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Young Indigenous Australians' Sexually Transmitted Infection Prevention Practices: A Community-based Participatory Research Project

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Abstract

National surveillance data indicate marked differences between Indigenous and other Australians in the prevalence of many sexually transmitted infections (STIs). Young Indigenous people bear a particularly high burden of these infections. A collaboration of university researchers, Indigenous health workers and young Indigenous people conducted 45 field interviews to examine how young Indigenous Australians keep themselves healthy and protected against STIs. Our findings emphasise the complexity of health behaviours, where individuals are rarely always 'risky' or always 'safe', as well as subtle gender differences in health practices. Preventive strategies employed by the young people were contingent on beliefs and knowledge about sexual partners, the type of relationship, the context of the sexual encounter, and access to condoms. Tangible strengths identified by our study should be celebrated and bolstered to enhance young Indigenous people's ability to protect themselves against adverse health outcomes and enhance their resilience against STIs. Focusing on strengths helps to counter the deficit model of health commonly deployed in Indigenous health research and draws attention to health issues facing young Indigenous people and their communities, without reinforcing negative stereotypes or focusing solely on individual risk behaviour. We provide concrete recommendations for health promotion and education.

Keywords

Sexual health; STI prevention; young people; Indigenous people; Australia

Introduction

If I meet 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).

National surveillance data indicate marked differences between Indigenous and other Australians in the prevalence of many sexually transmitted infections (STI) (National Centre in HIV Epidemiology and Clinical Research, 2009a, p. 9; 2009b, p. 8). Chlamydia, Gonorrhoea and Syphilis are considerably higher among rural/remote Indigenous populations and these disparities persist, though to a lesser degree, in urban populations. Patterns of infection suggest that Indigenous women and young people bear a higher burden of Gonorrhoea and Syphilis infection compared to their non-Indigenous counterparts pointing to differences in behaviours associated with transmission. Epidemiological data on the distribution of STIs in this population tell us little about young Indigenous people's perceptions of risk and protection, or the contexts in which they engage in practices that render them vulnerable to infection or that are protective. This behavioural and contextual data is important as efforts to prevent STI transmission need to be "positioned within the complex social world in which young people make decisions" (Sorenson & Brown, 2007, p. 7). As the interview extract above indicates, young people actively engage in specific STI prevention practices. This negotiation is complex and contextual, and is influenced by social, cultural and interpersonal dimensions.

The Indigenous Resiliency Project (IRP) aimed to identify, assess and enhance the STI resilience capability of young Aboriginal and Torres Strait Islander people; inform on opportunities to decrease the risk of STI transmission in site communities; and provide information for health service planning for Aboriginal and Torres Strait Islander STI interventions and programs. While condoms are clearly central to the prevention of STI transmission among young people, they are not the only strategy available. Our study prioritised young people's perspectives on the prevention of STIs by engaging them in the design and conduct of the study and attending to the prevention strategies they use when engaging in sex and negotiating relationships. Thus, this paper addresses the question; from their own perspective, how do young Indigenous Australians keep themselves healthy and protected against STI?

Methods

A Community-Based Participatory Research (CBPR) framework was used to develop a qualitative study around young Indigenous people's sexual health. Our participatory approach (explored in detail elsewhere, AUTHORS, 2008, 2009a, 2009b) involved a range of strategies to ensure the project was a genuine collaboration between university researchers and Indigenous community members, and in particular that young Indigenous people were actively involved throughout. Strategies included a three-day research development and training workshop at the beginning of the project. This was attended by eight young Indigenous people and five Indigenous health workers from Townsville Aboriginal and Islanders Health Service (TAIHS). Together we developed project questions reflecting local priorities and meanings, and established ways of conducting the project that were appropriate to the local community. We also identified young people who wanted to work with the project as peer-researchers. Thus two university researchers, a nurse and an Aboriginal sexual health worker from TAIHS and five young Indigenous people from the

Townsville community developed and ran the project during data collection in 2008 and analysis and report writing in 2009.

Reflecting our community-based approach, the TAIHS-based team members conducted a consultation process to identify a focus for the research project (CBPR emphasises research based on local priorities). The Mums and Babies Clinic, Social Health Unit, Youth Shelter, Early Intervention Program for Youth at Risk, and the Volatile Substance Misuse program at TAIHS; external services providers such as the Queensland Health Indigenous Sexual Health Clinic and Queensland Aboriginal and Islander Health Council; and community members were consulted. During the consultation process a clear perception emerged that Townsville was experiencing a shortage of suitable accommodation for young people in crisis or at risk of becoming homeless. Experience within the health services suggested that it was particularly challenging for the health services to develop and sustain relationships with these highly mobile young people.

Of particular concern for TAIHS was that these young people miss out on health promotion and education, generally delivered in school environments. Mobility also constrains access to regular screening and treatment for STIs. Townsville is a regional administrative centre for government services and an important hub for Aboriginal and Torres Strait Islander people from across a vast region, particularly Palm Island (an Aboriginal community 65 km to the north-west) and Mount Isa (a regional town 900km to the west). There are high rates of mobility within the region, with young people travelling between Townsville and regional centres and remote communities, for family, education, health services (often as part of family groups), or to seek work. State and national government STI prevention and management strategies have recognised that this kind of mobility is common among Aboriginal and Torres Strait Islander people and that young Aboriginal and Torres Strait Islander people experiencing residential insecurity are at increased risk of acquiring STI (Department of Health and Aging, 2005; Queensland Health, 2003). For all of these reasons, young people experiencing or at risk of homelessness became the project's target population.

Data collection was a time intensive process with the project team spending significant periods of time in the community, meeting and talking with young people (many of whom did not become participants). Participants were recruited in and around commercial precincts, public spaces, parks, drop-in centres, and homeless shelters. Interviews were opportunistic, taking place at the time and location where recruitment occurred. These field interviews were conducted by peer researchers (five young Indigenous people) and the site coordinator (author three) and were recorded as hand written field notes on a pro-forma that provided guiding questions covering knowledge, protective behaviours, health services use, and discussions with sexual partners. Interview length varied and was influenced by the time participants had available. All interviews began with the cultural protocol of introducing yourself and your family, this influenced the length to the interview as some interviewees and peer researchers had intricate family connections. Our sample consisted of 45 people, 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 and two thirds reported a history of homelessness. Pseudonyms are used in this paper to protect the identities of participants.

The university-based researchers (authors one and six) conducted a thematic analysis (Braun & Clarke, 2006), reading and rereading field interview notes for themes related to the project questions: how do young people describe staying healthy and protected against STIs, and how can we help young people be stronger so they can better prevent STIs and obtain appropriate care and treatment? This paper focuses on young people's narratives of *keeping safe*, a theme that covers their strategies for avoiding STI, and includes relevant aspects of a second theme, *sources of risk and barriers to keeping safe*, that elucidates challenges to prevention practices. We presented preliminary findings at a community workshop that included Indigenous community members (including young people), health workers, youth and welfare workers, and TAIHS management. This was as an important credibility check of our interpretations and allowed local health care providers and community members to provide local and cultural context. The findings presented here resonated with the workshop participants. Feedback resulted in some minor changes and clarification of interpretation. However, the majority of the feedback related to recommendations for action at the local level.

Results

During the 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 firstly about using condoms. They also described two other important strategies for protecting themselves from infection - establishing a trusting relationship with one partner and testing for STI infection - which we present here.

Condoms

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

Many young people emphasised the importance, to them personally, of condom use and indicated that they would abstain from sex if they did not have a condom. However, as we see later, condom use was mediated by situational complexities.

Both young men and women agreed that free condoms were widely available at Aboriginal Community-Controlled Health Services (ACCHS), dedicated sexual health services, hospitals and youth support services: "*Easily accessible*" (Nina, 26) and "*Never had trouble getting protection, no problem at all*" (Morris, 20). Young people described picking up free condoms opportunistically when visiting health services and proactively when they anticipated they would need them. Despite reporting the widespread availability of free condoms participants also discussed encountering barriers to access. For example, the supply of free condoms at health services was not always reliable: "*(They have) a basket of condoms kept in the clinic but the condoms sometimes run out*" (Lizzie, 18).

A few young women reported buying condoms at supermarkets or pharmacies, while other young people reported sharing condoms with friends or partners.

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

Yet, obtaining condoms was a relatively public act, and embarrassment and shame remained an issue for some young people:

Pretty shame, even if I wanted to grab a free condom at TAIHS I still feel too shame (Finn, 18)

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)

Some participants also said that they found it hard to anticipate when they would need condoms, as they needed to “*know the right time*” (Finn, 18). 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 where they have no condoms with them because they had not anticipate having sex and therefore they had unprotected sex. Perhaps not surprisingly, alcohol was often implicated in these situations. For example, the combination of alcohol and not having a condom was enough to disrupt Fred's resolve to use a condom.

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. (...) 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)

It may be particularly difficult for homeless (or highly mobile) young people to access condoms as they may not be having sex at home or have local knowledge of where to obtain free condoms. Several young people in our study reported regularly carrying condoms:

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

One potential downside to carrying condoms is that this can be interpreted by potential sexual partners as consent to sex, something that may put off young women who are worried about their reputation. There was no evidence of this in our study, indeed, young women talked about obtaining free condoms, buying condoms and carrying condoms:

I carry condoms with me all the time (Margaret, 26)

In addition to having access to a condom when they needed one, two other challenges to condom use emerged in our interviews: disparities in men's and women's commitment to consistent condom use; and alcohol and drug use.

Young male partners refusing to use condoms, or indicating a preference for sex without them, was reported by several 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. I would rather he use a condom just to be safe
(Karen, 24)

One young woman indicated that it was easier to go along with her partner and seek screening later. That is, potentially dealing with an infection was 'preferable' to having to insist on a condom within the dynamics of a sexual interaction. More broadly, young women's choice to engage in sexual intercourse, with or without condoms, was not always truly negotiated. One pregnant young woman, for example, suggested that her 'choice' to have sex 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)

While none of our male participants indicated that they refused to wear condoms or pressured women into sex, their ambivalence to condoms was evident: "Condoms are not as good as what they [are] made out to be" (James, 25) and "Everyone likes to be or go 'free willy' sometimes" (Eric, 26)

It is important to note that a few young men suggested that it was their female partner who needed to be reminded of their personal responsibility for safer sex. However, more commonly the dynamic appeared to be gendered suggesting that many young women still feel responsible for insisting on protection during sex but are often challenged by men's dislike for condoms, refusal to use them, or ambivalence to safer sex 'in the moment'.

Another 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:

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)

In their accounts of unprotected sex while intoxicated, young people characterised themselves as impulsive and irrational. However, these narratives of unprotected sex often coexisted with descriptions of subsequent rational behaviour in the form of STI screening. We see this, and the two challenges of intoxication and a partner's preference for no condom, in this extract from Ester:

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 (Ester, 26)*

Being in a trusting and committed relationship

The second preventive strategy raised by young people focused on trust and a committed relationship. 'Sleeping around', or having multiple casual partners, was seen by many young people as a risk for STI and some participants described personal experiences of having multiple partners and contracting an infection: *Like before I never have one partner and never use a condom and I had that thing (Chlamydia)* (Ester, 26). As such, not sleeping around or having only one partner was often presented as a protective strategy. 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 allowing time to get to know a potential sexual partner in order to develop trust were important STI prevention practices:

Develop a relationship first (Ester, 26)

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

Once participants felt that they had established trust (which included getting to know the other person and sometimes negotiating a relationship status – i.e. boyfriend/girlfriend – or monogamy) many young women indicated that condoms were no longer a relevant prevention strategy:

I never use condoms, not that important. I trust and know my husband. [...] I have never used a condom ever because there was no need for me to use a condom (Natalie, 25)

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)

Another young woman, Rachel, was currently using and endorsed the importance of condoms, but suggested that if she was in a relationship she would not use condoms because trust *should* be part of the relationship:

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)

It is unsurprising that when young people in our study did talk about using condoms in an established relationship it was linked with suspicion that a partner was having sex with other people:

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)

Some young people reported that their trust in their partner had been violated when a partner had cheated. This violation was not just about hurt feelings but potential exposure to infection, and often produced changes in subsequent prevention practices:

I had an STI from this other girl that I was going around with. [...] Up until now I don't trust girls (Mark, 26)

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. (Nina, 26)

Monitoring STI status

The third strategy for preventing infection reported by the young people in our study was STI screening. A quarter of our participants spontaneously spoke about regular checkups, blood tests, sexual health checks. This included monitoring their own and their partners' STI status through regular screening, and seeking screening when they perceived themselves at risk of infection. Young people reported proactively seeking screening both within specific time frames (*6 months, 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. It was common for young people's descriptions of regular screening to contain a sense of pride, particularly around being a responsible person and doing the right thing. This was evident when young people described themselves as a 'good' patient by having STI screening when their doctor suggested it or when women were proud to have been a 'good' expectant mother and sought STI screening.

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 (Rachel, 23)

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, age unknown)

Some young people also talked about using screening as a way to establish a partner's sexual health status prior to commencing a sexual relationship. Some young women suggested that they had refused to have sex until their partner had been screened:

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)

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

Discussion

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 health promotion (Brough, Bond, & Hunt, 2004). We are keen to draw attention to health issues facing young Indigenous people and their communities without reinforcing negative stereotypes or focusing solely on individual risk behaviour. We will discuss the findings of our study in relation to existing literature and practical recommendations that build on young Indigenous people's strengths and existing practices.

Many young people emphasised the importance of condom use and described widespread access to free condoms in their community. Some young people spoke of condoms not being available when and where they needed them. When it came to obtaining condoms from public spaces, embarrassment and shame remained an issue for some. These findings support calls to ensure free condoms are made available in ways that young people do not feel under surveillance (Bell, 2009; Stancome Research and Planning, 2008). Thus, our first recommendation is to facilitate young Indigenous people's access to condoms by providing them discreetly in retail outlets and community/health spaces so they can procure them without feeling under scrutiny.

Research suggests that carrying condoms can be interpreted by potential sexual partners as consent to sex (Marston & King, 2006). Research with young Indigenous mothers found carrying condoms was considered premeditation of sex, which was damaging for young women's reputations. The authors stated that young women "preferred to risk their health to protect their reputations" (Larkins et al., 2009, p. 9). There was no evidence of this in our study. Young women talked about obtaining free condoms, buying condoms and carrying condoms. Our second recommendation is to encourage all young people to find out where free condoms are available, take more than they need, carry condoms with them and share their knowledge and resources with friends and family. This acknowledges and builds on practices that already appear to work well for young Indigenous people in our sample, and has the potential to further normalise carrying condoms.

Still, a range of social and contextual forces mean that having knowledge and condoms may not be enough to ensure condoms are used, even when young people intend to use them (Marston & King, 2006). We found three particular reasons for not using condoms in the narratives of participants in this study: the situational factor of alcohol intoxication; gender disparity in the commitment to condom use; and feelings of trust in relationships.

In relation to reduced use of condoms with alcohol use, our findings are echoed in recent research with Australian Indigenous people in rural and remote communities (Miller, McDermott, McCulloch, Fairley, & Muller, 2003; Stark & Hope, 2007). Harmful alcohol use has been shown to be a predictor of STI diagnosis in Indigenous women attending antenatal programs (Panaretto et al., 2006). These findings are of course not specific to Indigenous people. Alcohol use is often a feature of casual sexual encounters (Carmody & Willis, 2006) and the effects of alcohol and drug use on risky behaviours are well documented in the broader Australian population (Smith et al., Published Online First: 10 September 2010). Specific recommendations arising from our findings include developing campaigns that tap into the idea that 'the right time is now' when it comes to carrying a condom and being

prepared for protective sex. Health professionals and youth workers could work with young people to develop STI prevention strategies for sexual activity while intoxicated, that is, adopt a harm reduction framework. Such strategies may include staying close to friends and family when intoxicated, always carrying condoms, and developing confidence around negotiating non-penetrative sexual activity.

Gender dynamics are an important feature in the negotiation of prevention strategies including condom use (Flicker et al., 2008). As has been reported elsewhere, we find a disparity between young men and young women's commitment to condoms (Bell, 2009; East, Jackson, O'Brien, & Peters, 2007; Flicker et al., 2008). Research suggests that women's use of safe sex practices are hindered by uneven power dynamics between them and men (Hillier, et al, 1998). The promotion of *shared* responsibility for prevention of STI transmission was the subject of considerable discussion at our community feedback workshop. One health worker commented that it was striking that while many of the young people we interviewed were in relationships, the preventive screening behaviours they described were linked to their own intentions rather than actions they took *together* as a couple. We would recommend skill-based programs to support young Indigenous people's negotiation of healthy and safe relationships and the notion of shared responsibility, especially the responsibility of men to use condoms and to respect women's rights. The literature suggests that young people consistently call for these types of skills-based programs (Arabena, 2006; Carmody & Willis, 2006; Flicker, et al., 2009).

Although the narratives from young people in our study tended to focus on individual behaviour, trust and being in a committed relationship were pertinent to their use or non-use of condoms (De Visser, Smith, Rissel, Richters, & Grulich, 2003; Hillier, et al., 1998). Participants commonly associated STIs with promiscuous sex outside of an intimate relationship and trust (faithfulness or monogamy) was assigned to ongoing relationships. When examining context, relationship type has been found to play a central role in condom use (Katz, et al, 2000; Woolf & Maisto, 2007). Getting to know someone and the development of a trusting relationship has been described as a prevention strategy used among young people in rural Australia (Hillier, at al, 1998) and Australian young men (Smith et al., Published Online First: 10 September 2010). In our research it was not clear what specific knowledge about a partner our young participants sought, but other research suggests this may involve informally gathering information to determine a partner's level of risk, often based on reputation or gossip (Hillier, et al., 1998). Our data do not tell us about the transition from casual to trusting relationship and how protective practices shift and are negotiated during this time. It was unclear how trust was established and whether it was based on talking, the passing of time (suggested by some data), or presumed to develop as part of the natural progression of the relationship (Lear, 1995). This would be a fruitful area for future research.

Safe sex is a "self-interested risk avoidance principle" and can be perceived to be "inconsistent with responsibilities towards culturally inclusive values such as caring and sharing" (Cusick and Rhodes, 2000, p, 483). The dangers of STIs are entrenched in ideas around casual sex and may not translate well to long-term relationships as individuals are not simply weighing up the risk of contracting an infection in a committed relationship and choosing to abandon condoms. Condom use is "not a neutral action. It implie(s) specific

relational meanings” (Graffigna & Olson, 2009, p. 796). Condom use in committed relationships suggests a lack of trust (Marston & King, 2006) and can imply a partner’s STI status is suspect. Thus, condom-free sex in a relationship becomes a sign of trust (Hillier et al., 1999; Marston & King, 2006), whilst simultaneously being an action based on trust. This was evident in data where young people, particularly women, indicated that condoms are simply unnecessary because they know/trust their partners. The social reality then, for young people in our study, is that condoms are not part of established trusting relationships. What is not clear is why the link between interpersonal trust and abandoning condoms was emphasised more among young women than men.

Although trust in relationships is viewed as a ‘safer’ sex practice by these young people and others (James et al. 2004), the concern here is that among this age group a trusting relationship may be one of a series of trusting, committed relationships (Hillier et al., 1998). Indeed, both men and women in our study described experiences of having trust violated when a partner cheated. While these experiences provided valuable lessons for the future and shaped young people’s prevention practices, the challenge for health promotion is surely to “help people protect themselves in the absence of betrayal” (Lear, 1995, p. 1321). There is a clear need for more complex health promotion messages that acknowledge situations where young people will *decide* not to use condoms. Campaigns that simplistically characterise unprotected sex as risky sex *regardless of relationship status* risk alienating young people, and close down spaces to talk with young people about negotiated safety. Negotiation of prevention strategies can be difficult and can be confounded by the faith that young people, particularly women, put in trust, rendering them ineffective in negotiating safer sex practices (East. et al, 2007). There remains an acute need to provide Indigenous young people with the knowledge and skill to negotiate ceasing condoms in relationships, including encouraging couple-based STI testing, and to deal with situations where they want to use condoms but feel challenged by a reticent partner.

In some respects many young people in this study already coped with situations in which a condom was not used. The (apparent) high level of regular screening among our study sample is arguably positive and will contribute to prevention of STI transmission and health complications. The screenings sought by young people may have been driven by effective health promotion, or a common cultural discourse of high STI prevalence of Indigenous communities. During the project’s lifetime media coverage of STI in remote Indigenous communities called for blanket treatment of entire communities (Robinson, 2008; The Australian, 2008). We have previously reported that some of these young people explained their current practice of regular screening in terms of a past experience of STI diagnosis (AUTHORS, 2011). Regardless, Indigenous young people’s pride and personal investment in screening should be celebrated and encouraged. Health care professionals should take heart that opportunistic screening appeared to be well accepted by young Indigenous people and programs could build on this positive orientation by encouraging young people to get screened during general health checks and following potential exposure. Echoing our findings that some young people used screening before engaging in unprotected sex or at the beginning of a relationship, 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). Screening may be one way young people establish that a partner can be trusted. A negative test result may be taken to mean a partner was infection

free and condoms are now unnecessary (Smith et al., Published Online First: 10 September 2010). Encouraging explicit couple-based screening as part of establishing a trusting committed relationship is worth further exploration by health services. This practice could be promoted as ethic of care (Carmody & Willis, 2006).

Our project was explicitly local, defined and conducted by young Indigenous people and health workers asking about young Indigenous people's experiences in their own community. There are many resonances between our findings and those reported previously in research with Indigenous and non-Indigenous young people in Australian and beyond. Like young people elsewhere, young Indigenous people in Townsville are sexually active, aware that STIs can be transmitted through sex, aware that condoms offer protection against STIs and are not consistently practising safe sex. The effect of alcohol on protective practices, a need to have easy free access to condoms, the gendered dynamics around condom use and trust as a STI prevention strategy practice have also been demonstrated internationally. A potential unique finding to emerge from our research is the high level of awareness about STI testing and consequent high level of reported screening for STIs among young Indigenous people in this urban setting.

As a result of our focus on homelessness, the majority of the young Indigenous people in our sample had or were currently living in temporary situations with a friend or extended family or in a homeless shelter. The majority reported disrupted schooling, including many who had not finished high school to the compulsory level (year 10). Discussion about problematic alcohol or drug use, incarceration and violence (a third of the young women described intimate partner violence) was common. Nearly half the young people had children and half of these reported that one or more child had been taken away or voluntarily placed with the State or extended family. These social, economic and personal issues undoubtedly play an important role in shaping sexual behaviour, especially when considered against a backdrop of Australia's history of colonisation (Devries & Free 2010; Arabena, 2006). That we have not explored *how* these socio-cultural factors may relate to sexual practices and STI prevention reflects the aims of our project. We were committed to producing knowledge for action (Viswanathan, et al, 2004) and to identifying practical and culturally appropriate health education responses for TAIHS and other health services. Moreover, rather than focusing on risk factors, we were interested in existing practices that could be seen as positive health behaviours to be built on. Thus, practical positive knowledge has been produced through the work of community members to improve the health of young people and the communities they belong to.

Conclusions

The experiences and perspectives of young Indigenous people in Australia are largely absent from the literature on STI prevention. Our project provided a unique opportunity to access these young people's experiences of keeping themselves protected against STIs. Our main objective was to highlight the positive behaviours young Indigenous people discuss as they enact their intentions to prevent infection and apply knowledge and rules around sexual health. They characterised themselves as responsible, in-control (largely), and aware. All of these examples provide a positive picture of the real concerns young Indigenous people have for their health and the lengths they go to enact healthy strategies for themselves, their partner(s) and their community. This demonstration by young people of tangible

strengths should be celebrated and bolstered to enhance young Indigenous people's ability to protect themselves against adverse health outcomes and enhance their resilience against STIs.

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