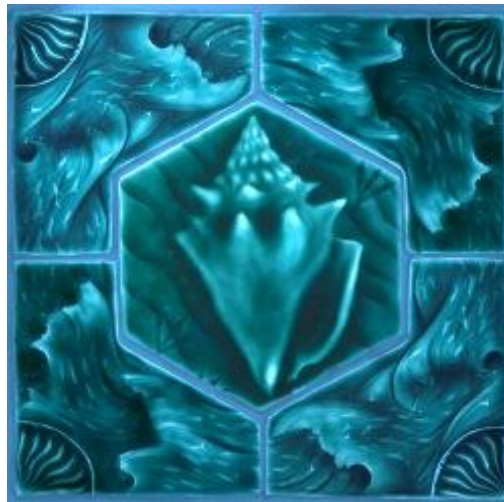


Sexual health through the eyes of Indigenous youth:

Community-Based Participatory Research with Indigenous young people in Townsville



Julie Mooney-Somers, Anna Olsen,
Wani Erick, Robert Scott,
Angie Akee and Lisa Maher

Contact details

Dr Julie Mooney-Somers

Qualitative Study Coordinator, Indigenous Resiliency Project
National Centre in HIV Epidemiology and Clinical Research
University of New South Wales
Sydney NSW 2052

jmooneysomers@nchechr.unsw.edu.au
02 9385 0943 www.nchechr.unsw.edu.au

Townsville Aboriginal and Islanders Health Service

57 - 59 Gorden Street
(PO Box 7534G BC)
Garbutt QLD 4814

07 4759 4000 www.taihs.net.au

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The Townsville Aboriginal and Islanders Health Service project team named their project Sexual health through the eyes of Indigenous youth, and chose the conch shell on the report cover to symbolise the calling of youth, linking the Pacific Ocean that connects Australia, Canada and New Zealand.

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1 Executive Summary

1.1 Aims

The project had the following aims:

1. Build the capacity of Aboriginal Community Controlled Health Services in research practice;
2. Identify, assess and enhance the blood borne viral and sexually transmitted infection (BBV/STI) resilience capability of Aboriginal and Torres Strait Islander people;
3. Inform on opportunities to decrease the risk of BBV/STI transmission in site communities;
4. Provide information for local and area health service planning for Aboriginal and Torres Strait Islander BBV/STI.

1.2 Methods

A Community-Based Participatory Research framework was used to develop a qualitative study of young people's perspectives on blood borne and sexually transmitted infections. Staff from the Townsville Aboriginal and Islanders Health Services (TAIHS) worked together with researchers from the National Centre in HIV Epidemiology and Clinical Research (NCHECR) to engage with young Indigenous people to design and conduct a qualitative research project with young people living in and around Townsville, far North Queensland.

A consultation process undertaken by the TAIHS-based project team with service providers and community members identified homeless young people as the priority population for the study. Research processes and materials such as the sampling frame and interview schedule were developed collaboratively during a research development workshop with young Indigenous people from the Townsville community and staff from TAIHS.

Interviews were conducted with 17 men and 28 women, aged between 17 and 26 years who self-identified as Aboriginal or Torres Strait Islander. At the time of their interview, two thirds of these young people were homeless or experiencing residential insecurity.

1.3 Key Findings

1.3.1 Knowledge about BBV/STI

Young people in our study were broadly aware of a range of BBV/STI and that these infections were typically transmitted through unprotected sexual intercourse. They said very little to our researchers about blood borne or non-sexual routes of transmission and there was some confusion around the meaning of 'blood borne'. Most young people indicated that they wanted to know more about these infections and many felt they had insufficient knowledge to protect themselves. BBV/STI were highly salient among our study sample, with many young people telling us about a previous diagnosis and others talking about a friend or close family member who had been diagnosed with an infection. These experiences overwhelmingly involved a sexually transmitted infection that had been successfully treated.

School played a central role in most young people's learning about BBV/STI, while health and other support services supplemented and reinforced existing knowledge or made up for a lack of knowledge in those who has missed out on school-based education. Family and friends were important sources of learning, support and encouragement, with young people reporting that a friend or sibling was the person they had spoken to (or would speak to) for advice when they suspected they had an infection. Many young people reported talking to a sexual partner about BBV/STI, but this had not always been easy. Shame featured in young people descriptions of their own and their partners' discomfort with the subject.

1.3.2 Strategies for preventing transmission of infections

Condoms were the first, and most often cited, protection strategy and they were strongly endorsed for casual and new sexual partners. A desire to avoid contracting an infection was the primary motivator for condom use, although the capacity of condoms to prevent pregnancy was also raised. Free condoms appeared to be relatively easy to access from health services like TAIHS and the Townsville Sexual Health Unit, and for younger people through school. Several important challenges were reported in relation to condoms, specifically, embarrassment at obtaining condoms in public or not having condoms in the event of an 'unplanned' sexual encounter. Many young people described attempts to work around these barriers - seeking out alternative sources and adapting to carrying condoms at all times so that they were always prepared. The two challenges that appeared to be more difficult and persistent in young people's sexual relationships were enacting a commitment to condom use in a context of alcohol and drug use and young men's ambivalence to condoms or outright refusal to use them.

The second strategy reported by young people in the prevention of STIs was developing a relationship. In this context condoms were often abandoned, on the assumptions that both partners were monogamous and thus trustworthy. There were some tensions around this, primarily for the young women in our study, and it was not clear that they were entirely happy to abandon condoms or felt able to insist on them. It seemed likely that this was in part related to condoms being an indicator of trust. That is, abandoning condoms was both an indication that there was trust in the relationship and that the relationship was based on trust. Condoms symbolised casual sex and thus ceasing condom use was depicted as a marker of commitment and trust.

The third strategy discussed by participants was monitoring BBV/STI status through medical screening, with many reporting they regularly had sexual health checks, BBV/STI screening or pap smears. For others, screening was undertaken in response to a perceived unsafe event. Seeking screening at the beginning of a relationship appeared to be common and part of an ongoing safety strategy for some. There was however little evidence to suggest that young people would ask a new partner to get screened, or that new couples do this together. Still, the importance placed on BBV/STI screening is one of the most positive findings from this study as it provides evidence that young Indigenous people in Townsville are aware of sexual health risks and that they can be pro-active. This high investment in screening as a preventive strategy should be celebrated and encouraged.

1.3.3 Experience accessing mainstream and community-controlled health services

Our findings revealed that positive experiences of health care for the diagnosis and treatment of BBV/STI were associated with the provision of information that facilitated the young person looking after themselves, and with feeling cared for, respected, and their concerns being taken seriously. Young people reported seeking additional health care when they were dissatisfied with a particular service or practitioner. When asked what recommendations they would give to a friend who feared they had a BBV/STI, young people reported that they would tell the friend to seek medical attention, usually as the first action, suggesting that young Indigenous people, in our sample at least, consider medical care relevant and important.

While young people did not report significant barriers to treatment seeking, their descriptions of the support they would provide a friend suggested several. Specifically, young people said that they would reassure a friend to not feel 'shame' about having a BBV/STI, offer to accompany them to a doctor, and vouch for particular services. This can be interpreted as, respect and openness, ability to see a health professional with a friend or family member, and choice of service are important for young people seeking BBV/STI related medical care. It was clear that the provision of practical support by health services, such as transport and help with booking appointments, was appreciated by young people. These findings also suggest that peer-support for young people who suspect they have contracted a BBV/STI could be a valuable development for health services to explore.

A 'good' health service for the young people in our study was characterised by the feeling that the health provider cared: they took time; provided information; and prioritised the individual's own concerns, including their identity as an Indigenous Australian. Although participants repeatedly associated these characteristics with ACCHS, our findings can help these services strengthen their programs for, and connections to young people, particularly in addressing some of the most sensitive, personal and socially shamed elements of health.

1.3.4 Motivations for preventing BBV/STI infections

Taking responsibility for their health was important to young people, and they spoke with pride when they described the things they did to look after their health. Young people often presented themselves as being able to act on their health intentions, suggesting a capacity for self-efficacy that is crucial for successful health promotion efforts. Young people often provided explanations for current protective behaviour that drew on past experiences. Moments of crisis were characterised as turning points that acted as catalysts for changes in protective behaviour. Thus, the past was an important source of knowledge and insight, and there was a sense that these opportunities should not be wasted. It was in this way that young people saw their past experiences as providing them with knowledge to share with others. The challenge for health promotion is to find ways for other young people to benefit from this, learning vicariously so they can avoid facing these challenges personally.

We interpret these results, especially the ability of young people in our study to see an infection as a learning opportunity, as a source of resilience. That is, infection prompted a resilient response to a stressful life event. Further, because the shame and stigma associated with these infections rarely featured strongly in their accounts, we suggest that individual and community strengths, as well as education, screening and treatment have

helped to create an understanding, judgement-free environment. Our findings demonstrated that health services and communities have an important role to play in facilitating and strengthening these resilient responses, providing young people with the skills and knowledge to tackle future stressful events with resilience.

Our finding that young people looked after their health because they worried about the consequences for others is an important reminder that highly mobile young people are still connected to families and communities. They worried that an infection would potentially expose others to ill health and affect their own ability to fulfil responsibilities to others. This concern for others was a powerful motivator for self-care, and an obvious point of leverage for health promotion around BBV/STI prevention. Our findings suggest that young men and young women would be responsive to family and community oriented BBV/STI health promotion strategies.

1.3.5 Recommendations for reducing BBV/STI

Young people overwhelmingly called for more education to improve the rates of BBV/STI infection among young Indigenous people in their communities. They highlighted a need for basic information around transmission and prevention, and specific behavioural messages around safer sex, developing trusting relationships, and regular screening. Calls to inform young people about the consequences of BBV/STI and the prevalence of these infections in Indigenous communities related to directly to making BBV/STI salient to young people. Participants saw schools, parents and elders having a key role in providing prevention information to young people. Young people suggested health services tailor prevention, screening and treatment to Indigenous young people, and target the groups most at risk. Crucially, there was a strong call for outreach and the provision of information and services to young people in community settings.

These findings indicated a need for community-wide efforts to make talking about BBV/STI acceptable across all age groups, with suggestions for community forums and spaces where young people can share experiences, model openness and educate each other. It is worth reiterating here our findings relating to young people's desire to share the lessons they have learnt with others. Community-controlled health services seem well placed to facilitate the knowledge transfer and peer-support that young people are requesting.

1.4 Project recommendations: Building on Indigenous young people's strengths

To support young people and build on their resilience to prevent BBV/STI, community-controlled and mainstream health services, and the Indigenous community need to emphasise the positive aspects of young people's practices and build on them in the following ways:

- Education was the primary suggestion for reducing BBV/STI, and there was a real thirst for knowledge among our participants. Young people identified gaps in their knowledge, with many suggesting they did not feel they knew enough to be able to protect themselves from infection. There is still a need for basic information on BBV/STI prevention, symptoms, and complications.

- Facilitate young people's access to condoms by providing them in discreet public spaces, as well as having them openly available in community spaces and at community events.
- Negotiation within casual or established relationships can be difficult and feeling confident and safe when discussing safe sex continues to be an issue for young people, in particular, for young women. Develop campaigns to provide strategies for situations that pose challenges to safer sex (where young people don't have condom or are intoxicated) and skill-based programs to support young people's development of safe, trusting intimate relationships.
- The high engagement with health services, particularly ACCHS, is encouraging and the support for BBV/STI screening among young people is something to be celebrated and reinforced.
- Although most young women recognised that hormonal contraception did not protect them from BBV/STI, Indigenous health workers need to work with young women around the need to maintain condom use, regular screening, and explicitly negotiate monogamy with sexual partners, when using hormonal contraception.
- It is heartening that the young Indigenous people involved in this study indicated that they had not experienced significant ongoing shame in relation to personal experience of BBV/STI diagnosis. Young people's personal experience, gained through their own or a family member's or friend's infection, appeared to have made BBV/STI highly salient. The challenge for health promotion in this context is both to raise awareness and reduce stigma and shame, while not normalising these infections.
- Young people spoke about learning from their friend's experiences and often compared themselves to their friends. There was a strong motivation among young women to share their experiences with other young people. Encouraging young people to become involved in peer education would have the double benefit of empowering those in educating roles to become active and involved members of their community, as well as empowering those in learning roles through socially relevant knowledge-building with those from similar backgrounds.
- In their interviews, young people often cast themselves as active health-seekers with respect to BBV/STI prevention. They talked about applying knowledge and rules in an attempt to act on their intentions to protect and maintain their health. They often characterised themselves as responsible, in-control, and aware. This openness and active engagement in self-care could be used to challenge shame and stigma associated with BBV/STI.
- There is a need for future research to explore the experiences and needs of Indigenous young people who are also injecting drug users, young people's negotiation of safer sex with casual partners and particularly how trust is established and condom cessation negotiated in the transition from casual to 'trusting' relationship, and young men's experiences of health care and the strategies they believe would encourage health seeking behaviour among their male peers.

1.5 Conclusion

This research, its findings and our recommendations are unique in that they represent a community-engaged research project for and by the community and a research project designed to explore youth resilience from their own perspective. The overt connection to TAIHS also brings a unique focus as our research not only investigated the role of the ACCHS in BBV/STI prevention and treatment, but worked to build the service's presence and connections in the community, particularly services targeted to young Indigenous people. The IRP-CBPR is a testament to the commitment and engagement of the community partners on this project: TAIHS Board of Directors and staff, and young Indigenous people in Townsville.

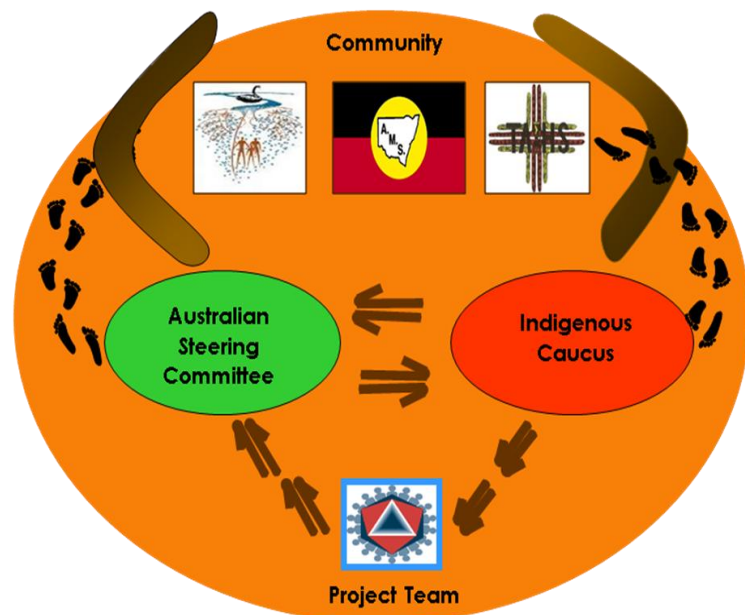
The 'take home' message from our project is that Indigenous young people in the Townsville region placed a high value on their health, demonstrated determination to prevent transmission of BBV/STI and had a very strong sense of community responsibility. These are tangible strengths that should be celebrated and bolstered to enhance young Indigenous people's ability to protect themselves against adverse health outcomes and enhance their resilience.

2 The Indigenous Resiliency Project

The Indigenous Resiliency Project (IRP) is part of an international research collaboration that aims to build capacity in Indigenous communities in Australia, New Zealand and Canada to conduct research into the factors that may support Indigenous people in responding to blood borne viral and sexually transmitted infections (BBV/STI). The project is funded by the International Collaborative Indigenous Health Research Partnership (ICIHRP), a tripartite funding partnership of the National Health and Medical Research Council (NHMRC) of Australia, the Health Research Council of New Zealand (HRC NZ) and the Canadian Institutes of Health Research (CIHR).

The Australian component is being conducted by a collaboration of Aboriginal Community Controlled Health Services (Townsville Aboriginal and Islanders Health Service (TAIHS), Aboriginal Medical Service, Redfern and Derbarl Yerrigan Health Service, Perth), the National Centre in HIV Epidemiology and Clinical Research (NCHECR) at the University of New South Wales, and several independent Indigenous researchers.

The IRP Australian Steering Committee (ASC), made up of representatives from the community partners, research partner, and the independent Indigenous researchers, provides guidance on scientific, administrative and budgetary matters and determines areas of priority for the project. The ASC plays a vital leadership role in advising on cultural matters related to the conduct of the study, including the review of all project outputs prior to dissemination, and assists in strengthening communication between key stakeholder communities. An Indigenous Caucus, made up of Indigenous members of the ASC, provides an additional layer of cultural oversight. The ASC is the forum through which shared decision-making is achieved and the shared ownership of research products is protected (Viswanathan et al., 2004).



The governance structure of the project

The Australian IRP has four research components: Health Service Provider Consultations; Clinical Services Audit; Community-Based Participatory Research; Young People's Survey. This report presents the findings from the third component, the IRP Community-Based Participatory Research (IRP-CBPR), conducted at the Townsville Aboriginal and Islanders Health Service (2007-2009).

2.1 Blood borne and sexually transmitted infections in Indigenous Australians

Australian national surveillance data shows marked differences between Indigenous and other Australians (National Centre in HIV Epidemiology and Clinical Research, 2008). Chlamydia, gonorrhoea and syphilis are considerably higher in many Indigenous populations and these disparities are evident in both rural/remote and urban populations. Compared to their non-Indigenous counterparts, Indigenous women and young people bear a higher burden of infection¹. While the rate of chlamydia has been increasing for all Australians, it is far higher among young Indigenous people: among 13 to 17 year olds diagnoses of chlamydia in 2007 were 7 times higher and among 20 to 20 year olds they were 3 times higher, than among non-Indigenous young people (National Centre in HIV Epidemiology and Clinical Research, 2008). Chlamydia is a particular issue among Indigenous women aged 13 to 19 years, who had the highest rate of diagnosis among Indigenous people and twice that of their male peers. Similar patterns of higher rates in younger people are evident for gonorrhoea (in 2007, people aged less than 30 years accounted for 78% of diagnoses compared to 54% among the non-Indigenous population) and syphilis (in 2007, people aged less than 30 years accounted for 68% of diagnoses compared to 20% among the non-Indigenous population). The rate of HIV diagnoses among Indigenous people remained relatively stable between 1998 and 2007, and similar to the non-Indigenous population. There was however a greater burden of infection among Indigenous women, who accounted for 30% of HIV infections diagnosed during that time period. The consistent difference in the female-to-male ratios for newly diagnosed gonorrhoea, syphilis and HIV suggest that heterosexual contact is a more significant route of transmission among Indigenous people than it is for the non-Indigenous population, for whom sex between men is the leading route of transmission.

Community-based and clinical research conducted in Northern Queensland, where the Townsville IRP-CBPR was conducted, provides specific information on STI prevalence among Indigenous people in the region. A study of 1500 people receiving Well Person Health Checks² in eight Indigenous communities around Cairns (the closest large regional town to Townsville), found that 153 (10%) screened positive for chlamydia or gonorrhoea (Fagan, 2001). A subsequent study of 456 women who presented for antenatal care at TAIHS Mums and Babies program between 2000 and 2003, found that a fifth screened positive for a STI. The prevalence of chlamydia was 14%, gonorrhoea 6%, trichomoniasis 7% and infectious syphilis 2.5%. Chlamydia and gonorrhoea prevalence was highest in women aged 24 years or younger, with a third of young women aged less than 20 years screening positive for chlamydia (Panaretto et al., 2006b). Recent research on the efficacy of outreach chlamydia screening to high prevalence groups found the prevalence of chlamydia among young Indigenous people at a local Townsville high school and youth-at-risk service was 15% and 17% respectively (Buhrer-Skinner et al., 2009).

The epidemiological data cited above indicates that BBV/STI are a serious public health issue for Indigenous communities. They also draw attention to differences in transmission routes

¹ These data need to be interpreted with care as there is considerable variation between communities, the potential for testing artefacts and limitations in the recording of Indigenous status across jurisdictions.

² Well Person Health Checks was a population screening program offered to all individuals over the age of 14 years.

and the distribution of infections across age and gender, highlighting a need for targeted and culturally appropriate education and health promotion programs (Queensland Health, 2003, Department of Health and Aging, 2005a, Department of Health and Aging, 2005b, Queensland Health, 2005). Education around the prevention of BBV/STI needs to be “positioned within the complex social world in which young people make decisions” (Sorenson and Brown, 2007). Yet we know little about the contexts in which young Indigenous people engage in practices that may leave them vulnerable to infection. Nor do we have much evidence of Indigenous young people’s knowledge and understandings of infections, prevention strategies, screening and treatment. Finally, and perhaps most importantly, there is an absence of strengths-based research on how young Indigenous people protect themselves against infection.

3 Methodology

3.1 IRP-CBPR project aims

The project had the following aims:

1. Build the capacity of Aboriginal Community Controlled Health Services in research practice;
2. Identify, assess and enhance the blood borne viral and sexually transmitted infection (BBV/STI) resilience capability of Aboriginal and Torres Strait Islander people;
3. Inform on opportunities to decrease the risk of BBV/STI transmission in site communities;
4. Provide information for local and area health service planning for Aboriginal and Torres Strait Islander BBV/STI.

During the research development and subsequent data collection and analysis, the peer researchers, health workers and university researchers focused on the following guiding questions:

1. What keeps young people healthy and protected against BBV/STI?
2. How can we help young people be stronger so they can better prevent these infections?
3. How can we strengthen young people's ability to obtain appropriate care and treatment?

3.2 Community-based participatory research

Community-Based Participatory Research (CBPR) provides a framework for researchers and communities to work together to generate knowledge about, and solutions to, problems faced by communities. This framework repositions the people who would usually be the object of the research, as participants in the research process; "the researched become the researchers" (Baum et al., 2006). CBPR involves more than consultation; it focuses on building community capacity to participate as co-investigators in developing, conducting and disseminating research (Viswanathan et al., 2004). It includes approaches such as participatory action research, action research, partnership research and collaborative inquiry. The research framework is characterised by two core elements: a reciprocal co-learner relationship between researchers and communities (including shared decision-making and the removal of barriers to participation), and the immediate and direct benefit of new knowledge (including shared ownership of research products) (Viswanathan et al., 2004).

CBPR has often been utilised in research with vulnerable or marginalised populations (Coupland and Maher, 2005, Bostock and Freeman, 2003, Nelson et al., 1998), and is increasingly employed in research with Indigenous communities (Holmes et al., 2002, Viswanathan et al., 2004, Pyett, 2002, Tsey et al., 2004, Hecker et al., 1997, Larkins et al., 2007, Brough et al., 2006). The principles and characteristics of CBPR are considered to have the potential to address some of the failings of previous research on Indigenous peoples. In addition to joint development of research questions, methods and data collection, affected

communities should be involved in the analysis and interpretation of data. The technical knowledge of researchers is valuable but not the only legitimate way of knowing about the world (Brydon-Miller, 2003), so instead of seeing 'experts' - usually non-Indigenous people - as the only legitimate source of knowledge on health issues, CBPR recognises and values the knowledge of 'ordinary' people. As a result, CBPR has the potential to avoid the misrepresentation of "Indigenous societies, culture and persons by non-Indigenous academics and professionals" (Baum et al., 2006). Prioritising community knowledge of community needs and perspectives may increase the likelihood of interventions arising from the research having beneficial outcomes for the affected community (Viswanathan et al., 2004).

The Indigenous Resiliency project used CBPR to bring young Indigenous people, Aboriginal Community-Controlled Health Services (ACCHS), and university-based researchers together to develop and conduct qualitative research with young Indigenous people on their perceptions of BBV/STI. In each of the three project sites, a locally-employed (project-funded) site coordinator and health service staff, under the guidance of the service's Board of Directors, worked with university-based researchers to engage with young Indigenous people from the local community. The young people trained and worked as peer researchers to develop and conduct the project. The IRP-CBPR is not a multi-site project where the same protocol was implemented across all sites. Instead, each project was "a custom job" (Kidd and Kral, 2005) with the projects recognising diversity by developing in response to the priorities - and capacities - of the local community and the ACCHS. This report describes the IRP-CBPR undertaken in Townsville, in partnership with TAIHS.

The Townsville Aboriginal and Islanders Health Service was established in 1975 and moved to its current purpose built premises in 2001. As an Aboriginal Community-Controlled Health Service, TAIHS is part of a network of "culturally appropriate, autonomous primary health services initiated, planned and governed by local Aboriginal communities through an elected board of directors" (Couzos, 2004).



Townsville Aboriginal and Islanders Health Service

Townsville is a large regional city on the north-east coast of Queensland. At the 2006 Census there were 143,328 people living in Townsville, 5.7% of whom identified as Indigenous (compared to 2.3% across the whole of Australia); nearly a fifth of Townsville residents fall in the age range 14 to 24 years (Australian Bureau of Statistics, 2007b). The estimated population in 2008 (when this study was conducted) was 175,542 (Australian Bureau of Statistics, 2007a). Townsville is an

administrative centre for government services, has a large university, army base, industrial port, and extensive health facilities servicing communities across northern Queensland. It is an important regional hub for Aboriginal and Torres Strait Islander people from across far North Queensland, particularly Palm Island and Mt Isa.

3.2.1 Identifying the priority population

The IRP ASC asked the Townsville project team to identify a priority population to engage with, and a decision matrix was developed to assist in this process (Appendix 1). The matrix listed eight priority groups of young people (including injecting drug users, homeless people, and new parents) and selection criteria (including public health significance, size of the population, health service's current contact with each group).

A broad-based consultation process allowed for the needs and aspirations of key stakeholders and the community to be voiced. Consultation began internally, with the project team in Townsville (Wani Erick, Site Coordinator, and Robert Scott, Research Assistant) speaking informally with staff working with young people in the Mums and Babies Clinic, Social Health Unit, Youth Shelter, Early Intervention Program for Youth at Risk, and the Volatile Substance Misuse program. The project team also engaged with external organisations such as the Queensland Health Indigenous Sexual Health Clinic and the Queensland Aboriginal and Islander Health Council. During the consultation, there was a clear perception that Townsville was experiencing a shortage of suitable accommodation for young people in crisis or at risk of becoming homeless. A consensus emerged that a key vulnerable population in the area were young people experiencing homelessness, and the project team spoke to relevant organisations like Gurindal Diversionary Centre and the Queensland Health Homeless Team to scope the possibility of engaging this population.

Young Aboriginal and Torres Strait Islander people experiencing residential insecurity have also been identified as being at increased risk of acquiring BBV/STI in Queensland's Indigenous Sexual Health Strategy (Queensland Health, 2003). More broadly, the National Aboriginal and Torres Strait Islander Sexual Health and Blood-Borne Virus Strategy (Department of Health and Aging, 2005a) recognises that mobility between urban centres and communities is common among Aboriginal and Torres Strait Islander people. Mobile young people can miss out on health promotion and education, generally delivered in school environments, and mobility can constrain access to treatment for BBV/STI.

Combining these local priorities with wider research and policy priorities, a proposal was put to the TAIHS Board of Directors for the project to work with young people experiencing homeless and residential insecurity. This decision was endorsed³. With the full support of the Board of TAIHS and ethical approval from the Human Research Ethics Committees at the Aboriginal Health and Medical Research Council and the University of New South Wales, the project moved from consultation to engagement. A project reference group was established, with members drawing on their local knowledge and expertise in working with young Indigenous people in Townsville to guide and support the project. The project team then used their contacts at TAIHS and outreach at health promotion and World AIDS Day

³ A more detailed description of this process can be found in Mooney-Somers, Erick, Brockman, Scott and Maher (2008).

events to engage a group of residentially insecure young people to participate in the project as peer researchers. From this process, we worked with five women and three men, aged 18 to 28 years, in a research training and development workshop to progress the project, develop local capacity and engage peer researchers.

3.2.2 Research development and training workshop

The university-based researchers developed a three-day research development and training workshop covering research ethics, communication, sampling and recruitment, individual and group interviewing, participant observation, writing field notes, and analysis of qualitative data (Erick et al., 2008). The workshop was tailored to the educational level of the attendees and the content adapted to reflect the focus on homelessness and residential insecurity among young people. Eight peer researchers and seven health services staff participated in the workshop.



Participants in the Research Development and Training Workshop, February 2008

During the workshop, we were guided by a site-specific training manual and participants were given opportunities for firsthand experience of interviewing, participant observation, writing field notes, and developing research materials.



Interviewing role play



Interviewing role play

Over the course of the workshops, research processes and materials fundamental to the project in Townsville were developed. These included inclusion and exclusion criteria for participants; a map of key field sites for recruitment and a recruitment plan; and a list of topics and questions for the individual and group interviews. In this way, peer researchers, health service staff and university-based researchers collaboratively developed project questions reflecting local priorities and meanings, and established ways of conducting the project that were appropriate to the priority population and the local community.



Developing inclusion and exclusion criteria



Mapping potential field sites for recruitment

3.2.3 IRP-CBPR Townsville: Selecting the peer researchers

The final aim of the workshop was to identify young people to take up peer researcher positions on the project team. The role of peer researchers in our research model was to work as part of the project team to further develop the research, conduct the fieldwork and data collection, and participate in the analysis of data. We developed selection criteria reflecting the needs of the project including: membership of different networks (i.e. connected to different groups of people through sport, performance, and school); a range of ages; and cultural protocols (male and female; Aboriginal and Torres Strait Islander). We spoke with the young people about their availability, such as transport and caring responsibilities, and interest in participating for the duration of the project. Four young people agreed to join the project team.

3.3 Qualitative research methods

CBPR is a dynamic process, with the project questions and processes emerging as the project progresses. Qualitative methods are particularly conducive to this. Methods are selected on the basis that they are “useful and useable to all those participating in the process” (Brydon-Miller, 2003). This means selecting methods that can be taught quickly to people with a broad range of educational experiences and literacy skills. Projects also need to be receptive to the developing skills and confidence of peer researchers and health service staff. In the IRP-CBPR, young people and health service staff were trained in qualitative sampling, developing interview questions, and conducting and recording interviews. These methods do not require expensive hardware or software and data can be collected using pen and paper. Such qualitative approaches offer the opportunity to understand the meaning of sexual behaviour and drug use, and the contexts in which people contract or avoid BBV/STI. We focused on individual interviews as a method of data collection as they allow for an in-depth exploration of young people’s lived experience of sexual behaviour and drug use, knowledge about BBV/STI in their families and communities, and experiences accessing services for prevention, testing and treatment.

Following the workshop we developed a template that allowed the project team to record all the required information about their interview (Appendix 2). The template included the interview topics/questions that were to be asked of participants, both specific demographic questions and broader questions about knowledge and experience. Questions were developed in the research development workshop with peer researchers and health service staff. The template included space for the researchers to record their impressions of the interview and participant, indicate if they had referred the participant to any services or given the participant other information. The project team regularly reviewed interview data during the data collection process. This process resulted in two iterations of the interview schedule. The first iteration contained a list of informational questions covering knowledge, protective behaviours, help seeking behaviour and discussions with sexual partners. This schedule was used for the 16 brief interviews. The second iteration built on this to elicit personal experiences and context. For example, asking participants to describe an experience of using a health service, obtaining condoms or talking to a partner about sexual health. This schedule was used for the 29 in-depth interviews.

The relationship between interviewer and interviewee is crucial in qualitative research, as data is generated through their interactions. The IRP-CBPR focuses on personal and often stigmatised behaviours, and the project team spent a lot of time discussing how to talk about these in sensitive and culturally appropriate ways. Before interviews began, interviewers and participants talked about where their families came from; this was an important cultural protocol. The amount of time spent on this varied considerably, especially if there was a shared family connection. This initial introduction was followed by a question about the participant’s life history, providing a context for their experience of BBV/STI.

3.4 Sampling and recruitment

To be eligible to participate in the study, young people were required to:

- Self-identify as Aboriginal and/or Torres Strait Islander
- Be aged between 17 and 26 years
- Currently (or temporarily) live in Townsville or the surrounding areas. Many of the young people were temporarily in Townsville, but usually resided in Palm Island
- Have experience of homelessness or residential insecurity. We defined this as not having access to stable shelter or accommodation (living in public places, parks or riverbeds), living in temporary accommodation, or escaping unsafe or unstable family circumstances. During the research development workshop, this was extended to include young people *at risk* of homelessness or who had experienced homelessness indirectly through a family member or close friend.

Participants were excluded if they did not meet these criteria, or if the researchers felt they could not provide voluntary informed consent because of mental illness or intoxication.

Young people were recruited in commercial precincts in Townsville, primarily Flinders Mall, in public spaces, such as parks where homeless youth hang out including one that houses a drop-in centre (Community Emergency Support Centre, Dean Park). The remaining participants were recruited at homeless hostels, primarily Iris Clay Aboriginal Hostel, and through TAIHS. The project team conducted a total of 51 interviews (17 brief and 34 in-depth interviews) between March and September 2008. Table 1 contains a summary of recruitment locations. Six interviews were subsequently excluded from the sample because consent was not obtained correctly or was withdrawn after the interview. Most of these interviews were conducted during the first few weeks of data collection, and we reviewed our processes to ensure the project was properly explained and informed consent obtained before interviews took place.

Commercial precincts	61%
Public streets and parks	17%
Homeless hostels	11%
TAIHS	11%

In most cases, interviews were conducted immediately after recruitment and usually in the same location, for example, in Flinders Mall. In a few cases arrangements were made to meet the following day. Data were recorded as hand written field notes that were typed up by the peer researchers or the site coordinator as soon as practical.



Recruitment site, Flinders Mall



Recruitment site, Flinders Mall



Recruitment site, TAIHS Youth Shelter



Recruitment site, Dean Park Drop-in Centre

Data collection was a time intensive process with the project team spending significant periods of time in the community, meeting and talking with potential participants and conducting interviews. Over the course of the data collection four young Aboriginal and Torres Strait Islander men and women (peer researchers) worked with the site coordinator. As data collection progressed, engagement from the peer researchers declined and only a fifth of the interviews were conducted by a peer researcher. The remaining interviews were conducted by the site coordinator with occasional engagement from a young person who had not been involved in the research workshop at the beginning of the project.

The need to respect cultural protocols around gender is a common theme in the literature on culturally appropriate health care and extends to gender separation in health promotion (Kelly and Luxford, 2007, Department of Health and Aging, 2005a). The site coordinator and most of our peer researchers were women and were not always comfortable approaching men to participate in the study (especially if they did not have a male peer researcher with them). It is impossible to know if any of the young men who declined to participate did so because there was no male peer researcher available. Some of the male participants who spoke with a male peer researcher suggested they would not have been comfortable, or as comfortable, if they had spoken with a woman. Young men are underrepresented in our

sample (17 out of 45 participants were male), and only half of these interviews were conducted by a male researcher.

3.4.1 Who we interviewed

Our study sample consisted of 45 people⁴, 17 men and 28 women, aged between 17 and 26 years who self-identified as Aboriginal or Torres Strait Islander. The average age was 22 years, with nearly 40% around the upper age limit (25/26 years). Table 2 gives a summary of place of residence. At the time of interview, over a third self identified as living in temporary accommodation, and a further third lived in homeless shelters (including Iris Clay, Apple Lodge, Kevin Saylor/Echlin St).

Table 2. Place of residence

Homeless/ temporary arrangement with friend/relative	39%
Hostel	31%
Living with family	19%
Rent	11%

While we did not ask for further demographic information, however during the course of their interviews, close to half the participants spoke about their children. Of these, eight young women and two young men mentioned that some or all of their children were not currently living with them. Six explicitly said their children had been taken away by the Department of Child Safety Services, in most cases the children were placed with a family member. Ten young women, or a third of the female sample, described intimate partner violence or reported that their partners had abused them.

At the beginning of the interviews, we asked young people to provide some background, to tell us about their life up till now. Participants described where they were born, where their families came from, their partners and children, and some of the hard things that had happened in their lives. Although we didn't ask, many young people talked about the future and their aspirations to get more education, find employment, find a stable place to live, and for some, get their family back together. We provide below a selection of extracts to demonstrate the positive future orientation of many of the young people we spoke to.

I'm looking for a house, my (family) are currently homeless (...) We find a house and all move in together (Finn, 18, living in hostel)

I just wanna get through life with my girl (participant pointed to girlfriend nearby) and to try and get our baby back. My family in (location) has got our child (Matthew, 23, living in hostel)

I feel happy that I'm doing something useful in life by doing this course at TAFE. I'm looking for a job with (employer). I'm still waiting, my name is on the waiting list, this is to work on (job). If I get a job I will be happy. I live with my sister at (suburb), she is

⁴ Six interviews were excluded from the sample of 51, because consent was not obtained correctly or was withdrawn after the interview.

good she helps me out you know I said to her when I get a job I will pay you money
(Mark, 26, living with family)

I wish I listen to my mother when I had the chance but I need now to look after myself because no one else will. Don't know what I will do, I'm doing this course at TAFE College but it is hard when there is no one to support you. I want to make things happen for me (Fred, 19, living with family)

(W)hat I want is to do some studying, go back to school or TAFE College and to get a good job (Lanie, 23, living with partner's family)

I have two children they were taken away from me when I started taking drugs the child safety had put them into foster homes but I want to get them back (...) Because I just feel that I'm on my way out of this hole and slowly getting better. I now go to church on Sundays and I feel alive, I now feel like someone understand the need in me to better myself and for my children. I have my children visiting me every 3-4 weeks, they are with their Dad right now (Nina, 26, living temporarily with friend)

3.5 Data analysis

A preliminary analysis of the interview data was undertaken toward the end of data collection, and discussed by the project team during a site visit by the university-based researcher. This preliminary work and the subsequent team discussion, forms the basis of the subsequent thematic analysis (Braun and Clarke, 2006) undertaken by the university-based researchers. Typed interview notes were entered into the software package NVivo and data read and re-read for themes related to the project questions: what keeps young people healthy and protected against BBV/STI, how can we help young people be stronger so they can better prevent BBV/STI and obtain appropriate care and treatment? Nine major themes were identified: *orientation to BBV/STI* (including knowledge and personal experiences); *keeping safe* (including strategies for avoiding BBV/STI); *sources of risk and barriers to keeping safe*; *reasons for safety*; *responsibility*; *health services*; *education*; *making things better*; and *context* (participant and community biographies). All interviews were coded along these thematic lines. A further theme relating to the participants' responses to being interviewed (their experience of the interview and actions prompted by the interview) was included in the coding frame.

To better address our project questions and make our findings more accessible, we present the results here under six headings, relating to young people's:

1. Knowledge about BBV/STI;
2. Strategies to prevent transmission of infection;
3. Experience accessing mainstream and community-controlled health services;
4. Motivations for preventing BBV/STI infections;
5. Recommendations for reducing BBV/STI.

In the process of preparing this report, we formally presented our findings at a community workshop that included Indigenous health workers, youth workers from TAIHS homeless shelters, and TAIHS management. This was as an important credibility-check for our

interpretation of young people's experiences and perspectives. It also allowed local health care providers to provide some context to young people's reports of health care service use. The findings generally resonated with the participants at this workshop, and their feedback resulted in some minor changes and clarifications to this final report. A few important points that expanded on our findings have been included in the body of the report.

3.5.1 Status of the data

The first aim of the IRP-CBPR focused on building research capacity. The IRP-CBPR was an opportunity to develop the research skill, knowledge, and confidence of staff in the participating ACCHS and young Indigenous people in the community (Mooney-Somers and Maher, 2009). The second aim of the project was oriented to generating knowledge and understanding that would provide insights into the prevention of BBV/STI in young Indigenous people. The IRP-CBPR prioritised the former - capacity building, participation and collaboration - which produced tensions for the production of knowledge. It was, for example, not always possible to meet traditional scientific notions of data quality and rigour. Echoing other participatory research, we would argue that our data need to be assessed within a different framework (Dyson and Meagher, 2001).

Our interviews were conducted in the field by people with no previous research experience. While they received training, as well as regular feedback through email and weekly phone meetings from the university researchers (based in Sydney), a professional researcher was not on-site and did not participate day-to-day in the research. The skills of the project team developed during the life of the project, but there were limits to the training and support that could be provided in this context. On the other hand, the cultural expertise that the peer researchers and site coordinator brought to the interviews cannot be underestimated.

In addition to the issue that interview notes are an imperfect record of a conversation between the participant and an interviewer (they should not be seen as a verbatim record or transcript), the interviewing skill of novice interviewers means the interview data does not contain the depth and breadth that may have been produced by experienced interviewers. There are several artefacts in the data illustrate this. The terms 'STI/BBV' or 'STI' and 'BBVs' appeared regularly in the data. It seems unlikely that young people used these phrases. Given the confusion around the meaning of blood borne viruses and silence around injecting drug use (both discussed later), it seems unlikely that young people used the term 'BBV', or blood borne viruses, as regularly as suggested by the interview notes. Following from this, there is a surprising lack of colloquialisms, suggesting that more formal terms were used by interviewers, which is unlikely in spoken dialogue, particularly among young people. Secondly, there are moments of slippage where interviewers shift between writing in the first person (recording the participant's own words), and writing in the third person (often summaries of participant's words). This was rarely marked in the data, as in the following example.

Yes but has to be push(ed) or prompt him to talk about it. He is very private with his sexual life. I look up to him and I love him, how he makes love to me (Maree, 26, living with partner's family)⁵

Thirdly, the interviewer's voice is inconsistently recorded in the data. Interviewers did not always include the questions they asked, and rarely included the prompts they used. They did however often record their own comments and make notes on the template; these usually appear in the typed up notes in parenthesis. The following extract is an extreme example of the different ways data were recorded, or represented, in the interview notes. The interviewer's question is marked with parenthesis, the participant's words are then recorded verbatim (*It can give you diseases*), then there is a third person summary (*knows about HIV*), followed by a verbatim recording with quotation marks, and a third person summary (*School is the only place she has learnt about STI*).

[What do you know about STI] It can give you diseases, knows about HIV. "I was the clumsy one in school and didn't pay attention". School is the only place she has learnt about STI (Janette, 18, living with partner's family)

Although these issues with data collection can be seen in a negative light, this project, at the outset, was committed to a participatory research framework rather than a traditional scientific process. As Tyler et al (2006), note, prioritising the quality of the data, that is the robustness and reliability of data, defeats the purpose of using participatory methods. If this is the priority, they suggest, a straightforward research project should be conducted instead. In our project, a more conventional research approach may have produced more robust and reliable data, but it would have not have built research capacity in the ACCHS, been community owned, and more importantly, it would not have benefited from the perspectives of the young people and the ACCHS staff who are working and living in the Indigenous community in Townsville. Using a participatory framework meant that the 'how' of our project development and process (how we sought approvals, asked questions, looked after participants, and thought about the implications of our data), was more likely to be culturally safe. It follows then that the 'what' (researcher experiences, built capacity and data collected) is also more likely to reflect locally informed cultural perspectives. As university-based researchers from a UK study of young people's health needs reflected:

(A) member of our project advisory group reminded us, the strength of this study lies not in the rediscovery of already-known facts about the health deficits of young people, but in considering from their perspective the ways in which health care is (or is not) made available and experienced (Smith et al., 2002)

We echo these sentiments and encourage readers to keep these issues in mind.

⁵ The following conventions have been used for interview extracts: interviewer questions are enclosed in square brackets; clarifying comments or explanations are enclosed in parentheses; ellipses in parentheses indicate text has been removed. For readability punctuation has been added and some repetitious text removed. All participants have been given pseudonyms and identifying details removed to protect anonymity.

3.6 Reflections on the interview process

We asked our study participants how they felt talking to us about BBV/STI; most stated they were comfortable. Some indicated that it was easier to open up to a stranger, while others said it was easier to talk because they knew one of the researchers. A few participants said they would expect to feel less comfortable if they had been interviewed by someone of the opposite gender.

Quite comfortable, it (sex) is a natural thing so why not be open about it, everyone does it (Kandy, 19, living in hostel)

It is easy to open up to a stranger you don't feel that they're so judgmental (Chad, 22, living with family)

Okay. I guess it is different with you and me because we know each other (Maree, 26, living with partner's family)

See if it is a girl worker I'm talking to I don't think that I can open up the way I am talking to you (Brandon, 17, living temporarily with friends)

A few young men said they felt uncomfortable during the interview because of the nature of the subject.

Not very comfortable, reason is the first time I have had someone from outside discussing it with me apart from my partner and some of my close friends. Feel like this a sensitive issue and not ok to talk to strangers about it (Nick, 25, boards with friend)

Don't like talking about it, aye, it is no one's business (...) Nah don't like talking about it (...) Sex is a taboo topic to me (Matthew, 23, living in hostel)

Participants agreed it was important to be able to talk about preventing infections. Several young people drew on their past experiences to illustrate how they had made a decision to be comfortable talking about BBV/STI in future.

You have to be comfortable talking to anyone about it (Finn, 18, living in hostel)

I don't use to like talking about these things but I soon found out that the more I talk about it the easier (it is) for me to talk about these things (Katie, 26, living in hostel)

Many of the young people indicated that the interview had been a welcome opportunity to talk about their experiences and several reported it was educational.

It was good to talk to you about it. I did not mind at all and it is good to bring it out, no good holding on to your feelings (Samantha, moves between Townsville and Palm Island)

Also felt helpful talking (Iona, 20, living temporarily with family)

All good, all right, educational, learning a lot. Shocked about the idea that I could get STI by sleeping with men to men (participant looked surprised and worried) (Andrew, 21, living temporarily with family)

I have learnt a lot from talking today about these issues and am more aware of talking to others about risks involved with unprotected sex (Lanie, 23, living with partner's family)

Finally, some young people said that participating in the research was an important way for them to help their community.

It's doing something for the community; I feel good knowing that we are doing something good by being part of this project, helping homeless people on the streets (Morris, 20, moves around, living temporarily in Townsville)

Shame! Naah! It's all right but I guess it is good to help you guys with the study (Lydia, 24, living with family)

I want also to ensure that this information will be useful in the long run especially if we are to help our young generation today (Susie, 23, living with family)

Wani Erick, the site coordinator, either conducted the interviews or provided support to peer researchers conducting interviews. As a registered nurse experienced in working with young people, particularly homeless young people, she was well placed to provide prevention, screening and treatment information. Young people were offered condoms and referrals to sexual health services, and Wani was a vital connection to specific services.

During the interview itself, nearly a third of participants asked the interviewer questions about the transmission and prevention of infections or requested help in access screening. The following notes made by interviewers demonstrate a range of questions they were asked by participants.

Discussed that he could have infertile (fertility) problems later on in life due to this (STI) (Interviewer note, Mark, 26, living with family)

Asked a question on whether she will become infected with an STI or BBV if she keeps on sleeping with the same person without using protection. Discussed that can be possible but dependant on open communication between a relationship, it would be useful now and then to use protection. Good also to maintain ongoing checks for sexual health, screening for BBV/STI through blood tests (Interviewer note, Susie, 23, living with family)

She wanted to know if condoms would protect you from STI and BBV. She also wanted to know if you could die from STI (Interviewer note, Janette, 18, living with partner's family)

Explained to participant that all sexually transmitted infections are now referred to as infections rather than diseases (Interviewer note, Lanie, 23, living with partner's family)

The IRP-CBPR formally supported the principle of 'no research without service' by organising referrals and having information available for peer researchers to distribute. During their interviews some young people raised a concern that they may have an infection and requested help making an appointment. Some indicated that information they had gained during the interview had caused them to consider their behaviour and they felt they could have contracted an infection. Of particular note was the increased awareness of the need for screening among the young men we interviewed.

Yes maybe I need to go for a sexual health check (Kevin, 21, moves from place to place)

I may have an infection (...) Good to talk to you about this. I have wanted to go for a check (...) I'm glad I talk to you today. I've wanted to talk to someone about this for a while (Brandon, 17, living temporarily with friends)

Can you get an appointment for me at the doctors? I want to go for a sexual health check. (Andrew, 21, living temporarily with family)

Some young women requested help making appointments for pap smears, and the interviewers were able to give specific information about TAIHS.

I'm due for a pap smear and a breast check. I will ring the lady at TAIHS and book an appointment to see her for a check - I'm overdue, last time I had a pap smear was back in 2003. Do you know who I can contact? I am overdue for my pap smear and breast check (Natalie, 25, living in hostel)

When I first found out about my cervical cancer, they said to me it is rare, I was a bit scared, now I feel scared, but I also now go and see the doctors for a sexual health check. I also want to go now and get my HPV vaccination from the doctors. (Discussed the HPV Program available at TAIHS for free to Indigenous women between the ages of 16-26 years) (Davina, 26, living in hostel)

Summary

The opportunity to participate in a research interview was welcomed by the young people in our study and it is worth reiterating that all of the interviews were conducted by an Indigenous researcher - a peer researcher or the site coordinator. Due to the nature of data collection, researchers spent a significant amount of time in the community which, in turn, promoted the presence of the community-controlled health service and the importance of health, and specifically BBV/STI. The site coordinator and peer researchers spoke to many people (who did not necessarily participate in the project), raising the profile of BBV/STI in the community. Thus, our community-based approach enabled researchers to establish connections with people who are considered 'hard to reach' (homeless or highly mobile youth), and connections between this group and health services.

4 Results

The IRP-CBPR was focused on blood borne viruses including HIV, hepatitis C and B, and sexually transmitted infections including chlamydia, gonorrhoea, syphilis, HIV. Transmission of these infections primarily occurs through sexual activity and injecting drug use. However, sexually transmitted infections emerged as the priority issue for the site-based project team. This was evident during our research development and training workshop when development of interview questions focused on sex and access to condoms rather than injecting drugs and access to sterile injecting equipment. This focus was also reflected in the site-based project team's project title: "Sexual health through the eyes of Indigenous youth". The few young people in our study (all women) who did talk about injecting drug use, talked about their personal experiences of injecting and often of hepatitis C. However, the experiences of injecting drug users are largely absent from our data.

4.1 Young people's knowledge about blood borne and sexually transmitted infections

In response to the question "Tell me what do you know about STI or BBV?" participants listed the names of STI or BBVs, most commonly chlamydia, HIV/AIDS, hepatitis A, hepatitis B, hepatitis C, and syphilis (or 'the pox'). Participants rarely mentioned gonorrhoea or trichomoniasis, though both came up in subsequent accounts of personal experiences of BBV/STI. Participants generally mentioned transmission through sexual activities or the need to use protection (condoms) during sex, for example "If you don't use protection with you (when you) have sexual intercourse you can get a STI if person is infected" (Susie, 23, living with family).

Only one participant described non-sexual routes of transmission when responding to the specific question about knowledge. Reflecting a lack of knowledge about blood borne viruses evident across the interviews, there was some confusion about the meaning of blood borne and the difference between sexually transmitted and blood borne infections.

Blood borne is exchanging of bodily fluids only through sex without protection (Joan, 22 living with family)

Know you can catch STI - anywhere, from cuts and sharing needles, smokes, saliva, things like that (Robert, 18, lives with family)

Surprisingly few participants mentioned symptoms of these infections, and those that did tended to be male. Knowledge of signs and symptoms appeared to come from young people's own experiences rather than health promotion information or other sources.

(G)et burning when you piss (Brandon, 17, living temporarily with friends)

I was scared because when I had that pus I couldn't walk properly, it was sore (Mark, 26, living with family)

The feeling, discomfort, dysuria I experienced then was still vivid in my memory life till now (Lanie, 23, living with partner's family)

In fact, during their interviews, many young people talked about the invisibility of these infections and commented that the absence of physical symptoms made it hard for people to know they had an infection or to seek treatment. Young people often cited their own (and their friends') experiences of having an infection and not being aware of it until they were screened.

Some disease these days you can't tell, you know, so people never bother to go for help unless they are asked to do a general check or when they are pregnant and need to do a general health screening (Natalie, 25, living in hostel)

I feel sorry for the ones out there with a STI. They don't probably know they have these diseases, make them aware (Davina, 26, living in hostel)

I had an STI before, didn't know until a sexual health worker came to see me to get a blood test done (Ester, 26, living with family)

The relatively common experience of asymptomatic infections (Fagan, 2001) is a key reason why routine screening is recommended (Queensland Aboriginal and Islander Health Council, 2008).

Similarly, few participants cited complications or long term health consequences of infection. One young woman, Edwina, talked about her own experience of hepatitis C.

I got really sick because of the hepatitis C. I lost a lot of weight, I was throwing up so much, could not eat, too stressed with what is happening in my life (Edwina, 24, living in hostel)

Echoing other research on BBV/STI, references to longer-term consequences of infection tended to be about life threatening outcomes, particularly in relation to HIV/AIDS (Garside et al., 2001). HIV/AIDS was presented as the worst, or most feared, infection because it could not be cured. The possibility of death or of contracting an untreatable infection featured in some people's explanations of why they felt it was important to protect themselves against these infections.

I learnt about HIV and that it makes you sick, very bad disease (Mark, 26, living with family)

Given the importance of family to Indigenous people and well established links between some infections and infertility in women (Fagan, 2001, Kildea and Bowden, 2000) it was surprising that infertility was mentioned by only one person in our study.

I understand the issues that come with not getting yourself clean from STI. [What are those issues?] Infertility! (Maree, 26, living with partner's family)

However the consequence for infants if a mother was infected was salient for a few young women.

(A)nd the poor baby can be infected as well (Natalie, 25, living in hostel)

We cannot say if the young people in our study were unaware that infertility can be a complication of some STI or whether it simply was not considered during the interviews. However, the lack of discussion lends support to calls for health promotion messages to be framed in terms of reproductive health and the potential consequences of untreated infection (Kildea and Bowden, 2000).

We asked young people a specific question about whether they felt they had enough information to prevent infection. A small number of participants, mostly men, characterised their knowledge as sufficient.

I feel I have a good knowledge of protection from STI (Nick, 25, boards with friend)

I feel I have enough awareness with protection to think when I'm out there (Finn, 18, living in hostel)

I do feel I have enough information regarding STI/BBV to protect myself and others in the future (Lanie, 23, living with partner's family)

We did not measure our participants' knowledge or test if their knowledge was correct, so we cannot say whether their confidence was misplaced. A recent study with young female university students found that despite high perceived knowledge of STI, most had difficulty naming symptoms associated with specific infections and displayed incorrect knowledge regarding prevention (Rouner and Lindsey, 2006). While a Western Australia study with Aboriginal young people aged 12 to 17 years found that the majority of young people who had limited knowledge of preventing infection also reported they had been taught how to avoid HIV and STI (Zubrick et al., 2005). The concern here is that young people who believe their knowledge to be sufficient will continue behaving in ways that may place them at risk and may not attend to information about preventing the transmission of infections.

It was more common, however, for the young people in our study to characterise their knowledge as insufficient, with some reflecting that they knew more about some infections than others. Several young people mentioned a specific lack of knowledge around blood borne viruses.

Don't know a lot aye! (Matthew, 23, living in hostel)

Yes I know the basics but it would be good to get a better understanding and knowledge of this issue (Jane, 19, living in rented accommodation)

I need to know about hepatitis B, hepatitis C, and what is that other one? [Hepatitis A?] Yeah, and what about AIDS? I guess people need to be aware today (Naomi, 26, living in hostel)

Sorry I can't explain what BBV means (Lydia, 24, living with family)

So, while a few young people in our study felt knowledgeable and well equipped to protect themselves from infection, most did not and wanted to know more. During their interviews, several participants described how their ignorance of transmission routes or methods of prevention were factors in contracting, or being vulnerable to contracting, infections.

My first boyfriend was 26, I was 16 and left (home) and came here to Townsville. He gave me chlamydia, I felt funny at night, did not know about this disease, he was a violent person. I went to the doctors and told him how I was feeling, I was naïve, they did blood test and found out that I had chlamydia. In reflection I feel upset leaving mum, home in the first place. My mum never talk to me about pregnancy and all that, she is very strict and protective (Lanie, 23, living with partner's family)

As mentioned above, we did not test young people's knowledge about BBV/STI, so we cannot make any claims about young people objective knowledge about preventing the transmission of infections. However, there were several areas where young people revealed a specific lack of knowledge that warrant remark. We have already mentioned the low level of knowledge about blood borne viruses, and how they differ from STI. Interviewers were asked questions about whether condoms would offer protection from infection, and one young man, Andrew, expressed surprise that sex with a man could put him at risk of infection.

Shocked about the idea that I could get STI by sleeping with men to men (participant looked surprised and worried) (Andrew, 21, living temporarily with family)

We also found some confusion around whether hormonal contraceptives could protect young women against infections (discussed in more detail below). This lack of knowledge around modes of transmission and methods of preventing infection, suggests a need for continued basic education.

We did not ask participants if they had ever had a BBV/STI. However a third self-reported as having received a diagnosis in the past and a few reported having had repeated infections.

I know a few, I had a few (Ester, 26, living with family)

Yeah, she gave me syphilis before and I went immediately to get help a couple of years ago (Eric, 26, living temporarily with family)

A woman back years ago gave me gonorrhoea. She said to me I had Crabs (James, 25, living in hostel)

I ended up with chlamydia before a couple of times (Samantha, moves between Townsville and Palm Island)

Many of young people gave detailed accounts of the contexts of infection and their experiences of receiving a diagnosis. Lindy provided a particular poignant account.

Don't know much about it, I found out that one of the boys I was sleeping with had chlamydia, he was my boyfriend. We are not together now, we broke up because he as cheating. I was shocked when I found out. I didn't know anything about STI. His (relative) came round to me and told me to get myself checked out. I didn't know anything and thought I might die. I went to the doctor to get medication (...) I don't like going out because ex-boyfriend's cousins want to bash me because they think I gave him an STI. He doesn't care. I went out with him for (relationship length) [Is it hard that everyone knows?] It is a small town and everyone knows everything (Lindy, 17, living with family)

Participants also told us about family members and friends who had contracted a BBV/STI.

AIDS is quite a terrible thing. I know of people back home on TI (Torres Strait Islands) that has AIDS. AIDS is scary you know. I have seen someone being sick (participant looked bad) I think he has gone now (Nick, 25, boards with friend)

I'm aware of these problems after seeing what my mate went through and even my sister. They all did not know that they had these diseases until the doctors told them after their blood test results (Finn, 18, living in hostel)

For the majority of young people in our study then, the possibility that they could contract a BBV/STI was highly salient. Young people located BBV/STI in their family and communities. This is in stark contrast to comparable research showing young people locate BBV/STI, in particular HIV/AIDS, in distant places or populations to which they do not belong (Graffigna and Olson, 2009). Moreover, during their interviews young people described BBV/STI as highly transmissible and easily transmitted in small communities, reinforcing the sense that they perceived themselves to be at risk of infection.

Oops! You end up with something (...) Everyone in this world has STI look at Julius Caesar, he has a sexually transmitted infection (...) Anyone can get it (Ester, 26, living with family)

A lot of people don't realise how easy it is to get STI, most young guys I know (think) that when they pull out it is ok, everything is ok. They don't know how easy it is to pick up STI (Edwina, 24, living in hostel)

I think he passed the STI to me, he was sleeping with my friends. Palm Island is a small place, easy to pass all these STI (Samantha, moves between Townsville and Palm Island)

The flip side of the high salience of STI in this population may be that infections are seen to be relatively mundane and perhaps inevitable (*oops*) when young people engage in sex. This resonates with a wealth of qualitative research showing IDUs perceive HCV as everywhere, easy to catch and inevitable; the authors of a synthesis review of this work noted that the

“perceived ubiquity of hepatitis C risk fosters a context in which hepatitis C infection is unavoidable, perceived as an inevitable consequence of drug injection” (Rhodes and Treloar, 2008). In contrast to hepatitis C, the ordinariness of STIs in our study is amplified by young people’s experiences of infections as asymptomatic and easily treated, representing a significant challenge for health promotion.

Although most participants had either direct personal experience or had known a friend or family member who had been infected, a very small number reported that they did not know anyone who had contracted an infection. The absence of a direct personal connection appeared to make infections less salient to these young people.

It’s good to talk about these things but I don’t think it plays a major part in my life. I mean I do worry about it but not like hard at. But it is important information, it’s good to know and be aware of it. But I don’t think much about it. It’s good to talk about with friends and all but I don’t really see it as a big issue only because I don’t even know anyone who has a STI (Jane, 19, living in rented accommodation)

A Canadian study found some young people applied a similar understanding to HIV/AIDS; not knowing anyone affected by HIV meant it could be framed as irrelevant with flow-on effects for decision making around safer sex (Graffigna and Olson, 2009). Young people also made comparisons between the low prevalence of HIV in their peer group/community and the high coverage of HIV in the media, leading them to question the reliability of the media and health promotion messages. The concern here is that applying this heuristic - I don’t know anyone who has been infected therefore prevalence is low and I’m not at risk - can mean young people ignore health promotion information. Health promotion efforts to address this framing may be necessary for the minority of young people in our study who saw BBV/STI as irrelevant to them.

4.1.1 Learning and talking about blood borne and sexually transmitted infections

When we asked young people a specific question about how they started learning about BBV/STI, they told us about structured teaching through school-based programs and informal learning through family. During their interviews they also talked about the information they had received in consultations with health professionals, through attending youth and other support services, and through conversations with friends and sexual partners.

School

When describing how they *first* learnt about BBV/STI, formal education, chiefly high school, was the most commonly reported. Education had often been delivered through physical education classes or programs such as Life Skills and Life Education.

Learnt about it in school (James, 25, living in hostel)

Learned about sex at school where health teams would visit (Ange, 26, living in hostel)

The central role of school in these young people’s education around BBV/STI echoes

previous research (Larkins et al., 2009, Flicker et al., 2009). Research with Aboriginal young people in Western Australia found that school was the most important source of information for 12 to 17 year olds, and for over a third it was the only source of information about how to avoid HIV and STI (Zubrick et al., 2005).

Formal schooling was not a source of information for everyone. Several participants reported that they had not paid sufficient attention to the information being provided or had generally not been engaged when at school. Young people did not associate their lack of attention with feeling shame or embarrassment, though research with similar populations has suggested this is an issue (Larkins et al., 2007). A significant proportion of young people in our study reported that they had missed out on school-based programs because of a disrupted education or leaving school early.

I think I still need to learn a lot about these things. I did not really take it seriously when they were talking to us at school, we think it was funny that they talk about those things, but now I wish I had listen then to the teachers (Lydia, 24, living with family)

I don't know much about STI. I left school in Grade 8 (...) I never had any education at school about STI (Sandra, 24, living in hostel)

One young woman, Sharon, gave a detailed account of how family mobility during her childhood meant she missed out on important information at school, leaving her feeling she had to gain new knowledge.

I'm uncomfortable talking about these things because of my upbringing. My parents moved us around so much when we were young and I feel I never have the opportunity to feel stable in an environment. That is why I feel uncomfortable talking about these issues (...) I never use to learn anything at school when we move around too much I did not like it. Now I have to learn about this new things (BBV/STI) I wish my parents had stopped moving us all the time when we were kids, I could maybe stop feeling uncomfortable about myself. The same as not having a proper place to call home. I'm here in Townsville to finish my community service then I go back to (location). I call (location) my home now because I was spending most of my teenage life there and because my parents were still living there. Can't wait to return home (Sharon, 18, living temporarily with family)

For others, the information provided had not been useful or it had been provided too long ago and had since been forgotten.

Learnt about STI in school but being 21 years of age I have forgotten what they had taught us. I know that an STI is a disease or something like that (Vince, 21, living in rented accommodation)

(S)tarted learning about STDs in primary school but information was not very clear (Jane, 19, living in rented accommodation)

Family

The second source of early learning about BBV/STI was family. Reflecting the range of family members who play significant roles in young people's lives, participants mentioned talking to parents, grandmothers (grandfathers were never mentioned), cousins and siblings.

I learnt about STI through family (Joan, 22 living with family)

While formal education delivered facts and information, young people described speaking to family members when they had concerns about infections. Some reported family members had also sought advice from them.

I just tell my cousin brother about it, he tell me to go straight to the hospital, if I don't go to the hospital I could have this for a long time (Mark, 26, living with family)

My sister had chlamydia, she told me and we told her to go to the doctors (Finn, 18, living in hostel)

Sisters in particular appeared to play an important role, acting as both a source of information and a source of support. They were especially important for young men, as Vince indicated.

Yeah my two sisters. Nah that's it, just talk to my sisters that's all (Vince, 21, living in rented accommodation)

These findings resonated with participants in our feedback workshop, who commented that older siblings and cousins often played an important role in caring for and supporting younger relatives.

It was an age group thing. Above us, not the parent's level, there were the 20 year olds and they would be the ones telling us and talking to us. Not like our parents or our aunties. They took on the role of explaining a lot of stuff to us (Male health worker)

Parents played an important role, providing *practical* information and encouraging young people to take measures to avoid contracting infections.

Mum and dad told me get a check every six months (James, 25, living in hostel)

My mum made sure that I was aware of safe sex, using protection (...) With my mum's influence and advice I take care with using protection when having sex (Rachel, 23, recently arrived in Townsville, living in temporary accommodation)

A study with young people in Western Australia found that Indigenous participants listed family member as authorities and sources of information about sexual health, and young women named extended family members as people they turned to for support (Sorenson and Brown, 2007). When researchers asked young Aboriginal people (12 to 17 years) in the same region where they had received information on avoiding HIV and STI, the most

common source, after school, was family (23%) (Zubrick et al., 2005). Sorenson et al. (2007) note the importance of recognising the importance of family as sources of sexual health education and call for programs to develop family members' skills and knowledge. We would support this call and suggest that such programs be made available at a community level.

Echoing our previous finding regarding school, some young people told us that at the time they had not necessarily paid attention to information provided by family members, or taken it seriously. Some expressed regret and linked a subsequent infection to this lack of attention.

I never really listen to my Gran, she use to growl at me all the time, my Gran is now gone, passed away (year) and now I look back I should have listened to her. I now is sorry I never listen to them. Never mind I have to carry on, by experience I know now to use protection after getting that chlamydia, twice (Samantha, moves between Townsville and Palm Island)

Not all family members are comfortable talking about BBV/STI (Larkins et al., 2007), something we also found in our research.

I talk to my cousin about it but my Grandma does not like it when we talk about it. I think it is bad in their eyes to talk about these things (Lydia, 24, living with family)

Moreover, four young women expressed regret that their parents had not spoken to them about sexual health. These young women talked at length about how this lack of knowledge had left them vulnerable. The young women in the first extract talks poignantly about the role parents play in building young people's confidence so they can deal with difficult situations later in their lives.

Parents need to be in touch with their children's lives right from day one. I wanted my mother to talk to us when we were young about these things. She never did (...) I remember those days she would flog us for any little mistake. I could never feel comfortable talking to her. I suggest that parents these days need to be more open minded and teach their kids about these infections so that children are much more prepared and feel confident enough to stand up for themselves. I learnt the hard way, maybe that is why up till now I still feel not too comfortable talking about these issues (Lanie, 23, living with partner's family)

If my parents had talked to me about sexual information I don't think I would have become pregnant at the age of 16. I love my daughter but I must admit if I had known better, if my mother talks openly to us about sex back in those days I would have made a decision to wait until I'm older before experiencing what it's like to have sex (Naomi, 26, living in hostel)

I wish that my family and friends had told me previously about these infections, if for example my mother was around for us other then mucking around drinking alcohol

with everyone here in (a local park) maybe I would have been able to protect myself from this cervical cancer that I ended up with before (Davina, 26, living in hostel)

A small number of participants said that they had not felt comfortable talking to a parent about preventing infections. Ester, the young woman in the second extract below, talked about how she would like to be able to talk freely with her own children. (Note: the first extract has been written in the third person)

But can't really talk about it with Mum, unless she brings it up. Is usually uncomfortable to talk about things like this with adults in fear of being told off or misunderstood (Jane, 19, living in rented accommodation)

I am all right talking about STI/BBV. I'm comfortable talking about it because I couldn't tell my mother at first when I had STI but now I tell younger people to be aware about those STI/BBV as anyone can get it. I would rather talk freely to my children about sexual health (Ester, 26, living with family)

Health and other support services

Very few participants reported that their early knowledge had come from a health care provider or support service. Those that did usually reported that they had missed out on school-based education and described a range of services that had supplemented their knowledge.

The lady (nurse) and I sit all morning to listen to her that way you can learn more. I'm not educated, I finish at Grade 9 (Samantha, moves between Townsville and Palm Island)

Look at me, I was in and out of (youth detention) since the age of 13. No one talks to me at all about these things. But now I learned from people like at TAIHS, they talk to us about these things (Morris, 20, moves around, living temporarily in Townsville)

(B)ut learnt more about them when I entered Rehab after being in a drug scene (Nina, 26, living temporarily with friend)

I learned about STI when I was 15, through youth sessions, there is a place called Open Youth Project and they talked about it all the time. (...) The project was mainly talking about our health, and even STI, they explain to us about how important it is use protection because of these diseases (Margaret, 26, living in hostel)

It was more common for young people to report receiving advice on prevention during more recent consultations with health care providers, and many reported that they had been given informational material such as pamphlets.

I went to the doctors and they told me that I have to use condoms (Mark, 26, living with family)

I reckon TAIHS is pretty good, they talk to me about prevention, signs and symptoms about STI (Margaret, 26, living in hostel)

I go to the hospital regularly for checkups and they also have condoms up for grab, they also got health and sex sort of pamphlets which I take and read, so that's pretty good (Jane, 19, living in rented accommodation)

I didn't know anything and thought I might die. I went to the doctor to get medication [Did the doctor give you advice?] The doctor mainly said to wear a condom (Lindy, 17, living with family)

These findings are heartening as they suggest that young people can and do seek medical advice for BBV/STIs and that during these interactions they are often exposed to health promotion interventions and information.

Friends

Many of the young people in our study, men and women, described talking with their friends about BBV/STI. This reflects recent research (Larkins et al., 2007, Flicker et al., 2009). While friends did provide information, young people appeared to value them more as a source of support. Participants' descriptions suggest that friends (experienced peers) often drew on their own experience of infection and treatment when providing advice and support.

I went through a 6 month period with waiting for whether I had hepatitis C or not, to find out is the test is clear, it was nerve wrecking (...) The waiting period was frightening but luckily I had friends who were aware and explain that hepatitis C was easily treatable (Nina, 26, living temporarily with friend)

I know a couple of friends who told me about this stuff, one of my mates had chlamydia (Finn, 18, living in hostel)

Unlike the other sources of knowledge cited, however, young people did not always think their friends had reliable information. Moreover, as demonstrated by the third and fourth extracts, friends could also undermine young people's attempts to talk about BBV/STI.

I was told by my friends to use glad wrap and someone also say to go straight to the toilet straight after so I don't get pregnant. Naah! I don't believe that, they made me shame talk like that (Lizzie, 18, living temporarily with friend)

Have some information but it's not all from good sources - boyfriend, friends (Jane, 19, living in rented accommodation)

When I catch up with my friends I tell them to use their condoms. I know they probably talk behind my back but I tell them you will not laugh when you have an STI. They just laugh and said that I was missing out, on the good parts by using a condom. They can laugh now but maybe when one of them has a problem they are the first to come to me and ask for help (Nick, 25, boards with friend)

When you talk to someone else they think that it is a great big joke, talking about, they may not feel comfortable talking about it you know. But I don't think it is a joke, especially when you get an STI, this is no joke! (Finn, 18, living in hostel)

Several young people contrasted their own understanding of BBV/STI infections as serious health issues with that of their friends who reportedly considered BBV/STI a joke. There seemed to be an amount of esteem to be gained from this juxtaposition. Several studies with young people have mentioned a similar phenomenon, with young people drawing distinctions between themselves as 'good druggies' as opposed to 'bad junkies' (Hillier et al., 1999) or 'good mothers' as opposed to 'bad mothers' (Larkins et al., 2009). It has been suggested that health promotion should attempt to harness people's 'good selves', particularly as this appears to be associated with a sense of being in control of their lives (Hillier et al., 1999, Hassin, 1994).

Sexual partners

We asked our participants to tell us about an experience of talking to a sexual partner about BBV/STI. Over a third reported that they had openly discussed prevention and screening, sexual history, disclosure of status, and their concerns about a partner sleeping with other people.

Regular partner. We are comfortable with talking to each other about STI. We are open minded (Travis, 23, living temporarily with partner)

I have a friend, I would openly talk to her about sex. I have known her for a couple of months. She is a Christian and I have a great deal of respect for her, but I can openly talk to her, it is honesty you know (Eric, 26, living temporarily with family)

I have a partner but is not here in Townsville he is in (location), we talk and understand the need to talk about these things (Naomi, 26, living in hostel)

I talk to my partner openly about STI, he ask me a lot of questions, like how people get STI, or STI and STD are they the same thing? People often think STI and STD are two different things. They are not. My husband said to me, "If you have a STI will you tell me" and I said to him, "Yes I will" (Natalie, 25, living in hostel)

There were, however, some limits to disclosure, particularly around sexual history, as Jade indicated.

I guess it is up to you as a person, I'm not seeing anyone in particular but I have this guy in (location) he rings me just about every day. We just talk about everything in general. He ask me one day whether I have slept with anyone over here and I said to him it is none of his business who I sleep with (Jade, 21, living temporarily with friends)

It was not always easy for young people to talk openly about BBV/STI. For some participants their own discomfort or shame made this difficult.

I found it shame, hard to talk to partner about this stuff (Lindy, 17, living with family)

I have not talked to my partner about STI. I have not spoken to anyone else about STI (Sandra, 24, living in hostel)

For others, it was a partner's shame or embarrassment that made discussion difficult, and in some cases, impossible. (Note: the last extract has been written in the third person)

My baby's mum would slap the shit out of me if I talk to her about sex, you know. I talk to her about STI but she's not comfortable, I reckon, don't know, maybe it is a trust thing (Eric, 26, living temporarily with family)

Not all the time, I've talked to them about, not comfortable they think that I have gone mad talking about it (Finn, 18, living in hostel)

Yes, but has to be push or prompt him to talk about it he is very private with his sexual life (Maree, 26, living with partner's family)

I do not talk about it with my partner, he is an old man, they are SHAME! (Lizzie, 18, living temporarily with friend)

Shame arose as an issue more often in young people's accounts of talking to partners, than it did around school, family or friends. It may be that talking about these infections directly or indirectly with a sexual partner while negotiating condom use or STI screening are more recent experiences. Negotiations with sexual partner are also likely to occur more regularly. Young people usually reported they had persisted with conversations about safer sex (for example) in the face of a reticent partner or their own feelings of shame. Two young women who described talking to very reticent partners about infection prevention framed their motivation for persisting as wanting to help a partner look after his health. While this example of persistent infection prevention evokes a positive picture of looking after the health of others, it is notable that young women may not place the same priority of care on their own health. On the other hand, the second extract suggests that framing difficult conversations about a partner's health may create a space where young women can enact prevention strategies, such as checking a partner's BBV/STI status through screening. (Note: the second extract has been written in the third person)

I don't talk to my partner about STI. He is embarrassed to talk to me about it. Told him females go through more than men do. I'm not shame to talk about STI, talking helps; it helps me to talk about it and should be both ways. No need to be shame about it, told him he stressed too much, anxiety is no good for him. I don't worry about these issues, everyone else see a doctor or counsellor about it. I lecture him about it, my (partner) thinks I'm mean by talking to him about it. I'm telling him what to do for his safety (Karen, 24, living in hostel)

She spoke to her boyfriend once about sexual health. Her boyfriend laughed and didn't take it seriously but it meant a lot to her because he was her first boyfriend. They spoke about AIDS and her boyfriend thought it was gross and that you couldn't get AIDS without protection. She spoke with her partner about his past girlfriends. She asked her boyfriend if he had any STI. She offered to take him to the doctor but he refused as he doesn't want a doctor looking at his penis (Janette, 18, living with partner's family)

This discussion has focused on communication in established relationships. We did not specifically ask young people about their experience of discussing safer sex with a new partner and no one provided a spontaneous account. However, there is evidence, presented in other research, that there is often little communication during casual sex encounters (Carmody and Willis, 2006, Browne and Minichiello, 1994), suggesting that talking about BBV/STI is unlikely. Moreover, talking about sex (including safer sex) can be used to create intimacy and trust, meaning it can be hard to have these kinds of conversation early in relationships (Lear, 1995). This has important implications for young people's adoption of prevention strategies that require partner participation, especially condoms.

Summary

Young people in our study were broadly aware of a range of BBV/STI and that these infections were typically transmitted through unprotected sexual intercourse. They said very little to our researchers about blood borne or non-sexual routes of transmission and there was some confusion around the meaning of 'blood borne'. When describing what they knew about these infections, young people said little about symptoms, treatment or long term complications. Most young people indicated that they wanted to know more about these infections and many felt they had insufficient knowledge to protect themselves. BBV/STI were highly salient among our study sample, with many young people telling us about a previous diagnosis and others talking about a friend or close family member who had been diagnosed with an STI. These experiences overwhelmingly involved a sexually transmitted infection that had been successfully treated.

Echoing the literature, school played a central role in most young people's knowledge about BBV/STI. We do not know the specific information that young people received, and the few complaints were not about content but about having missed the educational opportunity by not attending school or not paying attention. Health and other support services supplemented and reinforced existing knowledge, and importantly for some, made up for missed school-based education. Family was an important source of learning, support and encouragement. Again, the value that young people placed on family was highlighted in the comments from those who felt they had missed out because their parents had not taken a more active role in providing important knowledge. Friends were an important source of support for young people and many reported that a friend or sibling was the person they spoke to for advice when they suspected they had an infection. Unlike other sources, friends were not always seen as sources of credible information and their prioritising (or not) of BBV/STI presented additional challenges for young people. Finally, young people told us about talking to sexual partners about prevention. For some, these discussions took place alongside broader negotiations around sexual relationships. Talking about BBV/STI with a partner was not always easy and shame featured often in young people's descriptions.

4.2 Strategies young people employed to prevent transmission of infections

During their interviews we asked young people a direct question about how they protected themselves from infection: “What do you do for protection?” ‘Protection’ is a common synonym for condoms and young people, unsurprisingly, talked to us about using condoms. However they also described two other important strategies for protecting themselves from infection: establishing a trusting relationship with one partner and monitoring their status through sexual health screening.

4.2.1 Condoms

In response to our question about protecting themselves from BBV/STI, the majority of participants mentioned condoms (or ‘protection’) and reported using condoms during sex.

Condom is the best thing (...) Condoms! Best for keeping (Eric) safe (Eric, 26, living temporarily with family)

A boy or girl can transfer disease to someone else if they don't use protection. Some of them may end up with HIV positive, if do not have safe sex (Natalie, 25, living in hostel)

Very important to have protection to keep on the safe side (Morris, 20, moves around, living temporarily in Townsville)

Very important to me to use protection. Yes otherwise it would, otherwise you would have an infection and if you don't get it treated then others will catch the infections (Lydia, 24, living with family)

I do believe in safe sex, I might get a disease if I don't use a condom (Sandra, 24, living in hostel)

As already noted, a significant proportion of our sample spontaneously reported having had a sexually transmitted infection, and many of these young people linked their current condom use to a previous experience of infection.

I don't hold back with using condoms. I need protection because I had an infection before like pus coming out of my thing from all sorts of girls in (location), that is why I realise that I have to use the condom (Mark, 26, living with family)

Some young women linked current condom use to a previous experience of unwanted pregnancy.

She once ran out of condoms and fell pregnant. She has learnt from that and won't have sex without a condom (Janette, 18, living with partner's family)

While one young woman linked condom use to the perceived level of infection in her community.

I don't like having sex without protection. At the moment I think using protection is very important especially if we are seeing a lot of STI or BBV around our people (Sharon, 18, living temporarily with family)

Many of the young people in our study emphasised the importance, to them personally, of condom use. Many indicated that they would abstain from sex if they did not have a condom. This position was also endorsed *for* other young people.

If you want to sex someone ask to use protection. If they say no don't have sex (Ester, 26, living with family)

However, as we will see, condom use was mediated by situational complexities (Hillier et al., 1999). While many endorsed a position of condoms always being used during sex, there were a range of situations where this was actively challenged, including when other contraception was being used (see below) and when young people were in a trusting relationship (discussed later).

Condoms and contraception

Slippages around the meaning of safer sex, and between condoms as a means of preventing pregnancy or infection, are well documented (East et al., 2007, Kirkman et al., 1998b). There is evidence that heterosexual people associate condoms more strongly with preventing pregnancy than with preventing infection (East et al., 2007, Kirkman et al., 1998a). A recent representative survey of 16 to 29 year old Australians found that 44% of women and 23% of men associated safer sex with preventing unplanned pregnancy, and preventing pregnancy was the more significant concern for many (Stancome Research and Planning, 2008). For many young people, an unplanned pregnancy is a more common experience (personally and among their friends) than STI diagnoses, and thus is a more imaginable outcome of unprotected sex than an STI (Larkins et al., 2007, Graffigna and Olson, 2009). However, in our study, young people chiefly talked about condoms in terms of preventing infection, perhaps because direct personal experience of BBV/STI was high⁶.

Some young people talked about the dual function of condoms in preventing infections and pregnancy.

Very important to have protection, don't want to get pregnant or infected (Jane, 19, living in rented accommodation)

It has been suggested that because condoms are associated more strongly with contraception, condoms use will decline when another contraceptive is being used (East et al., 2007), and this is supported by Australian research that found condom use was significantly less likely when another form of contraception was being used (De Visser et al.,

⁶ Our project was explicitly framed as being about BBV/STI, which may also have led young people to focus on this aspect of condom use.

2003). De Visser and colleagues suggest that young people need to be made aware that “non-barrier methods of contraception do not offer protection against STI”. Several young women talked about using hormonal contraceptives, specifically, Depo-Provera™ (administered by injection every three months) and Implanon™ (a device implanted under the skin that releases a hormonal contraceptive that lasts up to three years). Some young people told us that they used condoms, in addition to hormonal contraceptives, to avoid contracting infections. Edwina, who was not currently sexually active, explained that she abstained from sex if she did not have a condom, even though she was using hormonal contraceptives. This suggests she was aware that despite the use of hormonal contraceptives she still needed a condom to protect her against infection.

I used to get the Depo needle every 3 months and buy condoms with my weekly grocery shopping at the supermarket. Yes very important to me now because I have two children. I would not have sex if I had no condoms left (Edwina, 24, living in hostel)

However, Maree’s response to a question about protecting herself did indicate some confusion about the role of ‘contraception’ in preventing infection.

[What do you do for protection? How do you keep yourself from getting sexually transmitted infections?] Contraception and I use a condom (Maree, 26, living with partner's family)

Two young women reported that their hormonal contraceptive meant they did not need to use condoms. They both subsequently said they were aware they were not protected from infection if they did not use a condom. It is not clear whether their later inclusion of condoms was prompted by an interviewer question, whether they prioritised risk of pregnancy over risk of STI or whether they did not completely understand STI prevention.

I did not use condoms maybe I am allergic to it, condoms gives me irritation around my private parts and that is why I never use them. Otherwise I’m on the Depo-Provera, contraception and I make sure I’m on right on time because I’m not ready for kids yet (...) I do not hesitate to get condoms from IGA supermarket. I’m not ashamed to grab them from the shelves it is a natural thing wanting to protect yourselves. Otherwise if I do not have condoms, I will still go ahead and have sex unprotected because I’m on Depo-Provera. However it is not 100% safe. Being homeless I do not have a stable relationship, stable housing so I worry with having or using no protection because it is all hygienic you know, you never know what you can pick up from these people. I’m not ashamed to say to people that I would have to think and maybe wait to get some form of protection before I can sleep with someone (Susie, 23, living with family)

I got Implanon therefore I don’t use protection. So I don’t have any more kids. Even though I don’t use protection I am still aware that I can still get an STI. It’s very important to have protection and to always use protection for my safety. I would go to the medical centre to get protection. It would affect me if I didn’t have protection

because I don't want to get and STI so I don't get sick and go to the hospital (Karen, 24, living in hostel)

It does appear that the some young women in our study might have been unaware or at least unsure about whether hormonal contraceptives could protect them against infections. At the very least, our findings suggest that young people may 'forget' about condoms because the prevention priority, pregnancy, has been taken care of with hormonal contraceptives. This suggests there is firstly, a need for targeted education regarding the fact that hormonal contraceptives do not prevent infection, and secondly, an opportunity to explicitly link condom use to infection prevention.

Access to condoms

Participants repeatedly indicated that free condoms were available at ACCHS, dedicated sexual health services, such as the Townsville Sexual Health Unit, hospitals and at youth support services such as the Open Youth Project. Men and women agreed that free condoms were widely available.

Easily accessible (Nina, 26, living temporarily with friend)

Never had trouble getting protection, no problem at all (Morris, 20, moves around, living temporarily in Townsville)

Participants described picking up free condoms opportunistically when visiting health services and proactively when they anticipated they would need them.

If I ever need protection I just go to medical centre to see if there is any protection available (Vince, 21, living in rented accommodation)

If I need anything I go to a sexual health clinic or TAIHS. It's free medicine at Sexual Health and condoms too. When I visit TAIHS I grab heaps of condoms (Ester, 26, living with family)

I went to Queensland Health Sexual Health Unit (...) (T)hey gave me condoms and I was ok with that (Naomi, 26, living in hostel)

During our community feedback workshop, a youth worker noted that the young Indigenous men he sees are happy to be given free condoms.

During intake with our boys we hand 'em condoms at that stage and they don't seem too embarrassed to take them or talk about them (male youth worker, homeless shelter)

The picture that emerges suggests that free condoms are widespread and available. It may also mean that this group of young people have a particularly high awareness of where they can obtain free condoms. A few young women (no men) reported buying condoms at supermarkets or pharmacies. In response to a question about preventing STI, the young woman in the following extract described buying condoms to ensure that she and her

partner were always protected and in the event that her partner does not have a condom. (Note: the extract has been written in the third person)

She buys condoms from the shop and gets free ones from school (...) She buys the condoms to be sure of protection as her boyfriend may forget (Janette, 18, living with partner's family)

Like the young woman above, a few young people reported obtaining condoms from friends or partners. Several reported providing condoms to friends and family members.

I carry (condoms) everywhere anyway. Also give to friend if any spare (Tim, 18, living temporarily with family)

Despite the reported widespread availability of free condoms participants did raise some barriers to access. The supply of free condoms at health services was not always reliable, as Lizzie commented about her local health service.

(They have) a basket of condoms kept in the clinic but the condoms sometimes run out (Lizzie, 18, living temporarily with friend)

Other participants said they found it hard to anticipate when they would need condoms, as they needed to *know the right time* (Finn, 18, living in hostel). *Knowing the right time* hints at a particular challenge for condom use raised by several young men in our study - unplanned sex. A small number of participants described instances of having unprotected sex because they did not have condoms (alcohol was often implicated). This difficulty negotiating unplanned sex and safe sex is echoed in the literature (Stancome Research and Planning, 2008).

So I like to use condoms when I can get them. I know TAIHS give out free condoms but it is hard to find some or to buy some when you need them (...) Not always easy to get condoms. Protection is very easy word but is hard to do. I have to always say to myself what next, it is easy to say use the condom but when you are out drinking and forgetting to get a condom you just go ahead and do it right there and then and not bother about protection. I have done this a few times before then I worry after the following day (Fred, 19, living with family)

While the young man above had a commitment to using a condom and tried to think ahead, the combination of alcohol and not having a condom was enough to undo his resolve, a well documented situation (Lear, 1995, Stancome Research and Planning, 2008). For people who rely on free condoms, issues of access include not having access outside clinic hours and condoms not being (freely) available where people are drinking (Stark and Hope, 2007). Research suggests that younger people, particularly men, are more likely to carry condoms. As people age and form monogamous relationships they tended to keep their condoms at home (De Visser et al., 2003). It may be particularly important to promote carrying condoms to younger men and women who are highly mobile as they may not be having sex at home and may not always have local knowledge of where to obtain condoms. Several young

people in our study did report carrying condoms, something Tim explicitly connected to the possibility of unplanned sex.

I know if you don't use protection you are in trouble. That is why I have start to carry condoms with me. You never know, aye (...) I carry condoms everywhere anyway
(Tim, 18, living temporarily with family)

Young women also described carrying condoms.

There is another thing and that is always to carry your plastic (condom) with you
(Samantha, moves between Townsville and Palm Island)

Very important to me to the point that I would say no if I do not have any protection. I carry condoms with me all the time (Margaret, 26, living in hostel)

It has been suggested that carrying condoms can be interpreted by potential sexual partners, especially men, as consent to sex. As a consequence, young women may prioritise maintaining control over a sexual situation, thereby putting them at risk of unsafe sex (De Visser, 2004, Browne and Minichiello, 1994, Marston and King, 2006). Previous research with young mothers in Townsville, for example, found that carrying condoms was considered premeditation of sex, which was bad for young women's reputations. The authors stated that young women "preferred to risk their health to protect their reputations" (Larkins et al., 2009). In contrast to this earlier research (Browne and Minichiello, 1994, Hillier et al., 1998, Wyn, 1994, Bell, 2009, Lear, 1995), there was no evidence in our study that carrying condoms was perceived to be (or experienced as) a slur on a young woman's reputation or an invitation for sexual intercourse. Indeed young women talked about obtaining free condoms, buying condoms and carrying condoms, suggesting that concern for reputation was not a significant issue. Or, these young women may simply prioritise their ability to protect their health over any negative judgements if they disclosed that they were carrying condoms.

Still, when it came to obtaining condoms, a relatively public act, embarrassment and shame remained an issue for young people (Bell, 2009). Young people talked about the shame of taking free condoms from public spaces and of buying condoms.

Pretty shame, even if I wanted to grab a free condom at TAIHS I still feel too shame but if I need to use them I would definitely use them if I know the right time (Finn, 18, living in hostel)

It's embarrassing trying to buy condoms at stores, it feels like everybody watching, that's why I just get them off a friend or my boyfriend (Jane, 19, living in rented accommodation)

The young woman in the second extract above expressed the commonly reported feeling of being under public scrutiny when obtaining condoms from a public space. This may be due to the perception that if young people are seen obtaining condoms then they are publically admitting to having sex (Graffigna and Olson, 2009, Bell, 2009). Making free condoms

available in discrete public spaces was a specific recommendation for young Indigenous people that arose out of research for the Federal Government's recent STI prevention program (Stancome Research and Planning, 2008, Bell, 2009), and our findings support this.

During the research process, health workers indicated that when condoms were not available, young people in Townsville sometimes used glad/plastic wrap, plastic bags and sweet wrappers to prevent transmission of infections and pregnancy. In our interviews, only three participants mentioned 'alternative' methods of preventing infection transmission, and two young men reported having used them.

Use a condom. I know the condom offers protection. I learn all that at school. When I don't have a condom I use a glad wrap or plastic bag (Andrew, 21, living temporarily with family)

The example above, and many of the extracts we have cited, show how young people present themselves as determined to look after their health. In particular, their motivation to prevent infection often overrode their shame or embarrassment. They went to public spaces to get condoms, obtained condoms from alternative sources, or used the knowledge they had about transmission to come up with creative solutions so they could have 'protected' sex. These findings do suggest that young people have both a high level of awareness and an investment in their health. Nevertheless, our findings also suggest that when condoms were not available, some young people relied on inadequate alternative, such as sweet wrappers, believing them to be protective or had unprotected sex. This emphasises the complexity of health behaviours, where individuals are rarely always 'risky' or always 'safe'. Our findings also emphasise the importance of context in people's actions, especially the difference ease of access to condoms makes in young people's more consistent use of protection.

Challenges to consistent condom use

As discussed above, a range of social and contextual forces mean that having information and condoms on hand is not enough to ensure protection is used (Marston and King). Two important challenges that emerged in our interviews were: disparities in men's and women's commitment to consistent condom use; and alcohol and drug use.

The disparity between men and women's commitment to condoms is a finding reported widely in the literature (East et al., 2007, Beusterien et al., 2008, Bell, 2009, De Visser, 2004, Flicker et al., 2008). Young male partners refusing to use condoms, or indicating a preference for sex without them, was a challenge also reported by young women in our study.

Only with my (partner), he doesn't like to use protection (...) I have asked him to use it a few times but he just says no. As I would rather he use a condom just to be safe (Karen, 24, living in hostel)

Young women's condom use has been shown to be influenced by men's attitudes to condoms (De Bro et al., 1994); this was echoed in our study. There was also a perception

that couples (boyfriends and girlfriends) do not always use condoms when a woman wants to, because of male partners' reluctance.

I read about the high statistics of STI in Indigenous people in the Koori Mail. SAD! I look around and to see so many of my friends and family not using protection especially my girlfriends, not using a condom because their boyfriend do not want them to use a condom. We hear so many of these fellas not wanting to use a condom (Jule, 20, living temporarily with friends)

Research with Victorian men and women documented men's passive compliance to condom use - men said they were *prepared to use condoms* but their concession to condoms was framed in terms of a partner's needs and thus was dependent on a partner insisting (Browne and Minichiello, 1994). Evidence of women as condom advocates and men as condom avoiders (De Bro et al., 1994) was apparent in our interviews. While none of the young men indicated that they refused to wear condoms, there was evidence of ambivalence around condoms, and a desire to have condom-free sex that was entirely absent in young women's accounts.

Condoms are not as good, as what they made out to be (James, 25, living in hostel)

Everyone likes to be or go 'free willy' sometimes (Eric, 26, living temporarily with family)

They (friends) just laugh and said that I was missing out on the good parts by using a condom (Nick, 25, boards with friend)

Ester described the difficulty of insisting on condoms when alcohol and drug use was combined with partner ambivalent to condom use.

With alcohol and drugs it would be easier not to use protection during sex, being under the influence of drugs and alcohol and go with the flow, and the fella may not want to use the protection. I would probably go along willingly being intoxicated (...) But still I have to think about the end result and then would have to go for a sexual health check later on. It is a lot easier aye! You know just go with the flow and then before you know it, oops! You end up with something (Ester, 26, living with family)

What is striking about the extract above is the young woman's description of her lack of autonomy during the risky event - she goes with the flow, goes along with someone else's wishes and an STI *happens to her*. After the event she regains her autonomy; thinking about the end result and seeking screening. It is possible that her account of sex while under the influence acts to protect her self-esteem and social image by absolving her of the risky behaviour, she can then take responsibility for her health when she has regained control.

The flip side of this was young men suggesting that their female partners needed to be reminded of their personal responsibility for safer sex. Young women who did not take responsibility by carrying their own condoms or suggesting condom use were judged negatively.

I always talk and ask my girlfriends previously because I think it is important that they are aware of their responsibility (Finn, 18, living in hostel)

It's not my responsibility to be looking after females. They can look after themselves (Vince, 21, living in rented accommodation)

(A)nd like the girls they think it is the males' responsibility, but I think it is both. For example I spoke to a girl who had unprotected sex and then blamed they guy for not having condoms. I reckon what happened if she had picked up something she should be responsible. Everyone should be responsible not just the males. Girls should be able to know these days that it is their responsibility also not just the guys. I knew someone who said to me, I would not sleep with him, but the minute I saw them together I had a feeling that they were (sleeping together) so I hope that she is being responsible and using protection not making it easy and jump into bed just because the guy likes her. If I meet someone one day when I'm ready I know it will be my responsibility as we as the fella to make sure we use protection (Edwina, 24, living in hostel)

A few women appeared to rely on male partners or saw their own responsibility for condoms as a back up to their partner's (second extract below), however none explicitly stated that men were solely responsible for condoms. (Note: the first extract has been written in the third person)

Partner asked if she knew about diseases, he sort of talked about it, open about it, discussions. Have open discussions about sexual diseases, they both see a doctor, have regular checks. Boyfriend has pamphlets about this topic talks about it usually. Since he knows about it, he will protect himself (Jane, 19, living in rented accommodation)

She buys the condoms to be sure of protection as her boyfriend may forget (Janette, 18, living with partner's family)

The discussion above reminds us that safer sex occurs, or does not occur, in an interaction between two people (De Bro et al., 1994), and gender dynamics are an important feature of this (Holland et al., 1991, Flicker et al., 2008). One young woman appeared to suggest that it is easier to go along with her partner and seek screening later; that is, personally dealing with an infection afterwards was 'preferable' to having to insist on a condom within dynamics of a sexual interaction. There is considerable evidence to show that young women often feel overpowered when negotiating condoms (Holland et al., 1990, De Visser, 2004, De Bro et al., 1994). For example, Lizzie suggested that her 'choice' to have sex or not was limited by her fear of her partner and reliance on him for accommodation.

I'm still sexually active but it is getting a bit uncomfortable you know with the baby and all. I know I was told to be careful from my doctors at TAIHS. But my friend (partner) wants it and I don't want him to be angry with me [Does he gets angry if he does not get it and do you feel scared?] All I want is a place to stay and yes he scares me sometimes (Lizzie, 18, living temporarily with friend)

This complex, gendered dynamic in sex suggests that young women, in particular, feel responsible for insisting on protection during sex but are often challenged by men's dislike for condoms, refusal to use them, or their own ambivalence to safer sex 'in the moment'. Young men's passiveness or refusal to take responsibility supports calls for health promotion efforts to promote the *shared* responsibility (not only women's empowerment to choose contraception, or men's willingness to use condoms) of condom use (Browne and Minichiello, 1994). We would also argue that there is clear evidence of a need for skill-based programs to support young people negotiate healthy and safe relationships. The literature suggested that young people consistently call for these types of programs (Carmody and Willis, 2006, Flicker et al., 2009, Arabena, 2006).

The second important challenge to condom use, described by both male and female participants, was alcohol and drug use. Specifically, intoxication increased the difficulty of following through on intentions to use condoms during sex.

(W)on't go along with it is he's sober but will when drunk (Kevin, 21, moves from place to place)

It is easy to say use the condom but when you are out drinking and forgetting to get a condom you just go ahead and do it right there and then and not bother about protection (Fred, 19, living with family)

When young people described occasions when they had not used condoms in the context of alcohol or drugs, they often talked about going with the flow. We can see again the same framing of 'irresponsible' behaviour as a moment of lost autonomy, where young people construct themselves as going along, not in control. Moreover, in the script of sex condoms require a break in the natural spontaneous progression of sex (Browne and Minichiello, 1994, Hillier et al., 1999); we can see evidence of this in the extract above from Fred.

In contrast to some previous research (Browne and Minichiello, 1994) which suggests that it is more typically women who feel concerned about their health after unprotected sex, both women *and* men in our study described experiencing concern after an unprotected sex event, particularly when it involved alcohol or drugs. Many indicated that they had subsequently sought screening after such an event and some suggested that they avoided heavy intoxication for fear of being out of control or losing control.

I like to go out and not get too drunk. You know anything can happen (Jade, 21, living temporarily with friends)

These are not new findings; the effects of alcohol and drug use on risky behaviours and their erosion of behavioural intentions are well documented (Lear, 1995). Young people's resolve

regarding strategies to manage risk, such as using condoms, often fails when they are drinking (Lear, 1995), and alcohol use is often a feature of young people's casual sexual encounters (Carmody and Willis, 2006). Similar findings have been shown in research with Indigenous people in rural and remote communities in Northern Queensland (Miller et al., 2003) and Central Australia (Stark and Hope, 2007). A study with women attending antenatal programs at TAIHS between 2000 and 2003 found that harmful alcohol use was a predictor of STI diagnosis (along with being aged less than 20 years old).

These two challenges - reticent partners and alcohol or drug use - represented a considerable test of young people's intentions to use condoms.

4.2.2 Being in a *trusting* committed relationship

Sleeping around or having multiple casual partners was seen as a risk for BBV/STI.

(Location) where I come from is a town that needs to start making young ones more aware of these diseases. The young ones sleep around a lot and do not want to know about the problem until it hit them, then they start to run around and look for people to help them (Katie, 26, living in hostel)

Far too many temptations (...) Stick to the one guy (Natalie, 25, living in hostel)

Some participants described personal experiences of having multiple partners and contracting an infection.

Stay with one partner or use protection like condoms, like before I never have one partner and never use a condom and I had that thing (Chlamydia) (Ester, 26, living with family)

Not sleeping around, or having one partner, was seen as a protective strategy, something echoed in previous research (Hillier et al., 1998). Just as casual relationships were seen to be risky, the opposite was true for boyfriend-girlfriend, de-facto or married relationships, which were expected to be trusting, monogamous and committed, thereby, inherently safe. Almost a third of participants (similar proportions of women and men) stated that getting to know a sexual partner and building a trusting relationship was a strategy for avoiding infection. This echoes research with young people in rural Australia (Hillier et al., 1998). For our participants, taking things slow and allowing time to get to know a sexual partner in order to develop trust were important features.

Develop a relationship first (Ester, 26, living with family)

I don't rush into anything, I never rush. It is important not to rush rather know a girl first (Finn, 18, living in hostel)

Don't jump into it, think, and use your head (Natalie, 25, living in hostel)

It was not clear what specific knowledge about a partner young people sought, but research suggests this may involve informally gathering information to determine a partner's level of risk, often based on reputation or through gossip (Hillier et al., 1998).

Trusting relationships and condoms

For many young people, condoms were no longer a relevant prevention strategy when there was trust in the relationship. The young women in the following extracts are currently in relationships and do not use condoms because they 'know' and 'trust' their partner to be monogamous.

I never use condoms, not that important. I trust and know my husband. If he plays around my back I will punch him in front of everyone. But he will never do it, he work as a tradesman carpenter. He is clever, not stupid like some men I know that comes into work and try to get help. I always say to my husband, "If I ever catch you I will punch you and the girl as well, in front of everyone". I have never used a condom ever because there was no need for me to use a condom (Natalie, 25, living in hostel)

I'm sexually active at the moment and I don't use protection because I know him (...) I trust my partner that is why I do not use protection (Katie, 26, living in hostel)

Long-term relationships are perceived to be less risky and therefore condoms are not necessary (De Visser et al., 2003, Hillier et al., 1998). As evident in the extracts above, a committed relationship indicates that a partner would not sleep with someone else, or is not infected with an STI. An Australian population-based study has shown that consistent condom use is less likely between regular partners, especially if they are cohabiting (De Visser et al., 2003). This is not simply a matter of people weighing up the risk of contracting an infection in a committed relationship and choosing to abandon condoms. The literature suggests that because condoms are used at the beginning of relationships, and with casual partners, their continued use becomes problematic in relationships (East et al., 2007). That is, condom use is "not a neutral action. It implicate(s) specific relational meanings" (Graffigna and Olson, 2009). Condoms can be seen as stigmatising; their use suggests a lack of trust (Marston and King, 2006). Asking a partner to use a condom can imply that they are diseased; condom free sex becomes a sign of trust (Marston and King, 2006, Lear, 1995, Hillier et al., 1999). This is evident in both extracts above, where the young women indicate that condoms are unnecessary because they know/trust their partners.

Young people's ideas about relationships, versus casual or non-committed partners, influenced their intentions around protective strategies, such as condoms, for future relationships. Despite currently using condoms and endorsing the importance of safer sex, Rachel suggested that if she was in a relationship she would not use condoms because trust *should* be part of the relationship.

With my mum's influence and advice I take care with using protection when having sex (...) (I)t is better to be safe than sorry and it doesn't matter at which age group because say for example it is better that they are being safe and using protection. It is important that partner relationships are being based on trust. If I know my partner and trust him then I would not have any problem with not using condoms. I guess it is

based on trust and developing that relationship with your partner (Rachel, 23, recently arrived in Townsville, living in temporary accommodation)

While the young people in our study indicated a strong commitment, desire and intention to use condoms, it is clear that this is challenged by the context of a relationship (Browne and Minichiello, 1994). This is particularly true when abandoning condoms is seen as a symbolic marker of love, commitment and trust (Kirkman et al., 1998a), as they appear to be for the young woman above. There was, however, evidence in our interviews, from young women, of some tension around trust and abandoning condoms. Ester said she would prefer to use a condom but that she does not use because she trusts her partner. It was not clear that she felt able to insist on condoms in her current relationship, or indeed if she wanted to insist.

I would prefer protection but now because I have had one same partner for the past 5 years it doesn't matter if no condoms. It is based on trust, which had led me not to use condoms during sexual intercourse. I would still go for a sexual health check for example a pap smear every two years, because you know it is important to check yourself (Ester, 26, living with family)

It is interesting that cervical cancer screening was seen as necessary by the young woman above; several young women in our study suggested the same. This differentiation may suggest that a pap smear is not seen as incompatible with having trust in your partner (at least for young women). Encouraging young women in relationships to attend cervical cancer screening may provide an opportunity to extend these consultations to BBV/STI screening. This echoes calls for BBV/STI screening to be integrated into Well Person Health Checks and antenatal care (Kildea and Bowden, 2000).

It appears that the social reality for young people in our study is that condoms are not a part of established relationships. When condom use and trusting a partner are set against each other, trust and not wearing a condom usually win out as condoms signify distrust in this context (Hillier et al., 1999, Marston and King, 2006). Indeed, when young people talked about using condoms in an established relationship, it tended to be linked with suspicion or knowledge that their partner was having sex with other people.

I had a hard life with my husband, he played up with this girl, all the dances at this place we stayed, he goes by himself. I did not believe my friends telling me that he is cheating on me. (...) I don't remember having an STI, maybe because I use protection all the time, you know. I think too I know what my husband was up to (Katie, 26, living in hostel)

Similarly, Joan, one of the older participants in our study, drew on her personal experience to suggest that caution and safer sex should not be abandoned in relationships.

I can talk openly to my ex-partner, I remember. I am comfortable with him. Even now we can talk about, not that we cheated on each other, but just thinking about it I had doubts and I'm concerned about STI, so for my safety and wellbeing and for his safety I bring it up. What I'm trying to say is that don't get too comfortable, always be

aware of risks involved and really just maintaining the safety aspects of having and practising safe sex (Joan, 22 living with family)

It is important to point out that some young men in our study, like James, talked about trust in relationships.

I wouldn't abstain if I knew the woman it is based on trust, I would go ahead. I would get a sexual health check that way we know each other are safe (James, 25, living in hostel)

However, it was young women who had the most to say about the role of trust in abandoning condoms. The faith that young women placed in trust as a prevention strategy was considerable and mirrors the findings of previous research. The concern here is that among this age group a trusting relationship may be one of a series of trusting, committed relationships increasing the risk of STI transmission between partners (Hillier et al., 1998). Moreover, young people's trust in their partner may be violated. Both men and women in our study described experiences of having their trust violated when a partner cheated. This violation was not just about hurt feelings but potentially about exposure to infection (Lear, 1995).

I'm now seeing someone new. I'd like to take it slowly. I use protection, he is still someone that I need to get to know gradually. I don't want to make the same mistake like before. It was easy to get into a relationship but once this gets serious they start to slowly show their true colours and they make you have to start thinking whether it is good idea to be in this relationship or not a good idea (Nina, 26, living temporarily with friend)

I had an STI from this other girl that I was going around with. She said that it was not her that gave it to me but I knew that it was her, she was the last one that I slept with. She denied that it was her, she would not listen, so I told her, I don't want her anymore. I just left her there and told her, I'm not seeing her again. Up until now I don't trust girls, it is hard for me to know the girls, even here in Townsville (Mark, 26, living with family)

While these experiences provided valuable lessons and shaped young people's current prevention practices (learning from the past was a consistent theme in our interviews), the challenge for health promotion is how to "help people protect themselves in the absence of betrayal" (Lear, 1995).

Our data does not tell us about the important transition from casual to trusting relationship and how protective practices shift and are negotiated during this time. How trust was established and whether it was based on talking, the passing of time (which is suggested by some extracts above), or presumed to develop as part of the natural progression of the relationship (Lear, 1995) is unclear.

4.2.3 Monitoring symptoms and BBV/STI status

The third strategy for preventing infection reported by the young people in our study was monitoring their own and their partner's status through regular screening, and screening as a direct result perceived risk of infection.

One quarter of our participants talked about having regular checkups, blood tests, sexual health checks, and, as mentioned above, a few young women talked about 'pap smears'. This is higher than reported by a recent representative survey with 16 to 29 year old Australians, a third of whom had ever been tested (STI or HIV) and two thirds of these had only been tested once or a couple of times (Stancome Research and Planning, 2009). The (apparent) high level of regular screening among our study sample suggests a perception of personal risk, perhaps driven by a visibly high prevalence of STI in their communities, effective health promotion, or previous experience of an infection. Again, young people explained their current practice of regular screening in terms of a past experience, usually of a diagnosis.

I was infected with hepatitis B. I went to the doctor in (location) for a sexual health check. I go every second month, I check for hepatitis (Mark, 26, living with family)

When I first found out about my cervical cancer, they said to me it is rare, I was a bit scared, now I feel scared, but I also now go and see the doctors for a sexual health check (Davina, 26, living in hostel)

Ester's regular screening practice (for cervical cancer) was prompted not by a personal experience, but by a family member's illness.

(M)y (relative) who died a few years ago from cervical cancer, at first I did not know and want to have pap smears but after I hear about my (relative) that died I was scared and made me go now every two years. SCARY! (Ester, 26, living with family)

While five young women in our study talked about having pap smears, only two spontaneously named cervical cancer and both had had personal experience (one young woman had been treated for cervical cancer). Cervical cancer is a serious health issues for Indigenous women (Manderson and Hoban, 2006). Screening rates are low, and compared to non-Indigenous women in Queensland, Indigenous women are 11 times more likely to be hospitalised for conditions of the cervix and 10 times more likely to die of cervical cancer (Panaretto et al., 2006a). Although several women talked about regular par smears, the apparent low salience of cervical cancer among the young women in our study suggests there is a need to raise awareness.

There were different patterns of health-seeking reported among the young people. Young people reported proactively seeking screening both within specific time frames (*6 months* or *2 years*), as well as in more general terms (*regular* or *when I can*). Young women, in particular, reported opportunistic screening when attending their regular health provider. TAIHS offers screening to all women seeking antenatal care.

Every time I go to TAIHS I go for a sexual health. I make sure that everything is clear. I'm now pregnant and I made sure as soon as I found out that I went for an antenatal check and they did screening and all blood tests came back clear for sexual health screening (Rachel, 23, recently arrived in Townsville, living in temporary accommodation)

All of the young ones these days are frightened to get a check up for STI, not me, I'm happy to go any time they need me to go for a pap smear (Samantha, moves between Townsville and Palm Island)

It was common for young people's descriptions of regular screening to contain a sense of pride, particularly around being a responsible person. This was evident in the extracts above, where the first young woman is proud to have been a 'good' expectant mother and the second a 'good' (and brave) patient. Young people who described situations involving unsafe sex often reported they subsequently sought screening. Screening was sometimes prompted by a condom breaking.

(B)ut still I have to think about the end result and then would have to go for a sexual health check later on (Ester, 26, living with family)

Do not think you are covered even when using the plastic (condoms) because you never know it might break; those things are very easy to break (laughs). It did to me and then I have to go and get a sexual health check to make sure I was safe and had not pick(ed) up anything (Samantha, moves between Townsville and Palm Island)

If he knew he had something he'd go for a check up, otherwise it is commonsense, isn't it. You have to really think about the afterwards you know (Kevin, 21, moves from place to place)

The way young people spoke about screening highlights the temporal nature of personal prevention strategies. Condoms and trust in a relationship were 'before' strategies - not only did they prevent transmission they also occurred before the potentially risky practice. On the other hand, screening was often an 'after' strategy - it was used to check if transmission had occurred and took place after a risky practice. We can see this in the extracts above where perceived consequences emphasise the importance of considering the time after sex (*the end result, think about the afterwards*). Some young people however, also talked about screening as a 'before' strategy, a way to establish a partner's status prior to commencing a sexual relationship. These two young women described telling their current partners to have a sexual health check to confirm they were not infected, before their sexual relationship began.

I have a partner that I trust obviously. I make sure that he gets a sexual health check first before I sleep with him (Naomi, 26, living in hostel)

We never use condoms, he is clean, I tell him to go for a check up before he touch me (Lydia, 24, living with family)

However, a health worker in our feedback workshop suggested that screening before stopping condom use was not widespread among the young women she sees in her work.

Most of the young women I speak to say they stop using condoms in the 3rd or 4th month of their relationship. As the relationship progresses they stop using condoms. When I ask them, "Did you both go for testing before you stopped using condoms?" they say no, they just trust them (Female health worker)

Other young people suggested that they planned to use screening in future relationships. For example, Samantha's decision to adopt this strategy was precipitated by a previous STI diagnosis.

Now I'm all clear, I don't want to have that disease again. When I meet someone new I would say to him to go first for a sexual health check before I sleep with him (Samantha, moves between Townsville and Palm Island)

All three of the young women above suggested that they had refused to have sex, or would in future, until their partner has been screened. This strategy - refusal of sex without condoms until a sexual health check has been performed - has been reported to be the most common strategy women use to convince male partners to use condoms (De Bro et al., 1994). But it is not known how effective this is as a strategy for women generally and Indigenous women in particular. We are unable to provide any data on how young women confirm that their partners have attended for screening or the results of this screening.

While no-one reported that a partner had insisted that they seek screening, one young man reported that he would be willing to seek screening, and gave the impression that he may expect the same of his partner. A few young people, like Jane, reported that they and their partner regularly sought regular screening. (Note: the extract has been written in the third person)

They both see a doctor. Have regular checks (Jane, 19, living in rented accommodation)

A recent Australian study found that a third of young people who had ever been tested for an STI did so at the beginning of a relationship (Stancome Research and Planning, 2009). For many young people then, a negative test result meant a partner was infection free and condoms were unnecessary. That is, screening appears to be one way young people establish that a partner can be trusted. What is interesting about these findings is that screening does not seem to receive the same level of stigmatization as requests to use condoms in established relationships. If 'partner screening' is indeed more acceptable to young people in relationships (than for example, using condoms), then this practice could be promoted, particularly as a health practice couples can do together, or share responsibility for. Though how effective this strategy is remains unclear.

During our feedback workshop, a female health worker noted that while many of the young people we interviewed were in relationships, it was striking that they rarely spoke in terms

of 'we'. The preventive behaviours they described were linked to their own intentions, or suspicions, rather than actions they took *together* as a couple. That is, 'I' go for screening rather than 'we' go for screening, suggesting that promoting shared responsibility may present some challenges. A consequence of this is that, should a member of a couple screen positive for an infection, it can be difficult to address future prevention or changes to risk behaviours with the couple.

For women who come here and get tested, if they have an infection it's very difficult for them to go and tell their partner. So we treat them and then in a few weeks they will come back with the same infection (Female health worker)

Several young people we interviewed made a link between being 'clean' and being free from infection.

It is very important to stay safe and clean (Sharon, 18, living temporarily with family)

I'm clean. I watch who I sleep with (Margaret, 26, living in hostel)

Condom helps you to stay clean (Jase, 24, living in hostel)

Looking for external signs of BBV/STI and, more generally, seeing cleanliness as an indicator of lack of infection, is well documented (Lear, 1995, Marston and King, 2006). However, only two young men indicated that they checked partners for physical signs of infection. In both cases, the lack of a smell was taken as an indication that their sexual partner did not have an infection and, condom use was unnecessary. (Note: the first extract has been written in the third person)

Thinks that if a girl's sexual area is "not smelly" then she is safe and is not possible to pass an STI to him (Brandon, 17, living temporarily with friends)

If there is no smell from the bottom area when we have sex I do not use a condom (Andrew, 21, living temporarily with family)

We do not have sufficient data to indicate whether young people believed they would be able to tell if a partner was infected or not. But, as noted earlier, several young people spoke about the invisibility of infections, and many young people related personal experiences of not knowing they had an infection until they received test results. Still, that some young men were relying on a perceived visibility of symptoms is a concern, and could be easily addressed through health promotion campaigns.

4.2.4 Combining strategies

As we have discussed, the preventive strategy a young person used was contingent on their beliefs and knowledge about their sexual partner, the type of relationship, and the context of the sexual encounter. Accordingly, some young people indicated they had rules about which strategy to select, and when. Naomi's description was a particularly strong example of this.

If I met someone in a nightclub I insist on using protection. But with a regular partner I find out first whether my partner is clean or protects himself. But when I break up from a relationship I always go for a sexual health check to make sure I'm clean. But I rather have a regular partner, good for companionship also. I have a partner that I trust obviously. I make sure that he gets a sexual health check first before I sleep with him (Naomi, 26, living in hostel)

In their interviews, young people often cast themselves as taking an active role in preventing infection, applying knowledge and rules in an attempt to enact their intentions to look after their health. They often characterised themselves as responsible, in-control, and aware: avoiding getting too drunk least they lose control; carrying condoms; insisting that partner's are screened before they have sex; and seeking screening after a perceived unsafe event. All of these examples provide a positive picture of the real concerns young people have for their health and the lengths they go to enact healthy strategies. These examples of pro-active thinking and action can be used to strengthen young people's resilience as they negotiate a variety of sexual experiences in a range of different contexts.

4.2.5 A note on injecting drugs

As previously discussed, there was very little in our interviews about injecting drug use, the primary mode of transmission for BBV. A few young people reported that they did not inject drugs.

I don't do needles at all (Robert, 18, lives with family)

I don't touch needles not at all or even take drugs. I have seen what happen to girls on TV when they do those things. BAD (Jade, 21, living temporarily with friends)

Several young women (no young men) talked about the importance of clean needles and of not sharing injecting equipment. With few exceptions, young people spoke from personal experience.

With BBV ensure clean needles are used, never use used ones or share. I went through a 6 month period with waiting for whether I had hepatitis C or not, to find out is the test is clear, it was nerve wrecking. I once shared a needle and had a needle stick injury once, and the person that used the needle was a hepatitis C carrier (Nina, 26, living temporarily with friend)

My ex partner who is now in jail takes drugs by injecting. These needles when used need to be clean all the time. Never trust dirty needles, you could easily pick up any disease like hepatitis C (...) I know a lot of people that get hepatitis C from using needles, I suggested use clean needles, the only reason why they wouldn't use it because it cost them and they think they do not need to pay for these needles (Edwina, 24, living in hostel)

Go to the sexual health clinic for free needles (Ester, 26, living with family)

Access to injecting equipment was only raised by the two young women above. Edwina suggested not having access to free injecting equipment could be a barrier to use. With very little data on injecting drug use among this sample, it is hard to gauge young people's knowledge about injecting risks and their use of prevention strategies.

Health workers and youth workers in our feedback workshop indicted that our findings reflected their experience. Only a tiny minority of their clients engaged in injecting drugs, and while some young people may have experimented with injecting drugs, marijuana was by far the more common among this age group. They also suggested that young people arriving in Townville with a history of injecting drugs tended not to continue using.

Some of our clients come up from the south and have been using hard drugs. They more or less mellow out - they do find it in Townsville but mostly its marijuana
(Coordinator of homeless shelter)

Summary

Condoms were the first, and most often cited, protection strategy and they were strongly endorsed for casual and new sexual partners. A desire to avoid contracting BBV/STI was the primary motivator for condom use, although the capacity of condoms to also prevent pregnancy was also raised. Among this group of young people, free condoms appeared to be relatively easy to access from health services like TAIHS and the Townsville Sexual Health Unit, and for younger people through school. Still, several important challenges were reported in relation to condoms. Access was less of an issue than young people's embarrassment at obtaining condoms in public or carrying them at all times in the event of an 'unplanned' sexual encounter. Many young people described attempts to work around these barriers - seeking out alternative sources when too embarrassed and adapting to carrying condoms at all times so that they were always prepared. The two challenges that appeared to be more difficult and persistent in young people's sexual relationships were: enacting a commitment to condom use in a context of alcohol and drug use; and young men's lesser role in condom negotiation through ambivalence, or their outright refusal of condom use.

The second strategy reported by young people in the prevention of BBV and STI was developing a relationship. In this context condoms were often abandoned, on the assumptions that both partners were monogamous and thus trustworthy. There were some tensions around this, primarily for the young women in our study, and it was not clear that they were entirely happy to abandon condoms or felt able to insist on them. It seemed likely that this was in part related to condoms being an indicator of trust. That is, abandoning condoms was both an indication that there was trust in the relationship and that the relationship was based on trust. Condoms symbolised casual sex and thus ceasing condom use was depicted as a marker of commitment and trust. The implications for continued condom use within friendships or love relationships may need to be explored further.

The third strategy discussed by participants was monitoring BBV/STI status through medical screening, with many reporting they regularly had sexual health checks, BBV/STI screening or pap smears. For others, screening was undertaken in response to a perceived unsafe event such as a condom breaking, sex without a condom or suspicions that a partner was

sleeping with someone else. Seeking screening at the beginning of a relationship was common and part of an ongoing safety strategy for some. Still, there was little evidence to suggest that young people would ask a new partner to get screened, or that new couples do this together. Still, the importance placed on BBV/STI screening is one of the most positive findings from this study as it provides evidence that young Indigenous people in Townsville are aware of sexual health risks and that they can be pro-active. This high investment in screening as a preventive strategy should be celebrated and encouraged.

4.3 Young people's experience accessing mainstream and community-controlled health services

Most young people in our study indicated that they had obtained information, 'hardware' (condoms, hormonal contraceptives) or clinical care related to preventing or treating BBV/STI through a health service. We cannot say, however, if attention to BBV/STI was initiated by the young person, or encouraged by a health care provider during a consultation for another health issue. Regardless, this finding contrasts with a Canadian survey of urban youth (13 - 18 years) which found that 83% had *never* been to a health service for services related to sexual health, with men and Aboriginal youth among the least likely to have accessed services (Flicker et al., 2009). In our study, TAIHS was the most commonly mentioned service⁷, followed by dedicated sexual health services (usually Townsville Sexual Health Service), general practice, and hospitals. That is, many young people accessed health services through a service provided by, and for, the Indigenous community. We asked young people to tell us about their experiences of sexual health services and of any experiences they had of using general health services for the treatment of BBV/STI. Many told us about obtaining free condoms (discussed above) and the more detailed accounts of screening tended to involve descriptions of receiving a diagnosis and then treatment.

Treatment experiences

A few young people gave detailed descriptions of the physical experience of treatment they had received following diagnosis.

Those tablets the lady gave me to take, that are this big (participant gestured to indicate size of tablets) (Samantha, moves between Townsville and Palm Island)

The test that I had previously is much more horrible, that urethral swab is painful (James, 25, living in hostel)

I was scared because when I had that pus I couldn't walk properly, it was sore. I went to the doctors and they told me that I have to use condoms, and they gave me these tablets those big ones and they poke a long cord down my penis. They were trying to make all these pus to come out and that was sore, they have to give me a needle to make me numb, it was sore. I can't hardly walk but I tell you, I will never want to be in that place again (Mark, 26, living with family)

⁷ TAIHS may have been named more often because the project team identified themselves as associated with that service.

However, young people who talked about attending a health service for treatment were more likely to tell us about their interaction with service providers. Participants who described experiences of diagnosis and treatment in a positive way noted the information they had received and the care they felt the health care professional had shown them.

Went and saw the people at the Sexual Health Clinic, referred by the staff at the rehab centre, and after the blood results came back I found out I had trichomoniasis (...) Easily treated. The service was great and very informative (Ange, 26, living in hostel)

When a Canadian study asked young people about the important attributes of a sexual health clinic, young men and women talked about being able to get information and being made to feel comfortable asking questions (Flicker et al., 2009). The importance of these characteristics was reinforced by young people in our study who had experiences negative interactions with health care, especially a *lack* of information or care.

The doctor at the emergency centre in (location) just blurted out that I have Hepatitis C, have a nice day, see ya later, and did not explain anything to me. I was upset, shocked, this doctor should have told, explained something to me (Edwina, 24, living in hostel)

I was infected with Hepatitis B, I went to the doctor in (location) for a sexual health check, I go every second month, I check for hepatitis (...) I feel it is important because I want to look after myself. They (doctors) didn't explain to me how I got the hepatitis B but they told me I had it, I didn't feel like they treated me fairly. It felt bad (Mark, 26, living with family)

Of the few participants who reported negative experiences, most described subsequently seeking out alternative care. This repeats the finding already reported that young people who reported experiencing challenges tended to report persisting with alternative strategies. Participants did not describe instances where they had not sought treatment (although we did not ask specifically for this) or where previous negative experiences had put them off seeking treatment. The majority of young people in our study indicated a willingness to seek screening and treatment if they suspected they had an infection. These findings suggest that these young people were willing to seek medical treatment if they suspected they needed it; this is encouraging given previous evidence of considerable mistrust in health services (Kelly and Luxford, 2007).

We asked participants what they would advise a friend who suspected they had an infection, and young people overwhelmingly reported they would tell their friend to see a doctor, reinforcing the positive orientation to health services noted above.

I would advise her to go to her GP (Lanie, 23, living with partner's family)

Go to the doctors and get yourself checked out bro (Vince, 21, living in rented accommodation)

I would help you but what you have needs to be seen by a doctor. I would love to help them out (Karen, 24, living in hostel)

Barriers to health service access

Evidence of challenges to treatment seeking rarely came from participants' own experiences; it tended to come from their responses to a friend who suspected they had an infection. A third of young people in our study, all women, raised the potential shame a friend might feel about having an infection and having to seek treatment for it. Participants reported they would offer reassurance such as letting their friend know they were not the only one to have an STI, and support their friend being proactive in seeking treatment rather than ignoring their health concerns.

Get help as soon as possible. Don't be shy to seek help. You are not the only one that go through these things (Katie, 26, living in hostel)

Don't take it on personally. This is everyone's business. Seek help and talk about your feelings. Do not feel that you will be kept down there. I use to feel dirty when I was told I had trichomoniasis. But now I have got over it and is now aware to be taking precautions and to feel good about myself for keeping myself free from these troubles (Nina, 26, living temporarily with friend)

Young women indicated they would offer practical support including talking through options, offering to accompany their friend to a doctor, and vouching for specific health services. (Note: the first extract has been written in the third person)

She would sit down and talk about the situation (Janette, 18, living with partner's family),

Don't worry we'll go see a doctor together (Jane, 19, living in rented accommodation)

(A)nd if she is uncomfortable or scared I would offer her support and go with her myself (Sharon, 18, living temporarily with family)

The people at the clinic are very good they listen to you and they try to help (Samantha, moves between Townsville and Palm Island)

These offers of social, practical and emotional support echo research with disadvantaged young women living in Glebe (an inner Sydney suburb), where a strong ethic of care was evident among the young women's primary social network (Bottrell, 2007). Many of the supportive actions suggested by the young women in our study address known barriers to medical screening, especially potentially embarrassing procedures such as cervical cancer screening. Specifically, shame, embarrassment of the procedure, characteristics of the service (lack of flexibility for appointment times) and distrust of facilities and staff have been found to be barriers (Manderson and Hoban, 2006, Panaretto et al., 2006a, Hunt and Geia, 2002). It is interesting that young women appeared to prioritise supporting a friend over any shame or embarrassment they may experience in identifying themselves as having needed treatment in the past.

I would tell them to go to a doctor, and support them because I've been through that (Lindy, 17, living with family)

Our findings provide strong support for developing peer-support and education. Peer networks and peer-based education are widely used and recommended for the provision of health information (Sorenson and Brown, 2007, Mellanby et al., 2001), particularly for 'hidden' or hard to reach groups. Many young women in our study were (apparently) motivated to offer support beyond a listening ear to friends backing calls for programs that develop peer educating in *informal* settings (Sorenson and Brown, 2007). Further, the offer to attend a health service with their friend echoes findings from other research with young women (for example, Bottrell, 2007) and support a recommendation arising out of the Federal Government's research for a recent national STI prevention program encouraging people to 'take a friend/sista with you' (Stancome Research and Planning, 2009). We would further recommend exploring options for engaging young people with experience navigating health services as allies to guide others through screening and treatment services. The lack of male voices in these personal accounts of supportive health interactions or health promotion suggests a need for further research on strategies that would encourage health seeking behaviour among men.

Related to support, primarily the lack of such strong networks, homelessness was cited as a specific barrier to accessing health services by young people. This was one of the few challenges to looking after their health that young people raised in their interviews.

Being homeless it is hard for me to arrange appointments and to stick to a schedule or routine. At (Hostel) where we are living now, my son and I have to stay in our room from 8pm onwards, not allowed to come out except to use a bathroom or toilet (...) That is why I find it hard to stick and make appointments at the doctor to look after myself (Davina, 26, living in hostel)

I can even take the person myself to the clinic. Because they do not bother sometimes and before you know it is all too late (Samantha, moves between Townsville and Palm Island)

A lot of people on the streets lived their lives on the street, they need help, don't know how to book appointments to see a doctor or get help from the bank, etc (...) A lot harder for people that are homeless to get help. They drink too much; they won't go and get help if they get an STI. They don't know how to book appointments, people at TAIHS come here and help them. Sometimes they need transport and help to get them to the doctors. It is hard which is why I think they end up with STI (Morris, 20, moves around, living temporarily in Townsville)

Get a blood test at sexual health clinic, to know for sure, plus they have transport so they can pick you up and drop you off (Ester, 26, living with family)

The issues around getting, remembering and keeping appointments are echoed by other research (Manderson and Hoban, 2006). Canadian Aboriginal young people and young

people living in shelters, for example, cite walk-in care (medical attention without an appointment) as the most important characteristic of a sexual health clinic (Flicker et al., 2009). The young people in our study provided some important context as to why 'appointments' are a barrier facing homeless young people needing to access health care including a lack of control over time management, a lack of experience and knowledge about how to navigate the health care system, and competing priorities. In our study, providing transport appeared to be an important facilitator of access, not because it addressed challenges of geographical distance (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008, Plummer and Forrest, 1999), although poor public transport can be an issue, but because this outreach facilitated relationships with health service staff.

The cost of health care was not raised as an issue by the young people in our study. The absence of financial concerns may reflect the level of public health care available in Townsville: a large well established ACCHS; a dedicated mainstream sexual health service; a large public hospital; and numerous general practices and community health centres. However, the concerns raised in the extracts above suggest that while the cost of health care may not have been an issue, socioeconomic disadvantage was salient for young people. Specifically, lack of economic and material livelihood impacts on health and attention to health as more immediate needs prevail. As Natalie commented, some young people's resources were fully committed to survival.

I think it is a poverty thing; our kids can't afford to get proper health care. We are way too busy trying to survive, before you know, diseases are being spread from another to another (Natalie, 25, living in hostel)

Canadian research with Aboriginal youth suggests that the absence of talk about socioeconomic and structural factors (such as colonisation, which was strikingly absent in our data) in young people's descriptions of health and health care, may be connected to young people's belief that avoiding infections is about self management. That is, linking individual risk to structural inequalities could be seen as "an attempt to shirk personal responsibility. Self determination was something to be proud of and showed character and strength" (Flicker et al., 2008). There is plenty of evidence in our study of young people characterising themselves as autonomous individuals who take responsibility for their health. For example, young people who told us that when they engaged in sex without a condom they subsequently sought an STI check, reflecting a reassertion of self-control and responsibility after an 'irresponsible' act. Still, the extracts above also indicate that some young people considered structural inequalities an indication of increased vulnerability to infection. For example, some participants suggested that homeless people may not have acquired the skills to negotiate the health system.

4.3.1 Community-controlled health services for sexual health

When young people talked about using health services for the prevention, diagnosis and treatment of BBV/STI, we asked them how they felt using Aboriginal Community-Controlled Health Services (ACCHS). Two thirds described having accessed an ACCHS for sexual health checks, treatment, advice on prevention, and free condoms. Unsurprisingly, for this Townsville-based sample, this was primarily through TAIHS. TAIHS was well known among

the young people, and many reported a family member had introduced them to the service, with some using the service since childhood. (Note: the third extract has been written in the third person)

(E)veryone knows about TAIHS (Ange, 26, living in hostel)

My grandmother takes me there when I was small and I now know the place very well (Finn, 18, living in hostel)

She found out about TAIHS through her brother (Janette, 18, living with partner's family)

Some young people said that personal relationships with members of staff were important, and they talked about individual health care providers at TAIHS.

I know and get on well with (staff name). He understands me a lot (...) I think he knows what he is doing and talking about because he works at TAIHS (Jase, 24, living in hostel)

I know this lady that works at the hospital at Palm Island, her name is (staff name). She is good. I talk to her if I'm concern about getting an STI (Samantha, moves between Townsville and Palm Island)

The overwhelming majority of young people indicated that they were satisfied with the services they had received.

It's very helpful, like they understand what I go through. The doctors listen to you and understand what I got. And they give you free condoms so you don't have to pay for them. Yeah it was easy, the service is easy. There you can talk to a doctor, health worker or youth worker on a daily basis (Karen, 24, living in hostel)

The doctor explained everything better. She put it in ways that I could understand. I felt like I can relate to her when I have issues surrounding sexual health in general (Joan, 22 living with family)

Almost half the participants who described using ACCHS, mentioned they felt comfortable and respected. This appeared to stem from the health worker sharing the young person's Indigenous cultural identity.

Alright feeling about Indigenous medical centres. It's good, I feel more comfortable explaining to doctors, great service. It feels good having Aboriginal and Torres Strait Islander workers makes me feel very comfortable. They understand me and I can understand them (Morris, 20, moves around, living temporarily in Townsville)

I feel comfortable because they are black people like you and me (Margaret, 26, living in hostel)

I feel comfortable using Indigenous medical centre because I'm one of them, not a white person (Natalie, 25, living in hostel)

This contrasts strongly with Vince's description of how he felt when speaking with non-Indigenous health care providers.

I don't like going to any other doctor or medical centre, if they are white I won't talk, I get shame and feel very uncomfortable (Vince, 21, living in rented accommodation)

While clients at ACCHSs are likely to be seen by non-Indigenous and possibly overseas trained general practitioners (Panaretto and Wenitong, 2006, Arkles et al., 2007), an Indigenous health worker or nurse is likely to be involved in their consultation (Larkins et al., 2006). Our data do not allow us to tease out the importance of Indigenous health workers as cultural brokers between clients and non-Indigenous care providers (Andrews et al., 2002), or the impact of a consultation taking place in culturally appropriate ways in community-controlled settings.

Respecting cultural protocols around gender is a common theme in the literature (Department of Health and Aging, 2005a, Hayman et al., 2009, Kelly and Luxford, 2007), but did not emerge as a strong issue in our study. This may be because it was taken for granted and participants had not experienced difficulties accessing a same-gender health care provider. Two young women reported satisfaction with TAIHS because they could see a female doctor and nurse

I am comfortable with using their sexual health service especially with using and request lady doctors and lady nurses to look after me at TAIHS (Rachel, 23, recently arrived in Townsville, living in temporary accommodation)

However, the participants' experiences of ACCHS were not uniformly positive. Four described dissatisfying or negative experiences ranging from the relatively mundane (waiting times) to unhappiness with staff-patient interactions.

[Where did you go for treatment?] I went to the sexual health unit. I went to (service name) first but they take ages, we sat for an hour. A Murray lady from the school took me down to (service name) (Lindy, 17, living with family)

There is an old nurse that works at (service name), and she is not a nice person. I don't want her to touch me. The only reason I keep on going there is because of the other staff, they are nice to me except the old nurse (Lizzie, 18, living temporarily with friend)

Three of these young people continued to utilise the same service, perhaps because the incident did not overshadow their general satisfaction with the service. However, Naomi gave a detailed description of a visit to an ACCHS that she perceived to be a waste of time.

I went to an Indigenous medical centre for advice on using a contraceptive device and I came out with a bad experience. I felt like no one there was able to assist me. I was

advised by the GP there to hand in a complaint form. I see a different doctor at a different medical centre now and I'm happy with the way they treat me there. They explained everything thoroughly and properly so I do not need to waste anymore of my time. Every time when I go to this previous medical centre they (the receptionist) give me this look like I, "Oh here we go, what she wants now?" I was told by this fella that works there, "Oh, you have to bring in your own Implanon and the doctors will put it in for you". Maybe if they have had explained to me when I made the appointment then I would know other than to arrive at the appointment and to be told that I can't have it done, because I need to bring in my own Implanon. What a waste of time for everybody. I took a day off you know from work. It was easy for me to use this centre thinking that it is Indigenous, they would be helpful, but they are not really helpful, I feel like I like I was taking up their time with my issues. Are they qualified to teach people and to talk to people about STI? (Naomi, 26, living in hostel)

In addition to her irritation that she had wasted her time because she had not be given the correct information in advance, Naomi described being made to feel like she had wasted the health care provider's time, and that her concerns were not important. The lack of care she describes and the feeling of being a burden is framed as a particular disappointment that her expectations of an *Indigenous* medical service were not met. This account also contrasts strongly with the earlier descriptions of ACCHSs as places where young people felt comfortable, understood and cared for.

It has been suggested that perceptions of a lack of confidently and privacy are significant issues for Indigenous people accessing BBV/STI prevention and treatment services (Department of Health and Aging, 2005a, Junga-Williams, 1998, Coupland et al., 2006). A recent qualitative study found that privacy and confidentiality concerns were significant barriers for young Indigenous people seeking screening at ACCHSs (Stancome Research and Planning, 2008), while Indigenous IDUs have reported reluctance to use ACCHSs for drug related problems because of confidentiality concerns (Larson, 1999). Aboriginal Health Workers can face particular challenges establishing trusting relationships with clients, especially needing to reassure them that they adhere to confidentiality (Kelly and Luxford, 2007). Concerns about confidentiality and privacy did not emerge in our interviews. However, Samantha hinted that confidentiality was an issue.

(B)ut they give you this look, you know, when you go to the clinic, and they probably talk. It is easier to know because (location) is only a small place, everyone know what everyone is up to (Samantha, moves between Townsville and Palm Island)

Even in this extract there is a sense that Samantha expected the people in the clinic to talk, though she did not frame this as a problem. While some participants reported using mainstream services for BBV/STI screening and/or treatment, it is not possible to determine whether this stemmed from a particular discomfort using a health service staffed by members of their community or by extended family. For example, Indigenous women in Townsville do use multiple service providers for cervical cancer screening, particularly the local hospital (Panaretto et al., 2006a). The absence of overt concerns about privacy and confidentiality in our study may reflect the specific confidence and comfort participants had

in TAIHS and its staff⁸. Indeed, the earlier descriptions of TAIHS as part of the community and the emphasis on personal relationships with staff, suggest being personally known is highly valued by some young people. This personal and community connection may give Indigenous health care providers permission to chastise an individual about their health, much like a family member might. Katie experienced this chastising (*growl*) by health care providers as genuine care for her wellbeing.

I realise they growl you more rather than to you at the Indigenous centre, maybe they care for me, it was maybe easier when they are Indigenous, and I'm Indigenous, easy to growl and know they really do care. And I know most of them there, so I don't really mind because I know they are looking out for me (Katie, 26, living in hostel)

Summary

The findings reveal that positive experiences of health care for the diagnosis and treatment of BBV/STI were associated with the provision of information that facilitated the young person looking after themselves, and with feeling cared for, respected, and their concerns being taken seriously. Building the theme of resilience, many young people reported seeking additional health care when they were dissatisfied with a particular service or practitioner and none suggested they had not sought health care because of a previous bad experience. Indeed, when asked what recommendations they would give to a friend who feared they had an BBV/STI, young people reported that they would tell the friend to seek medical attention, usually as the first action, suggesting that young Indigenous people, in our sample at least, consider medical care relevant and important.

While young people did not report significant barriers to treatment seeking, their descriptions of the support they would provide a friend suggested several. Young people said that they would reassure a friend to not 'feel shame' about having a BBV/STI, offer to accompany them to a doctor, and vouch for particular services. This can be interpreted as, respect and openness, ability to see a health professional with a friend or family member, and choice of service are important for young people seeking BBV/STI related medical care. It was also clear that the provision of practical support by health services, such as transport and help with booking appointments, was appreciated by young people. These findings suggest that peer-support for young people who suspect they have contracted a BBV/STI could be a valuable development for health services to explore.

A 'good' health service for the young people in our study was characterised by the feeling that the health provider cared: they took time; provided information; and prioritised the individual's own concerns, including their identity as an Indigenous Australian. Although participants repeatedly associated these characteristics with ACCHS, our findings can help these services strengthen their programs for, and connections to young people, particularly in addressing some of the most sensitive, personal and socially shamed elements of health.

⁸ It is important to acknowledge that the IRP-CBPR was explicitly connected to TAIHS and participants may have felt some apprehension expressing negative views about the service.

4.4 Young people's motivations for preventing blood borne and sexually transmitted infections

The second aim of the IRP-CBPR was to identify, assess and enhance the BBV/STI resilience capability of Aboriginal and Torres Strait Islander people. Thus far, we have documented young people's perspectives on BBV/STI, specifically their knowledge, the strategies they used to protect themselves from BBV/STI, and the barriers that made it difficult to enact these strategies. Although we did not specifically ask young people why it was important to avoid contracting BBV/STI, they repeatedly provided us with accounts of in which self care was prioritised and valued. Across the interviews, young people constructed themselves as autonomous and determined individuals, using past experiences to inform current practices. They repeatedly demonstrated an investment in their health, not only through their intentions but through their persistence when faced with barriers, which confirmed they felt it was very important to prevent BBV/STI. Thus, before moving on to young people's recommendations for reducing BBV/STI, we will turn to young people's motivations for looking after their health.

4.4.1 Responsibility for others as a motivation for self care

Young people often talked about the consequences for their partners and families if they contracted an infection, and they linked a range of preventive actions they used to address these concerns. For Kevin, talking to his partner about BBV/STI was motivated by a feeling of responsibility for her. (Note: the first sentence has been written in the third person)

No if he had a partner he would be open to her to make sure he/she is safe. I guess it is a matter of looking out for each other and trusting each other (Kevin, 21, moves from place to place)

For Matthew, an intention to promptly seek medical care (if he suspected he had contracted an infection) was motivated by a feeling of family responsibility.

I would not hesitate to get help from the doctors, not for my sake but for her sake (partner). It is for me too but I'd like to keep an eye out for my girl and my baby (Matthew, 23, living in hostel)

Two young women talked about their commitment to using protection during sex as motivated by care for their children. Indeed, both suggest that preventing BBV/STI became salient following their birth of their children.

After I was infected with chlamydia I still did not use protection. I did not think about it, I did not think that it was important at the time. But having kids, my second boy was born, I started thinking about protection (Lanie, 23, living with partner's family)

Yes very important to me now because I have 2 children, I would not have sex if I had no condoms left (...) Their father and I talked about it before because he uses needles which are why we came to a decision of wearing a condom all the time, if no condom we don't do it (Edwina, 24, living in hostel)

Finally, for a pregnant young woman, Rachel, having BBV/STI screening as part of her antenatal care, meant she was caring for her unborn child and her partner.

Every time I go to TAIHS I go for a sexual health. I make sure that everything is clear. I'm now pregnant and I made sure as soon as I found out that I went for an antenatal check and they did screening and all, blood tests came back clear for sexual health screening. I felt really good because I know that I'm looking after myself, my unborn baby and my partner (Rachel, 23, recently arrived in Townsville, living in temporary accommodation)

It is striking how often the young people in the extracts above used terms such as *looking after* and *looking out* for their partner and children. There may be two slightly different concerns operating here. Firstly, if young people have an infection, then they may pass it on to their partners, and as two young people above suggested, to their children. Secondly, if young people have an infection, then they may be unable to fulfil their obligations to their family. This is a well documented concern for Indigenous people, and ties in with an Indigenous concept of health as “not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community” (National Aboriginal Health Strategy Working Party, 1989). For example, among Indigenous women dealing with cervical cancer, their good health was important for the family and crucial to social relationships. Indeed being in good health meant being able to perform their daily activities and fulfil their family roles (Manderson and Hoban, 2006). It is this second motivation - fulfilling obligations to family and community - that research has suggested could form the basis of motivational messages to increase BBV/STI screening among Indigenous young people. For example, ‘if you’ve got kids, you need to be healthy for yourself as you can’t function if you’re sick’ (Stancome Research and Planning, 2009). Both motivations are evident in the following extract from Morris.

I have two children, they both live (location), my youngest child is only 2 months old, he lives (location) with my auntie. I think of my children and want to make sure I'm doing something good, you know. What happens if I have an STI and I pass it on to my partner? She will not be able to look after our kids properly. That is why I take care of using protection and to know I'm looking after my family (...) Very important for me and the mother of my children to talk about prevention and also important because of our children, that we are clean and safe. You never know we might pass anything to our children (Morris, 20, moves around, living temporarily in Townsville)

It is notable that young women *and* men cited family as an important motivator for self-care. Speaking to young men about their family responsibilities as fathers, uncles and partners may be an important direction for health promotion about preventing BBV/STI. This is particularly important given suggestions that the loss of traditional male roles has been a significant health issue for Indigenous men (Briscoe, 2000).

4.4.2 Young people as autonomous and determined individuals

In their interviews, young people repeatedly characterised themselves as self-determining individuals who valued, and took personal responsibility, for their health. We saw this in young people’s accounts of taking particular preventive actions because *they* felt it was

important to look after their health. Preventative behaviours were discussed earlier in this report and included insisting a partner had a sexual health check before commencing a sexual relationship, carrying condoms safer sex and seeking regular screening. We also saw this in young people's accounts of their actions after unsafe sex events, where they suspected they may have an infection, or when showing their accountability, they reported seeking screening. Many spoke explicitly about how they felt responsible for preventing BBV/STI.

It is I feel my responsibility also to protect myself. I don't want to catch any STI, you know (Finn, 18, living in hostel)

Up to each person to protect themselves (Ange, 26, living in hostel)

I like to look out for myself, my safety, my health. I like to know that I'm safe from STI (Jade, 21, living temporarily with friends)

Being responsible for their health was not experienced as a burden; rather it was a source of pride for many young people.

By (abstaining) from sex or don't have sex I feel that I'm doing something good for my body (Morris, 20, moves around, living temporarily in Townsville)

(F)eel good about myself for keeping myself free from these troubles (Nina, 26, living temporarily with friend)

But you know what? I have never got an STI in my whole life. I keep myself clean, you know when people said and look at me, I'm a health worker and I'm proud to say that I am (Natalie, 25, living in hostel)

A discourse of individual responsibility for health (Fraser, 2004) was ubiquitous in young people's accounts of health and health behaviour. One way young people constructed themselves as autonomous and responsible, was by contrasting their own 'responsible' behaviour with the 'irresponsible' (or fearful) actions of others. Many accounts included stories about friends who treated BBV/STI as a joke, while our participant understood the seriousness, or friends who were afraid to seek screening, while our participant agreed to screening when her doctor suggested it.

Echoing a range of previous research with young mothers, young people talking about sex and IDUs (Larkins et al., 2009, Hillier et al., 1999, Hassin, 1994, Fraser, 2004), there appeared to be a sense of pride in constructing these juxtapositions. Edwina drew a comparison between a friend who did not take responsibility for protection and her own (hypothesised) intentions were she in a similar situation.

I spoke to a girl who had unprotected sex and then blamed the guy for not having condoms. I reckon what happened if she had picked up something? She should be responsible. Everyone should be responsible not just the males (...) So I hope that she is being responsible and using protection not making it easy and jump into bed just

because the guy likes her. If I meet someone one day when I'm ready I know it will be my responsibility as well as the fella to make sure we use protection (Edwina, 24, living in hostel)

The insinuation made within the comparison above is that individuals who do not take responsibility for their sexual behaviour are to blame if they do subsequently contract an infection (Fraser, 2004). Reflecting social morals about sex, self care and responsibility, there is little room in these descriptions for the complex social realities of condom negotiation discussed earlier in this report. Rather, the young woman suggests that her friend is entirely responsible, not only for preventing BBV/STI, but also for determining the rate of relationship progression (her role being 'gatekeeper', slowing down the occurrence of sex). Vince attributed individual responsibility (blame) for infection when asked what he would tell a friend who came to him because they feared they had an infection.

Just tell them to go away, that is their business. Would tell the person that they should have used a condom (Vince, 21, living in rented accommodation)

Accentuating individual responsibility for their health and playing down the role of structural, social and cultural forces can result in blaming individuals for ill health (Minkler, 1999). A significant proportion of the young people in our study disclosed a previous BBV/STI diagnosis and many of those who did not reported seeking screening because they feared they may have contracted an infection. Yet, when these young people talked about autonomy, and their own responsibility for their health, there was little self-blaming or indication that young people were distressed that they themselves 'failed' to do the right thing. Indeed, young people appeared remarkably sanguine regarding their apparent 'irresponsibility' regarding their health. We saw this earlier when young people framed instances of unprotected sex during intoxication where they were not autonomous (they went 'with the flow' or went along with their partner's desires). We suggest that this framing may protect a young person's self-esteem by absolving them of the responsibility for risky behaviour.

Other young people provided accounts of attempting to use prevention strategies, but becoming infected when prevention failed or lapsed. The young woman below described a number of strategies she employed to protect herself from hepatitis C and her sense of injustice when, despite doing the right thing (*I thought I was safe*), she is now living with hepatitis C.

My ex-partner who is now in jail takes drugs by injecting. These needles when used need to be clean all the time. Never trust dirty needles, you could easily pick up any disease like hepatitis C. Hepatitis C is a horrible disease, look at me I thought I was safe, no way, I was using condoms and then I got this hepatitis C the other way (participant attributed her infection to exposure to blood during a violent incident). Not fair I reckon but I have to carry on. I have 2 young kids to look after. They need me you know (Edwina, 24, living in hostel)

Like the young woman above, Lizzie reported that she had *tried to do the right thing* but became pregnant.

Look at me I'm pregnant even though I try to use protection (Lizzie, 18, living temporarily with friend)

While these accounts, in which people describe themselves as trying to maintain preventative behaviours or doing the right thing after a risky act, may protect young people's self-esteem, they can mean that individuals fail acknowledge risky practices or, crucially, consider the possibility that they need to modify their behaviour. That is, they may not learn from their experience. It is also possible, however, that these accounts of past risk, prevention and responsibility are used by young people to counter their shame. Indeed, as we will see in the next section, many young people in our study may not have explicitly blamed themselves after a risky act or when they found out they had contracted a BBV/STI yet they often framed these experiences as opportunities for behaviour change.

4.4.3 Learning from past experiences

It was very common for young people to talk about past experiences as 'lessons' or turning points in their lives that led to changes in risk and preventive behaviours. For many, the turning point was a BBV/STI diagnosis, or the symptoms or treatment associated with an infection.

I would not go back there again once I catch it. Silly person not to learn (Eric, 26, living temporarily with family)

I had this rash and the doctor said that it is an STI. What was it again? It started with C or K? [Chlamydia or gonorrhoea?] Learnt my lesson at the time. I was told by this doctor that next time I have to use protection, so I like to use condoms when I can get them (Fred, 19, living with family)

I don't hold back with using condoms. I need protection because I had an infection before like pus coming out of my thing from all sorts of girls in (location), that is why I realise that I have to use the condom, I feel like I learned a lesson from this. I was scared because when I had that pus I couldn't walk properly. It was sore. I went to the doctors and they told me that I have to use condoms, and they gave me these tablets those big ones and they poke a long cord down my penis. They were trying to make all these pus to come out and that was sore, they have to give me a needle to make me numb, it was sore. I can't hardly walk but I tell you, I will never want to be in that place again (Mark, 26, living with family)

I hope that cancer will stay away. I do not want to get this cancer back so I am going to make sure that I go for my Gardasil injection (HPV Vaccine) at TAIHS (Davina, 26, living in hostel)

The experience I had made me more wiser. The test that I had previously is much more horrible, that urethral swab is painful. Now I don't get much around and ha(ve) a selection of good safe sex. At the age now where I'm settled, a long term relationship is important (James, 25, living in hostel)

For some young women, such as Janette, it was an unplanned pregnancy that led to changes in attitudes and behaviours.

She wouldn't have sex if there were no condoms. She once ran out of condoms and fell pregnant. She has learnt from that and won't have sex without a condom
(Janette, 18, living with partner's family)

In the extracts above, the 'lesson' for most young people was that they were at risk of infection and that their practices had made them vulnerable. For some there was an additional message; they could have contracted something much worse - HIV.

[Why is it important to look after yourself?] Now have had it I can see, that guy could have anything, like AIDS. You can get treatment for some stuff but some you can't
(Lindy, 17, living with family)

Of course, not everyone is so 'lucky', and it is important to note that the majority of young people in our study who described having an infection reported it had been treated (usually relatively easily).

It is possible to read young people's narratives of their past mistakes, and the 'lessons' they learnt, as attempts to provide a positive ending to a shameful time in their lives (Newman et al., 2007), or to demonstrate to the interviewer how they have redeemed or bettered themselves. In Richardson's resiliency model, "resiliency is the process of coping with disruptive, stressful or challenging life events in a way that provides the individual with added protective and coping skills than prior to the disruption that results from the event" (Richardson, 2002). For this reason, we read young people's accounts of learning from their BBV/STI experiences as exemplary resiliency stories.

Many young people directly linked current consistent condoms use, regular BBV/STI screening, or other preventive action (such as HPV vaccination) to their past experiences. What is implied in these accounts is that young people were behaving in risky ways prior to their diagnosis; they may not have had the necessary information or they may not have acted on it. The few accounts of repeated diagnoses, particularly of chlamydia, in our study suggest that young people did not necessarily become aware in the ways described above *just* because they contracted a BBV/STI. Richardson's model of resiliency refers to this as 'homeostatic reintegration'; this describes individuals trying to return to life as it was before the stressor (Richardson, 2002). According to Richardson, individuals who do not learn from a stressful life event are likely to re-experience it. In contrast, most of the extracts from young people evoke 'resilient reintegration', where an individual responding to a stressful life event "puts his/her life back together in a way that leaves him/her with more protective factors and skills to effectively reintegrate in the face of future life events" (Richardson, 2002). That is, by learning from their experience they are better prepared to deal with subsequent life events and stressors. Sometimes referred to as the challenge model of resiliency, a metaphor of muscle building is often used to explain how resiliency is developed with the right amount of 'exercise'; too much stress causes damage (Bell, 2001, Fleming and Ledogar, 2008).

While an experience can be strengthening in that we learn, overcome or gain esteem, the challenge of that experience can still be distressing. Indeed without some level of distress (disruption to our normal view of the world) learning cannot occur. Experiencing a BBV/STI was distressing for some young people. As the young woman in the extract below said, *I felt dirty, had a lot of showers in one day (...) Yuck! I felt dirty and not wanted* (Nina, 26, living temporarily with friend). Young people often described learning by experience as the hard way to learn, and spoke with regret that they had needed these lessons at all.

I never really listen to my Gran, she use to growl at me all the time, my Gran is now gone, passed away (year) and now I look back I should have listened to her. I now is sorry I never listen to them. Never mind I have to carry on, by experience I know now to use protection after getting that chlamydia, twice (Samantha, moves between Townsville and Palm Island)

I learn by experience about it and unfortunately [why unfortunately?] Some of the things about I have never heard about it before, like when I had trichomoniasis from having unprotected sex, I had a big shock (....) I was easily treatable, I felt dirty, had a lot of showers in one day, makes me think twice about the stupid things I did, never heard about trichomoniasis before. Education regard STI should start from an early age, we never really touch on it. I remember when I was at school they did not really talk and explain to the students about the consequences. I had to find out myself from experience. It was a hard lesson for me, a big shock for me after I learned I had picked up trichomoniasis after having unsafe sex! Yuck! I felt dirty and not wanted. Reassure people and staff need to be realistic about people's feelings when they have been diagnosed especially if it is HIV, my god I cannot imagine myself with that disease (Nina, 26, living temporarily with friend)

Richardson describes two unproductive responses to stressful life events: 'maladaptive reintegration' (where an individual has fewer protective skills than before) or 'dysfunctional reintegration' (where an individual becomes psychologically distressed and retreats into substance use or becomes suicidal) (Richardson, 2002). Thus, the positive and productive responses to BBV/STI described by young people in our study need to be seen as more than just learning lessons and changing behaviour. The young people who participated in our study did not appear to become overwhelmed by the diagnosis (for example, by the shame and stigma of an infection) and used the experience to build their confidence to deal with sex and relationships in a more skilled manner. As we saw earlier, despite living with the reality of a chronic illness and a sense that she had been dealt an unfair hand, Edwina described carrying on, motivated by responsibility for her children.

The LFTs are getting higher and higher (elevated levels of some enzymes measured by the Liver Function Test indicate liver damage). I'm not sick at the moment just very tired, try to drink water. I don't drink alcohol (...) Hepatitis C is a horrible disease, look at me I thought I was safe, no way, I was using condoms and then I got this hepatitis C the other way. Not fair I reckon but I have to carry on. I have 2 young kids to look after. They need me you know (Edwina, 24, living in hostel)

Another common theme in the accounts of past experiences providing opportunities for learning was a desire among young women (only) to share their new awareness of BBV/STI (or the importance of) with others. They often indicated that this was motivated by a hope that others could be spared having to learn the hard way, by experience.

I'm comfortable talking about because I couldn't tell my mother at first when I had STI but now I tell younger people to be aware about those BBV/STI as anyone can get it (Ester, 26, living with family)

It is interesting that despite having ignored advice from others, these young people remained hopeful that other young people would learn from their mistakes.

I never listen before to my parents and my Gran, she bought me up, this is important, I learned the hard way, now it is my turn to tell these young people not to be shy to get help (Samantha, moves between Townsville and Palm Island)

For some young women then, a personal experience of a blood borne or sexually transmitted infection provided insights and a desire to help others. This echoes our earlier discussion of the support young women indicated they would offer a friend who suspected they had a BBV/STI, and is reflected in previous research with disadvantaged young women (Bottrell, 2007). The connection to family and community in these motivations were also evident in young men's accounts of looking after their health because of family; connectedness has been shown to be central to resiliency (Bell, 2001). Our data suggest that these strengths are a source of esteem for young people that can be harnessed to inform and develop education and prevention efforts to help young people protect and improve their health.

Summary

The finding that young people looked after their health because they worried about the consequences for others is an important reminder that highly mobile young Indigenous people are still connected to families and communities. They worried that an infection would potentially expose others to ill health and affect their personal ability to fulfil responsibilities to others. This concern for others was a powerful motivator for self-care, and an obvious point of leverage for health promotion around BBV/STI prevention. Our findings suggest that young men and young women would be responsive to family and community oriented BBV/STI health promotion strategies.

Taking responsibility for their health was important to young people, and they spoke with pride when they described the things they did to look after their health. Young people often presented themselves as being able to act on their health intentions, suggesting a capacity for self-efficacy that is crucial for successful health promotion efforts.

Young people often provided explanations for current protective behaviour that drew on past experiences. Moments of crisis were turning points that acted as catalysts for changes in protective behaviours. The past was an important source of knowledge and insight, and there was a sense that these opportunities should not be wasted. It was in this way that young people saw their past experiences as providing them with knowledge to share with

others. The challenge for health promotion is to find ways for other young people to benefit from this, learning vicariously so they can avoid facing these challenges personally.

We interpret these results, especially the ability of young people in our study to see BBV/STI infection as a learning opportunity, as a source of resilience. That is, infection prompted a resilient response to a stressful life event. Further, because the shame and stigma associated with these infections rarely featured strongly in their accounts, we suggest that individual and community strengths, as well as education, screening and treatment have helped to create an understanding, judgement-free environment. Health services and communities have an important role to play in facilitating and strengthening these resilient responses, providing young people with the skills and knowledge to tackle future stressful events with resilience.

4.5 Young people's recommendations for reducing BBV/STI

Finally, we asked participants if they had any suggestions for services for improving the prevention and treatment of BBV/STI, specifically related to reducing the rate of infection among young Indigenous people in Queensland. These are young people's recommendations for action.

4.5.1 Education

Raise awareness

Young people requested more education to raise awareness of BBV/STI, and specifically to inform young Indigenous people about the consequences of these infections.

Not enough education around today, all I had was a pamphlet, basic check up, none of this education, I think there should be more education (James, 25, living in hostel)

More prevention, more education, how to control it or something or how to get rid of it (Kevin, 21, moves from place to place)

Make sure that everyone, kids, remember STI and BBV is not fun at all (Lydia, 24, living with family)

They need to be made aware of the problems they face later on (Finn, 18, living in hostel)

They also suggested providing clear information about strategies that would prevent infection. These often reflected the strategies participants reported using personally, including safer sex, developing a monogamous relationship and regular screening.

Encourage our youth to have no more than one sexual partner. If you want to sex someone, ask to use protection, if they say no, don't have sex. Try just being friends instead (of) jump(ing) straight into a sexual relationship. Develop a relationship first. Get a blood test before sleeping with a new partner. Don't be shy, communication is important. Talk to someone and be open minded (Ester, 26, living with family)

Talk to them about awareness of using protection, practice safe sex, ask them to see a doctor for sexual health check. Check up is very important. It is not a good thing that we see too much of STI and BBV among our young people. No good, sad, for the young Aboriginal and Torres Strait Islander people to have these diseases, not fair on us, you know (Morris, 20, moves around, living temporarily in Townsville)

Some participants were keen that young people be made aware of the high rates of infection in some Indigenous communities.

Have a workshop to make the young indigenous aware of the high rates of STI here in Queensland (Vince, 21, living in rented accommodation)

Many of these suggestions relate directly to increasing young people's perceptions that BBV/STI are personally relevant to them, that is, that prevalence in their community is high and the consequences of infection are real and potentially serious. This echoes research with young Canadians that called for young people to be made aware of the 'reality' and closeness of HIV (Graffigna and Olson, 2009).

Education through schools

Participants felt very strongly that schools had a central role to play in educating young people about prevention, and there was an emphasis on starting education early, before young people entered sexual relationships. Several participants specifically mentioned starting education in grade 7, which in the Queensland education system is the last year of primary school (ages 11-12 years). Earlier research with young Indigenous people in Townsville reported a similar finding, with calls for all young people to receive sex education by Grade 8 (Larkins et al., 2009).

They should start early from school in talking to these young people (Morris, 20, moves around, living temporarily in Townsville)

They need to talk to them while in school. Good thing they get to know while in school because they are boys and girls in school already in a relationship. They need to know the details otherwise it is too late. So many young ones these days getting pregnant so it is good that they are aware (Natalie, 25, living in hostel)

In school there are talks on puberty but I reckon they need to include sexual health education in grade 7 to start off with (Jule, 20, living temporarily with friends)

Participants suggested regular discussion in schools to refresh and reinforce key preventive messages.

Schools should do follow up education not just one day to let the message sink in (Janette, 18, living with partner's family)

It is necessary to talk to them every day (...) The idea is to keep talking to them about safe sex (Katie, 26, living in hostel)

Parents, elders, and community have a role

Echoing the regret expressed by some participants that their parents had not educated them about preventing infection, young people stated that parents and elders needed to take a more active role in educating and guiding young people in sexual and reproductive health and infection prevention.

Parents should explain to children why they should use protection (Janette, 18, living with partner's family)

Elders should be educated so they can pass it on to youths (Janette, 18, living with partner's family)

Get the young ones today to listen to the older person when they try to teach you about anything because the topic will come up (Samantha, moves between Townsville and Palm Island)

These suggestions echo the findings of research with young Indigenous people in Canada, which recommended that the whole community needed to be involved in HIV prevention, with elders and parents also needing education (Flicker et al., 2008).

The emphasis on education and providing information suggests a high level of confidence that given the right information young people will take actions to protect themselves from infection.

If they are aware of it, they would be better off (James, 25, living in hostel)

We hear so many of these fellas not wanting to use a condom BUT I reckon education on all these sexual diseases would go a long way maybe that would help make them think about protection (Jule, 20, living temporarily with friends)

4.5.2 Health services

Hardware

When talking about their own experiences, many young people in this study reported that they found it easy to access the 'hardware' of STI prevention, namely condoms. However, participants did suggest better targeting of free condoms to at risk populations, and increasing the locations where free condoms were available.

Offer condoms. Especially to people on the streets (James, 25, living in hostel)

Free condoms available in all doctors, medical practices and chemists (Lanie, 23, living with partner's family)

Services and programs

Young people talked about a need to extend existing prevention and treatment services to ensure they were accessible and friendly to Indigenous young people, and develop dedicated services for Indigenous young people.

All interventions to prevent and reduce STI/BBVs should be made available at all medical centres. Increase programmes targeting young Indigenous adolescents specifically on sexual health promotion and prevention (Rachel, 23, recently arrived in Townsville, living in temporary accommodation)

Have a youth centre or something similar so that Aboriginal and Torres Strait Islanders can go for any help (Jane, 19, living in rented accommodation)

Having call centres for our Indigenous people I'm sure will help (Nick, 25, boards with friend)

Targeted outreach

Participants highlighted the importance of delivering health services directly to people in their communities. Providing information at community events and festivals was a common suggestion, as was using interactive formats such as seminars, workshops, and information forums.

NAIDOC day and special events stall to give out information on STI and BBV (Karen, 24, living in hostel)

Talk to the youth about it (...) Open forum on the issue (Janette, 18, living with partner's family)

Offer some seminars that are free and workshops with educating young Indigenous people about sexual health (Susie, 23, living with family)

Building on the call for targeted delivery of BBV/STI prevention interventions, participants suggested that health workers identify young people that may be particularly vulnerable to infection, such as those living in high prevalence areas or engaged in risky practices, and work directly with them.

There need to be people like you working in little towns and talking to people (Katie, 26, living in hostel)

Worker should visit areas affected greatly and talk about these issues and give out condoms (Jane, 19, living in rented accommodation)

A lot of health workers need to go out and target areas, parks, youth shelter, drop-in centres and women's shelter, and give them talks on sexual health and to offer them advice. Stress to the target group the importance of the awareness, of the consequences if not being aware (Joan, 22 living with family)

I reckon it is useful for them to come out and talk to these young ones out here in the city about protecting themselves from STI (Morris, 20, moves around, living temporarily in Townsville)

4.5.3 Challenging shame and stigma

Finally, participants repeatedly said that young people should be encouraged not to 'be shame' or shy about talking about BBV/STI.

Don't be shame to talk to somebody about it. Talk to your partner about the importance of having safe sex (Sharon, 18, living temporarily with family)

Not be shy, communication is important, talk to someone and be open minded (Ester, 26, living with family)

Many young people emphasised the importance of young people talking to each other and sharing experiences and knowledge as a way to counter shame and stigma, and to educate.

Sharing experiences with other young people to educate about the risk of having sex (Janette, 18, living with partner's family)

Use ideas and young ones to talk to people about STI. Don't get the old ones or (staff member) that work in the clinic because they think that STI should not be talked about. I do not believe that, I think people young ones should talk about it (Lizzie, 18, living temporarily with friend)

I have collected pamphlets and books that tell me information and I find them handy, especially when my cousins come over home I talk to them about sexual health (Rachel, 23, recently arrived in Townsville, living in temporary accommodation)

Indeed, talking emerged as a significant way for young people to learn about preventing these infections. Lindy suggested verbal communication could overcome the lack of interest young people sometimes expressed.

What doing now is pretty good but there is apathy. People need more verbal, (they) look at pamphlets but then throw them out (Lindy, 17, living with family)

This echoes the sentiments of a young Aboriginal woman in a Canadian study who said, "Pamphlets are useless. We need real people connecting to the community" (Flicker et al., 2008). Involving young people in the provision of BBV/STI prevention and education is commonly suggested, especially by young people (Flicker et al., 2009, Flicker et al., 2008, Sorenson and Brown, 2007). Peer involvement is seen as crucial to reducing the stigma experienced by those who have contracted infections (Flicker et al., 2008), and has been suggested as a way to reduce taboos around condom use (Stancome Research and Planning, 2009). Research on peer-led sex education has found that this method appears to be more successful at changing young people's *attitudes* than education led by teachers or older educators (Mellanby et al., 2001). The reports by many of the young women in our study that they would share their knowledge and experiences gained through diagnosis and/or treatment of an infection highlight the value of peer-based support and education.

Summary

Young people overwhelmingly called for more education to improve the rates of BBV/STI infection among young Indigenous people in their communities. They highlighted a need for basic information around transmission and prevention, and specific behavioural messages around safer sex, developing trusting relationships, and regular screening. Calls to inform young people about the consequences of BBV/STI and the prevalence of BBV/STI in Indigenous communities, relate directly to making BBV/STI salient to young people. These calls resonated with our earlier finding that young people rarely spoke of the consequences of BBV/STI, most notably of infertility as an outcome of some STIs. Participants saw schools, parents and elders having a key role in providing BBV/STI information to young people. Young people suggested health services tailor prevention, screening and treatment to Indigenous young people, and target the groups most at risk. Crucially, there was a strong call for outreach and the provision of information and services to young people in community settings.

Our findings indicated a need for community-wide efforts to make talking about BBV/STI acceptable across all age groups, with suggestions for community forums and spaces where young people can share experiences, model openness and educate each other. It is worth reiterating here the findings reported earlier relating to young people's desire to share the lessons they have learnt with others. Community-controlled health services seem well placed to facilitate the knowledge transfer and peer-support that young people are requesting.

5 Building on young people's strengths

In this report we have documented the perspectives and experiences of young Indigenous people in Townsville in relation to BBV/STI, as well as demonstrating how they utilised individual and community strengths to protect themselves against adverse health outcomes and enhance their health and wellbeing. Echoing Pyett et al. (2008), we believe that focusing on young people's strengths helps to counter the deficit model of health commonly deployed in health research and draw attention to health issues facing young Indigenous people and their communities, without reinforcing negative stereotypes or focusing solely on individual risk behaviour. Our recommendations build on young Indigenous people's strengths, which have been identified in this report.

To support young people and build on their resilience to prevent BBV/STI, ACCHS, mainstream health services, and the Indigenous community need to emphasise the positive aspects of young people's practices and build on them in the following ways:

- Education was the primary suggestion for reducing BBV/STI, and there was a real thirst for knowledge among our participants. Young people identified gaps in their knowledge, with many suggesting they did not feel they knew enough to be able to protect themselves from infection.
 - Provide basic information on BBV/STI prevention, symptoms, and complications, with a specific focus on HPV.
 - Provide information about the differences between blood borne and sexually transmitted infections and what this means for transmission and prevention.
 - Education around BBV/STI is everyone's business. It needs to be provided across a range of contexts (school, health services, and community spaces) and by a range of people (parents, elders, friends, health care providers).
 - Recognise young people's desire for information and support from family by encouraging family members to take an active role in young people's health, and explore how health services can better support and educate families and communities to take up this role.
- Facilitate young people's access to condoms.
 - Improve access to free condoms by providing them in discreet public spaces, as well as having them openly available in community spaces and at community events.
 - Encourage young people to find out where free condoms are available, take more than they need, and carry condoms with them.
 - Supporting young people to share their knowledge of where free condoms are available and provide condoms to friends and family celebrates their desire to care for friends and family.
 - Young people could be engaged to create a map of where to source free condoms (day time and night time) or buy them discretely (such as vending machines), which TAIHS could develop and distribute.

- Negotiation within casual or established relationships can be difficult and feeling confident and safe when discussing safe sex continues to be an issue for young people, and young women in particular.
 - Develop a campaign that taps into the idea that ‘the right time is now’ when it comes to having and using a condom. A program could be developed to engage young people to come up with strategies to use in situations where they don’t have a condom and encourage the idea of shared responsibility between partners. This program could also work with young people to develop BBV/STI prevention strategies for sexual activity while intoxicated. This may include staying close to friends and family when intoxicated, always carrying condoms, and confidence to negotiate non-penetrative sexual activity. An important outcome of this program could be a peer-led resource (a play, poster, music video, etc) designed to communicate strategies for using condoms in these situations to other young people.
 - Support young people’s autonomy with more complex health promotion messages acknowledging that there are situations where they will decide not to use condoms. These messages need to be supported by an education program to provide young people with the knowledge and skill to negotiate ceasing condoms in relationships, and to deal with situations where they want to use condoms but feel challenged (such as a reticent partner or intoxication).
 - Develop skill-based programs to support young people’s development of safe, trusting intimate relationships. This includes empowering men, as well as women, to openly talk about BBV/STI and pregnancy including negotiating condom use, monogamy, and regular testing. These strategies for empowerment could tap into the cultural significance of demonstrating care for self, partner, family and community.
 - Provide opportunities for young people to discuss their ideas about relationships and their experiences. This may be one way to deal head-on with the idea that relationships are inherently safe.

- The high engagement with health services, particularly ACCHS, is encouraging and the support for BBV/STI screening among young people is something to be celebrated.
 - Build on the positive orientation to screening by encouraging young people to have regular screening and opportunistic screening following potential exposure.
 - Health care providers suggesting opportunistic screening appeared to be well accepted by young people and BBV/STI screening should be offered during general health checks and as part of cervical cancer screening programs.
 - Regarding young people’s calls for targeted outreach, the feasibility of BBV/STI screening delivered in community settings could be further investigated (community-based chlamydia screening has been shown to be feasible in Townsville (Buhrer-Skinner et al., 2009)).
 - Some young people reported seeking BBV/STI screening at the start of a relationship. This positive health behaviour could be used to encourage young couples to seek screening *together* or to strengthen skills to ask partners to be screened. Indeed, our research suggests that many young

people already possess the skills to ask a new partner to have a test before they decide to stop using condoms. Asking partners was not presented as raising friction around distrust or stigma and this positive ability to negotiate could be used to broaden people's skills. In particular, because many young people reported experiencing infidelity within relationships, screening should be encouraged throughout relationships. An important part of this approach is for health care providers to encourage young couples to pursue this strategy together.

- Although most young women recognised that hormonal contraception did not protect them from BBV/STI, there was still some confusion about strategies that prevented pregnancy versus strategies that prevented infection.
 - Initiatives to strengthen young women's control over their reproductive health could involve Indigenous health workers working with young women providing advice around the need to maintain condom use, regular screening, and explicitly negotiating monogamy with sexual partners, when using hormonal contraception.
- It is heartening that the Indigenous young people involved in this study indicated that they had not experienced significant ongoing shame in relation to personal experience of BBV/STI diagnosis. Young people's personal experiences, gained through their own and their family member's and friend's infection, appeared to have made BBV/STI highly salient. The challenge for health promotion in this context is both to raise awareness and reduce stigma and shame, while not normalising these infections.
- Young people also spoke about learning from their friend's experiences and often compared themselves to their friends. There was a strong motivation among young women to share their experiences with other young people. Encouraging young people to become involved in peer education would have the double benefit of empowering those in educating roles to become active and involved members of their community, as well as empowering those in learning roles through socially relevant knowledge-building with those from similar backgrounds.
 - Developing formal peer-education and support such as health service-experienced allies to guide young people attending for screening or treatment initiatives would complement the promotion of informal peer-education and support such as looking out for your friends, sharing condoms and encourage the uptake of screening.
- In their interviews, young people often cast themselves as active health-seekers with respect to BBV/STI prevention. They talked about applying knowledge and rules in an attempt to act on their intentions to protect and maintain their health. They often characterised themselves as responsible, in-control, and aware. This openness and active engagement in self-care could be used to challenge any shame and stigma associated with BBV/STI.

- Finally, there were some important gaps in our data that require further exploration.
 - Among the young people in our project there was a lack of personal experience of injecting drug use. As a result, we know little of the experiences and needs of Indigenous young people in Townsville who are also injecting drug users.
 - There is a need to further explore Indigenous young people's negotiation of safer sex with casual partners and how trust is established and condom cessation negotiated in the important transition stage to a long-term relationship.
 - Young men's perspectives are under-represented in our study. The lack of male voices in personal accounts of supportive health interactions or health promotion presented here suggest that further research is needed to engage young men to talk about their experiences of health care and strategies they believe would encourage health seeking behaviour among their male peers.

Conclusions

This research, its findings and our recommendations are unique in that they represent a community-engaged research project for and by the community and a research project designed to explore youth resilience from their own perspective. The overt connection to the TAIHS also brings a unique focus as our research not only investigated the role of the ACCHS in BBV/STI prevention and treatment, but worked to build the service's capacity to undertake research and their presence and connections in the community, particularly among young Indigenous people. The IRP-CBPR is a testament to the commitment and engagement of the community partners on this project: TAIHS Board of Directors and staff, and young Indigenous people in Townsville.

The 'take home' message from this project is that Indigenous young people in the Townsville region placed a high value on their health, demonstrated determination to prevent transmission of BBV/STI and had a very strong sense of community responsibility. These are tangible strengths that should be celebrated and bolstered to enhance young Indigenous people's ability to protect themselves against adverse health outcomes and enhance their resilience.

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7 Appendices

7.1 Appendix 1

TAIHS- ICIHRP STI/BBV Indigenous Resiliency Project

Activity Sheet for Research Officer/ Research Assistant/Peer Researchers

Date of Activity

Venue

Interventions/ Impressions

Questions

Please tell me a bit of background information about yourself, your family, where you are born, your life up till now and how you started learning about sexual transmitted infections and blood borne virus. Tell me what do you know about STI or BBV?

Note: we have reduced the space for recording participant responses

Please describe a personal experience you have had using sexual health services relating to your sexual health behaviour in general. Are you sexually active? Where do you go to get treatment for STI and BBV and how do you feel about using Indigenous medical centres. How did you find out about the services, was it easy?

Describe an experience you have had trying to get condoms or protection from STI and BBV. What do you do for protection? How important is it to you to have protection? Would not having protection affect whether you would have sex.

If any or what suggestions do you have for making services better to improve the high rates of STI and BBV that we see among our young indigenous population here in QLD.

Can you tell me about a personal experience of talking about STI/BBV with a partner and if you have a partner now can you please tell me about an experience with them. Tell me about your partner is he or she open minded about her or his sexual health behaviour?

How do you feel about you and me talking about the topic at the moment? Who else do you talk to about these issues?

What would you advise to a person if she or he approach you and stated that he or she has got an infection from having sex? Do you feel you have enough information to keep yourself protected from STI/BBV and where have you got this knowledge.

Peer Researchers

Sexual Health Promotion

Sexual Health Referral

Sexual Health Follow up

Research Officer/Assistant

Sexual Health Screening

Sexual Health Treatment

Assessment

Current living arrangements

Male

DOB

Aboriginal

Phone

Female

Age

Torres Strait Islander

Subjective

Plan

Outcome/Evaluation

Staff Name

Staff Signature

7.2 Appendix 2

IRP-CBPR DECISION MATRIX

	Young mums and/or dads	Mobile young people (coming to region for family funeral/business, medical treatment, sports carnivals)	Young people involved in organised sport	Young people in detention
Health issues for this group				
Public health significance				
Estimated size of the population				
Nature/extent AMS current contact with this group				
Partners working with this group				
Access issues				
Issues for staff working with this group (e.g. comfortable)				
Key worker(s) in AMS working with this group				

	Young IDU	Young people in families with inter-generational issues	Homeless/residentially unstable young people, and in SAP and care	Young gay men
Health issues for this group				
Public health significance				
Estimated size of the population				
Nature/extent AMS current contact with this group				
Partners working with this group				
Access issues				
Issues for staff working with this group (e.g. comfortable)				
Key worker(s) in AMS working with this group				