workforce entry and childrearing.[19, 20]

The "U Mob Yarn Up" project emerged from expressed needs of young Indigenous mothers at Townsville Aboriginal and Islander Health Service (TAIHS), and aimed to investigate attitudes and behaviours of young Indigenous people around relationships and pregnancy and the relationship between attitudes, behaviours and outcomes. This paper briefly reports on findings from the project, then discusses the implications of these findings in terms of practice for health care providers, and for policy makers. Given the high rates of teenage pregnancy and STIs in Aboriginal and Torres Strait Islander and rural and remote young people these are priority areas for rural and remote health care providers.
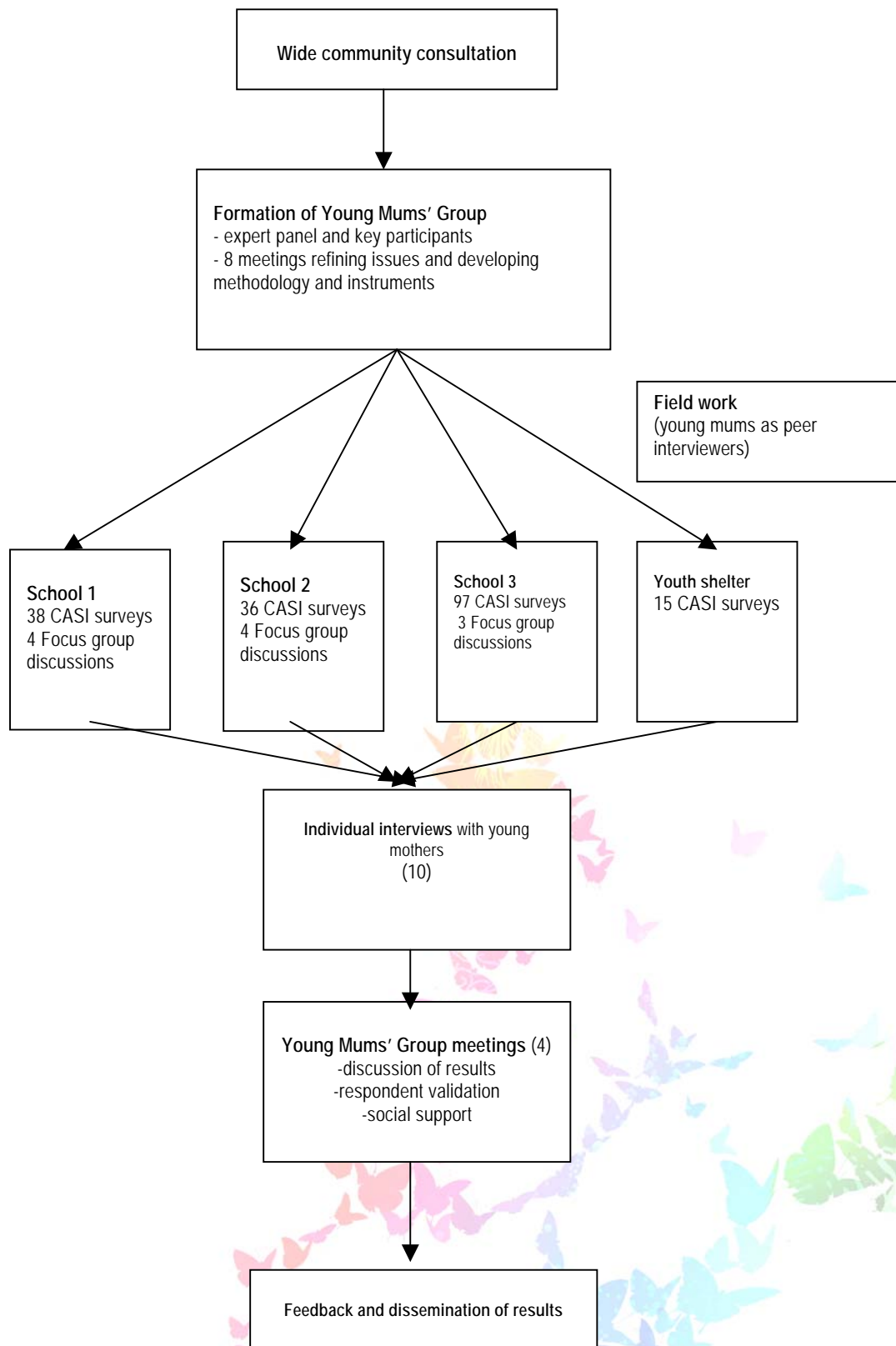
Methods

The Townsville region has a large Indigenous population of 16,750 (5.2% of the total population).[21] Of the Indigenous population, 70% are Aboriginal and 30% are Torres Strait Islanders. 3,178 Indigenous young people between the ages of 15 and 24 lived in the Townsville ATSIC region at the 2001 Census, reflecting the younger population distribution for Indigenous Australians.[22]

Study design

A mixed-methods design was chosen, with an inductive qualitative approach. Data collection involved computer-assisted self-interviews (CASI), focus groups and individual interviews. The innovative consultative methodology of the project is reported elsewhere (Figure 1).[23, 24] Briefly, a Young Mums' Group operating on a participatory action model[25, 26] served to design the project, act as key participants and peer interviewers and as a social support group.

Figure 1   U Mob Yarn Up Project Structure

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                    ┌─────────────────────────────────┐
                    │   Wide community consultation    │
                    └─────────────────────────────────┘
                                     │
                                     ▼
          ┌───────────────────────────────────────────────┐
          │ Formation of Young Mums' Group                │
          │ - expert panel and key participants           │
          │ - 8 meetings refining issues and developing   │
          │ methodology and instruments                   │
          └───────────────────────────────────────────────┘
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Field work
(young mums as peer
interviewers)

School 1	School 2	School 3	Youth shelter
38 CASI surveys	36 CASI surveys	97 CASI surveys	15 CASI surveys
4 Focus group discussions	4 Focus group discussions	3 Focus group discussions	

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          │ Individual interviews with young              │
          │ mothers                                       │
          │ (10)                                          │
          └───────────────────────────────────────────────┘
                                     │
                                     ▼
          ┌───────────────────────────────────────────────┐
          │ Young Mums' Group meetings (4)                │
          │        -discussion of results                 │
          │        -respondent validation                 │
          │        -social support                        │
          └───────────────────────────────────────────────┘
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          ┌───────────────────────────────────────────────┐
          │ Feedback and dissemination of results         │
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These data were obtained in 2004 from CASI surveys and focus group discussions from 3 public schools in Townsville with the highest enrolments of Indigenous students and a homeless youth shelter, and from group discussions and individual interviews with young mothers. The laptop-based CASI, originally designed with input from other surveys[27-29], enquired about home, school, general health and substance use, relationships, sex and contraception and attitudes towards childbearing using appealing, multimedia technology. Focus group discussions, facilitated by an Indigenous and a non-Indigenous researcher, included a theoretically sampled subgroup of survey participants in single-sex friendship groups and covered similar areas.[30] Focus groups were audiotaped and transcribed in full. Consent was obtained from participants and their parents for school students and participants alone for Youth Shelter residents and young mothers.

In addition to the multiple Young Mums' Group discussions, individual in-depth interviews were carried out with 10 young pregnant and parenting Aboriginal and Islander women in late 2004. These interviews were carried out in various locations according to the preference of the young woman. They ranged in length from 40 to 85 minutes. In one case the young woman's partner was present, and in several, children were present. The project received ethical approval from the James Cook University Human Research Ethics Committee, Education Queensland and the TAIHS Board of Directors.

Quantitative data were analysed using univariate descriptive measures (such as percentages with 95% confidence intervals) and t-tests or Chi-square tests (with continuity correction).[31] A two-tailed p-value of less than 0.05 was considered significant. Qualitative data were managed within N-Vivo software[32] and analysed thematically using inductive methods based on grounded theory.[33] Our theoretical approach attempting to gain an appreciation of young people's "storying of the future" provided a loose framework for our interpretation of the rich narratives provided by young people.[34 (p. 189)] Triangulation, respondent validation and exploration of deviant cases were all used to strengthen our findings.[30]

Results

Young people in schools and youth shelter

Demographics

Overall, 186 completed CASI surveys were received; 171 from the 3 high schools visited and 15 from the homeless youth shelter. Missing data were low for most variables. Difficulty in accurately calculating response rates related to uncertainty in the denominator of eligible Aboriginal or Torres Strait Islander students attending schools. Estimated response rates were around 60% overall.[24] Eleven focus group discussions were held across the three schools, mostly with between four and eight participants. Fifty-nine students participated in focus group discussions, 41 girls (in 8 groups) and 18 boys (in 3 groups).

One hundred participants (53.8%) were female, and 86 (46.2%) were male. The age range was 12 to 18 (mean 14.91; SD 1.13); however most participants (66.3%) were 14 and 15 reflecting lower Indigenous senior school retention rates.[35, 36] More detailed demographic findings have been reported elsewhere.[23, 24]

Findings

Education and aspirations

Almost all students wanted to finish Year 12 and either get more training or get a job, however the pathways and transitions for achieving this were unclear. They were limited by few roles models in higher education (with family norms of early school leaving and childbearing, low expectations and discrimination at school, inadequate career advice and practical issues at home.

Having sex

Eighty-four of 183 (45.9%) participants reported past sexual intercourse, with most commencing at 13-14 years (46/82; 56.1%), although for 16 it was 12 years or younger. The likelihood of having had sex increased significantly with being male, increasing age, increasing perceived sexual activity of the peer group, and drinking alcohol at least weekly.[21] A younger age of sexual initiation was associated with idealisation of parenthood (p=0.003), and personal plans and parental expectation for tertiary education were associated with later age at sexual initiation (p=0.03 and 0.016). Some gender differences in CASI responses are reported in Table 1.

Table 1   Gender differences in CASI responses

	Females N=100[a]	Males N=86[a]	P-value
Age (mean)	14.86 [14.64, 15.08]	14.98 [14.74, 15.22]	0.473
Ever had sex	33.7% [24.3%, 43.1%]	60.0% [49.6%, 70.4%]	0.001
First sex at age 12 years or younger[b]	9.7% [-0.7%, 20.1%]	25.5% [13.5%, 37.5%]	0.143
Condom use at first sex[b]	62.5% [45.7%, 79.3%]	80.4% [69.5%, 91.3%]	0.123
Not happy or satisfied with life	25.0% [16.5%, 33.5%]	9.4% [3.2%, 15.6%]	0.018
Plan to get more education after school	51.5% [41.7%, 61.3%]	28.6% [18.9%, 38.3%]	0.004
Report parents expect tertiary study	53.1% [43.2%, 63.0%]	29.8% [20.0%, 39.6%]	0.006
Believe having children improves a relationship	60.0% [48.5%, 71.5%]	83.9% [74.8%, 93.0%]	0.005
Relationship would be closer during pregnancy	70.0% [59.3%, 80.7%]	92.2% [85.6%, 98.8%]	0.002

[a]Mean or % and 95% confidence interval. [b]Questions asked only of those who reported they had had sexual intercourse—denominator fell to 33 for females and 51 for males

Sex was perceived as having a different role in relationships and different consequences for young women and young men. Older students were better able to resist coercion, and negotiate the onset of a sexual relationship and the use of contraception. Some young people, especially the older ones, resisted the stereotypes about young women and desire and the demonising of young men as sexual predators.[20,21]

"It just happened": Sex and contraception

Condom use was intermittent, with 73.5% reporting condom use at their first sexual experience, and inconsistent use thereafter. Forty-nine of 80 (61.3%) always used condoms when having sex. Nineteen of the sexually active participants (25.7%) reported always using hormonal contraception, while 32 (43.2%) never did. The most common reported reason for not using contraception was "I don't think about it" (37/84 students), although other reasons included "I don't think she/I will get pregnant" (15), and "having sex was unexpected" (19 students). Despite inconsistent condom use, only 3 participants reported having had an STI. In comparison, 67.9% of female participants said that at least one of their friends had been pregnant and 4 had been pregnant themselves.

Inconsistent contraceptive use was reflected in discussions. Students expressed some understanding about safe sexual practices, but in practice ignored this, especially in the context of alcohol use at parties. Barriers to contraceptive use included getting carried away, "the shame factor", damage to reputation for girls from carrying condoms, limited knowledge about hormonal contraceptives and STIs, limited access, and boys not liking condoms. For both boys and girls avoiding pregnancy was a more salient reason for using a condom than fear of STIs, related to the higher reported prevalence of pregnancies compared to known STIs in their peer groups. For girls, carrying condoms implied premeditation of sex, and thus rendered them "sluts", so it was better for sex to "just happen" in the absence of protection. Thus they preferred risking their health to protect their reputations.

School-based sex education gave some students reasonable information about the mechanics of sexual relationships but many students missed it altogether, due to "shame", timetabling issues and absenteeism. Almost all students thought that school sex education should be yearly from Year 8, ideally in small single-sex groups, as they felt comfortable talking in small groups of their Indigenous peers.

Young mums

Demographics

Ten individual interviews were held with young Indigenous mothers, with an age range of between 16 and 24, and between 1 and 4 children. Their first children were born between the ages of 15 and 19.

Findings

The main themes from the interviews and group discussions with young mothers are summarised here and in Table 2 and are elaborated in full elsewhere.[20]

Table 2   Main themes from narratives of young mothers

Backgrounds of young mothers	Reactions to pregnancy
• High mobility	• Self
• Relationships with mother	• Partner, family and others
• Distrust of men	• Thoughts about abortion
• Family age of childbearing	**Transformative potential of motherhood**
"Storying the future"	• Rewards and challenges
• Plans and aspirations before pregnancy	• Taking responsibility and transformation
• Educational (dis)engagement	• Protection from unreliable fathers
• Trusted guides and mentors	**Creating a future**
• Agency and survival	• Hopes, dreams and aspirations
"Falling pregnant"	
• "It just happened"	
• Relationship with partner	
• "He'd just force me": power and resistance	
• Contraceptive use	

Early years

The young mothers reported difficult early lives, characterised by high mobility (3 had attended more than 10 schools), often poor relationships with their mothers, and a distrust of men, often related to past abuse or family violence. Seven out of 10 of the young mums interviewed had been born to

teenage mothers themselves, and their family backgrounds were characterised by early educational disengagement and childbearing, often in difficult circumstances.

Prior to becoming pregnant, a majority of the young women interviewed had disengaged from school (often due to disciplinary issues and lack of academic success) and found they were drifting in some way, often involved in substance abuse, petty crime, and in unsatisfying or abusive relationships.

There was a sense of passive detachment, whereby the women were observers and reporters of life events that happened to them, rather than creators and executors of a positive future. In addition, much of the energy and motivation of the young women was consumed in meeting the most basic of physical needs in the contexts of chaotic lives. When homelessness, hunger, poverty and leaving abusive home situations were salient, education and long-term goals became irrelevant.

"Falling pregnant"

The semantics of the language used indicates that pregnancy was something that happened to these young women. Although most women acknowledged that their sexual relationships were quite likely to lead to pregnancy, many had not actively considered this as a possibility. None of the first pregnancies were planned, although some would consider inconsistent or non-use of contraception in a sexual relationship to render the pregnancy not entirely unplanned.[33] For many of the young mothers, pregnancy occurred while relationships were still on shaky ground, with issues around age differences, power and trust within the relationships still unresolved.

"He'd just force me": power and resistance

The young women were fairly united in their distrust of men and their sexual motives, especially if there was a large age (and thus power) difference. They discussed violence within their sexual relationships and unwanted forced sex. Participants believed that for men, pregnancy was a bit of a game, so they were not to be trusted with contraception.

Contraceptive use

Contraceptive use for the young mothers had mostly been fairly erratic and inconsistent, however most had a rudimentary knowledge of the basic methods available to them. Sex education at school was felt to be too little and too late, but even with adequate knowledge it was difficult to find the power within relationships to use contraception effectively. Many of the young women used condoms intermittently as their only form of protection.

Reactions to pregnancy

Many young women had a period of disbelief or shock when they first found out that they were pregnant. Most of the young women were against abortion on principle, and did not consider it a realistic possibility. Some had family members suggest it, but far more had family members who were very opposed to abortion.

Transformative potential of motherhood

The young women took their responsibility as a mother extremely seriously. They saw becoming a parent as a turning point in their lives; a point at which they took on responsibility that previously they had been avoiding. Many spoke of becoming a mother as a transformative event that gave meaning to their lives, and clear differences were discernible in their narratives between their descriptions of lives before parenthood, characterised by hopelessness, drifting and unhealthy behaviour, and their lives as mothers, in which they highlighted the positive steps they had made in terms of taking responsibility, and their plans and dreams for the future, while acknowledging the real stressors they faced.

"I'm a mum now, and I've got to start acting like one": taking responsibility

Becoming pregnant and having a child seemed to be a critical turning point for the young women interviewed. Although prior to this point many of them had been drifting without much a sense of purpose, the pregnancy and child gave them a strong motivation to take responsibility, which they did with gusto. Many described becoming a mother as a miracle, a gift and an opportunity. Taking responsibility often involved tackling substance use issues, obtaining stable housing, and disentangling themselves from unhelpful relationships, all things that they perceived as important for the child's welfare and a part of "acting like a mum".

The young mothers often expressed a justifiable pride in what they had accomplished in terms of raising their children with minimal support and resources, and making considerable lifestyle changes. They invested considerable energy in their constructions of themselves as "good mothers", in contrast with their depictions of some other young mothers as "bad mothers" and the felt stigma from health service providers and members of the wider community.

Discussion

Some caution must be used in interpreting the results given the relatively small and geographically limited sample of participants. However, although the views of young people in schools and the views of young mothers differed somewhat, both revealed relationships dominated by coercion, inconsistent use of contraception, disapproval of abortion as an option if a pregnancy occurred, and a paucity of role models in the educational realm.

The net result was that the immediate negative consequences of having a child while still a teenager in terms of truncated education or family disapproval were not particularly pertinent to these young people, as they were already struggling with educational options and pathways, and felt confident in the likelihood of family support. Although they recognised some difficulties inherent in having a child while still a teenager, in many ways, for them, this was the "least hard" of a limited set of options. These findings are very similar to those since reported from a remote Arnhem Land community in terms of young girls' attitudes towards sexual relationships and pregnancy.[34]

The young mothers viewed their children as "transformative gifts" that while not traditionally "planned", were also not entirely unplanned, but something that "just happened" to them. The birth of their children had motivated them to make a number of positive changes in their lives, from an extremely disadvantaged starting point. Family support, where it existed, was extremely important in assisting them with their parenting. However, they continued to face difficulties due to inaccessible childcare, housing and education, ongoing relationship difficulties, poverty, and stigma and judgement from others. They were clearly requesting help with some of these challenges, in order to be the best mothers that they could be.

Implications for practice and policy

So what are the implications of these findings in terms of the day to day practice of rural and remote primary health care providers dealing with young Aboriginal and Torres Strait Islander women and men (Table 3). As health care providers, we have a responsibility to support rather than judge young women who parent in their teen years, and work to increase the range of options open to all Aboriginal and Torres Strait Islander young people in terms of education, employment, family formation and a healthy sexual and reproductive life. Ongoing discrimination and harassment further hinder young parents

(often already vulnerable through poor self-esteem and poverty) from seeking assistance with education, workforce entry and childrearing.[19,20]

Table 3   Implications of findings for primary health care practice and policy

Implication	Process	Impact
Sensitive antenatal and postnatal care	• Antenatal and postnatal care based on evidence based best practice • Culturally sensitive antenatal education provided individually and in small groups • Age appropriate and free of stigma • Links to other care providers or services where necessary	• Better access and acceptability for young Indigenous women to antenatal and postnatal services • Better perinatal outcomes (both physical and psychosocial)
Young Mums' support groups	• Small groups of young Indigenous mothers meeting regularly in groups facilitated by a dedicated Indigenous health worker • Functions include informal parenting education and support and social support • Transport and practical assistance often needed	• Better social support and networks for young Indigenous mothers • Increased self-esteem • Support to make changes they consider necessary to be "good mothers"
Increased access to contraception, STI testing and abortion	• Personal sexual and reproductive health care provision • Expanding the role of school-based nurses • Increasing links between schools and youth-focused primary health care services	• Improved access to contraception and preventive reproductive health care • Access to youth friendly primary health care
Broad-based sexuality and relationships education	• Sex positive, factual relationships education • In single sex small groups yearly from year 8 (and out-of-school) • Peer education likely to be useful • Negotiating and communicating about sensitive issues • Realistic information about pregnancy and parenting	• Indigenous young people have information and life skills to have choices in relationships, sexuality and parenthood • Increased realism about parenthood
Links with other initiatives and groups	• Further training and education for young mothers • Programs to address family and domestic violence • Child safety support • Broad pedagogical initiatives to increase Indigenous student engagement and retention and training pathways	• Greater responsiveness and integration of services • Broader range of options for Indigenous young people before and after having children

Sensitive and non-judgemental antenatal and postnatal health care

Good quality, acceptable antenatal and postnatal health care is especially important for young Aboriginal and Torres Strait Islander mothers and their families, given poorer obstetric outcomes overall and a historical distrust of health services and providers. Young mothers in this study felt stigma from mainstream health care providers and other clients, and this was a deterrent to accessing these services, especially antenatal classes. Comprehensive and sensitive antenatal education can be provided individually and in small groups, and needs to be both culturally sensitive and age appropriate, with links to other care providers or services where necessary. We have found that young mothers can be well catered for within a "Mums and Babies" Program, featuring transport, a culturally

safe environment separated from the main clinic, flexible appointments and a children's playground[8], and have shown that such a program produces measurable improvements in antenatal attendance, perinatal mortality, low birth weight and prematurity.[35] Substance use, domestic violence and social situation and support are all very important areas to discuss with young women, as well as information about foetal growth, the process and practicalities of birth, breast feeding and parenting information. Information for young fathers should be provided where appropriate. An important part of postnatal care includes discussion about and implementation of contraception where desired, and ongoing parenting advice and support.

Establishment of local Young Mums' Groups with a dedicated Indigenous Health Worker

These groups should meet regularly (and are probably best co-ordinated by antenatal services) and provide informal parenting education and social support in a relaxed fashion, as well as facilitating linkages with other services where these are required. Involvement with such a group is especially important for young mothers lacking in family support. Providing transport and refreshments is important for the success of such groups, as is the continuity of relationships with a health worker for individual social and personal support. Building up a sense of self-esteem is important to help young Indigenous parents fulfil their potential. Part of this involves making life changes to fit in with the category of "good motherhood".[17] This may include changing health habits or substance use, working on or ending unhelpful relationships, making plans for stable housing or future employment and training.

Increase access for young Indigenous people to contraception, STI testing and treatment and abortion

Young Indigenous people value personal and non-judgemental sexual health care provision through culturally safe primary health care services. Access could be increased by expanding the role of school-based nurses, particularly through the distribution of contraception, and also by forging closer relationships between schools and youth-focused primary health care centres with youth clinics. For example, specific youth health clinics sessions can be established, with a GP and female and male Indigenous health workers that could provide "in clinic" services, and also be involved with outreach work in schools and youth centres.

In addition there are a number of suggestions from this work that rely on cooperation between providers and policy makers in different domains; for example, schools and community health providers working together may best provide school sex education.

Increase the provision of broadly based school sexuality and relationships education

Ideally this should occur in small single sex groups, starting in Year 8 at the latest and occurring yearly, with the incorporation of peer education being a promising initiative. This must be sex positive, and include broader issues of sexuality, gender, power and coercion, as well as practice in negotiating and communicating about sensitive issues. Providing factual and realistic information about pregnancy, childbirth and parenthood for both young women and young men is also important in reducing idealisation of parenthood among young people. Although there is a curriculum framework within both State and Catholic Schools in this area,[36] it is variably implemented. Young people in this study were clear that large coeducational class-based information sessions, especially when led by older male teachers were inappropriate for them, and many students did not attend as a result. Similar education needs to be provided for young people disengaged from the school system through youth shelters and youth health services.

Other important collaborative efforts include: providing further training opportunities for young mothers that are flexible and responsive to their needs; advocating for programs to prevent violence and abuse

within Indigenous families; and reinforcing and evaluating broader pedagogical initiatives aimed at increasing school engagement and training pathways for Indigenous young people.

Conclusions

This project has built up a rich contextual picture of the views of young Aboriginal and Torres Strait Islander people in Townsville to pregnancy and parenthood, and fills a gap by describing how Aboriginal and Torres Strait Islander young people in Townsville are constructing their futures in terms of education and aspirations, social and sexual relationships and having children. Other work suggests that there are likely to be strong similarities with the situation for Indigenous adolescents in rural and remote communities.[37] For these young people, young parenthood may not be so much an active choice, as a lack of alternative options, with different consequences in terms of educational opportunity or social disapproval compared to young people from more advantaged backgrounds.

The young parents come from particularly disadvantaged backgrounds, and view their children as transformative gifts, helping them to make changes to create a future for themselves. However, they continue to experience many challenges, not least stigma and discrimination from the community, and on occasion, from service providers. They are clearly asking for practical and emotional support to assist them to close the gap between their dreams for their family and the limited social realities.

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Presenters

Sarah Larkins is a GP with a special interest in Aboriginal and Torres Strait Islander health and a Senior Lecturer in Primary Health Care with the School of Medicine and Dentistry at JCU. Her current work involves undergraduate and postgraduate teaching in primary health care and PHC research methods, and PHC research and research capacity building.

Priscilla Page is originally from the north-west region of Queensland, an Aboriginal Waanyi woman on her mother's side and Kalkadoon through her father's side. Concerns about her own family and her community's health led her to move into Indigenous health work, initially as a clinical health worker and also as an Indigenous research assistant on the 'U Mob Yarn Up' young parent's project. Currently as the Development Officer for Indigenous Health with Tropical Medical Training, Priscilla delivers the Indigenous health component that involves cross-cultural awareness learning for GP registrars. She works closely with GP registrars and Aboriginal medical services within the training region. She has presented and facilitated at national and north Queensland conferences on Indigenous health issues.