

Working with Aboriginal young people in sexual health research: a peer research methodology in remote Australia

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Abstract

In a context of ongoing colonization and dispossession in Australia, many Aboriginal people live with experiences of health research that is done “on” rather than “with” or “by” them. Recognizing the agency of young people and contributing to Aboriginal self-determination and community control of research, we used a peer research methodology involving Aboriginal young people as researchers, advisors, and participants in a qualitative sexual health study in one remote setting in the Northern Territory, Australia. We document the methodology, while critically reflecting on its benefits and limitations as a decolonizing method. Findings confirm the importance of enabling Aboriginal young people to play a central role in research with other young people about their own sexual health. Future priorities include developing more enduring forms of coinvestigation with Aboriginal young people beyond data collection during single studies, and support for young researchers to gain formal qualifications to enhance future employability.

Keywords

qualitative; Aboriginal; young people; youth; sexual health; Australia; self-determination; decolonizing methods

Introduction

In Australia, increasing ownership of, participation in, and control over health research is demanded by Aboriginal and Torres Strait Islander peoples (hereafter referred to as Aboriginal peoples, except when referring to international documents and literature where we use the term “Indigenous peoples”) (Bond, 2019; Elston et al., 2013; Rigney, 1999; Sherwood, 2010). As a result of ongoing colonization and dispossession in Australia, and the continued multiple devastating effects of these on Indigenous peoples, many Aboriginal people and organizations remain distrustful of health research and health researchers (Bainbridge et al., 2015; Elston et al., 2013; Humphery, 2001; Tuhiwai Smith, 2012). Many Aboriginal people live with experiences of health research that is done “on” rather than “with” or “by” them (Tuhiwai Smith, 2012). This sentiment extends more broadly into social and political spheres in Australia, most recently demonstrated by the inaction on the “Uluru Statement from the Heart”—a statement from Aboriginal peoples setting out a way forward to work with Government (Commonwealth of Australia, 2017). Such imposition,

when aligned to efforts to acquire health-related knowledge primarily through a non-Aboriginal lens, may be viewed as a form of cultural imperialism. This can only be overcome by decolonization—and use of alternative methods including decolonizing research frameworks, methods, and

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systems—if Aboriginal peoples' health in Australia is to be properly understood (Sherwood, 2013; Tuhiwai Smith, 2012).

The decolonization of health research and health research methodologies is a process that requires recognizing Aboriginal peoples as agents, leading and participating in research, with expert knowledge about themselves, their circumstances and strengths, and the solutions to their needs and problems (Tuhiwai Smith, 2012). Through processes of self-determination, respectful contemporary health research can enable the collection and dissemination of knowledge that engages with and genuinely represents Aboriginal peoples' understandings of the world (Johnstone, 2007; Sherwood, 2010). This in turn can facilitate evidence-informed strategic planning and action to address health issues that are identified by communities as outstanding and in need of resolution, and implement solutions with a higher likelihood of being effective. In support of Aboriginal researchers working to drive this agenda and lead research to reduce inequity in health care, there are important responsibilities for non-Aboriginal researchers. These responsibilities include adopting methodologies and methods aligned with and committed to decolonizing research agendas (Johnstone, 2007; Tuhiwai Smith, 2012), and providing long-term support for Aboriginal researchers to undertake high-quality research on issues of community concern that respects and foregrounds Aboriginal cultural values, systems, and knowledges (Clapham, 2011; Dudgeon et al., 2010; Prior, 2007; Tuhiwai Smith, 2012).

There remain extreme and therefore unacceptable disparities between the sexual health of Aboriginal and non-Aboriginal young people throughout Australia today. For example, national surveillance data from 2017 document substantially higher notification rates of Chlamydia, infectious syphilis, and gonorrhea among Aboriginal young people aged 15 to 29 years compared with non-Aboriginal age peers, particularly in remote rather than urban settings (The Kirby Institute, 2018). A number of research initiatives have focused on addressing these disparities. One of them, the “More Options for STI Testing” (MOST) trial being conducted in the Northern Territory of Australia between 2013 and 2020, had as its original aim to trial two strategies to increase sexually transmitted infection (STI) testing among Aboriginal young people: the use of an incentive to encourage clinic-based STI testing and the use of community-based specimen collection to facilitate STI testing among young people reluctant to attend clinics. To assess the validity of these strategies for the community setting, and identify how they might best be implemented, Aboriginal young people in one remote setting were employed as “peer researchers” and trained and supported to conduct qualitative research to better understand young people's

experiences accessing STI testing services. These peer researchers also participated in workshops to review, validate, and advise on implementation of these strategies prior to the trial commencing, or reject strategies that were not deemed appropriate for use.

Drawing on peer research with Aboriginal young people during 2015 to 2017 in a remote setting in the Northern Territory, Australia, this article documents the process of working with Aboriginal young people as coresearchers—rather than research participants—to support self-determination and community control in qualitative sexual health research. This was a collaborative study with Aboriginal research officers employed by a local Aboriginal primary health care service in Alice Springs. The underlying principle of this work is to acknowledge, integrate, and learn from the agency, expertise, and insight that Aboriginal young people bring to sexual health research. We review the research process and outcomes of this peer research, while considering the further steps needed to move toward the more systemic use of decolonizing research methods.

Background

Self-Determination and Community Control

Indigenous peoples' right to participate in the planning and implementation of their health care is recognized internationally in the World Health Organization's (WHO) 1978 *Declaration of Alma-Ata* (WHO & UNICEF, 1978) and the *United Nations Declaration on the Rights of Indigenous Peoples* in 2007 (UNDRIP; UN General Assembly, 2007). The UNDRIP, endorsed belatedly by Australia in 2009 (Mazel, 2016), was the first international declaration to recognize the collective, cultural, religious, social, economic, and political rights of Indigenous peoples. It acknowledges Indigenous peoples' right to self-determination, defined as the freedom to determine political status and pursue their economic, social, and cultural development (Mazel, 2016; UN General Assembly, 2007). The right of self-determination is in addition to the right which all people have to freedom from discrimination (UN General Assembly, 1966).

In Australia, the struggle by Aboriginal peoples for self-determination significantly predates these Declarations (Foley, 2000). Building on long-standing grievances, discriminatory policy agendas such as White Australia Policy and Assimilation eras, as well as the failure to address health, education, employment, and community needs, the Aboriginal civil rights movements grew under the banner of self-determination in the 1960s (Mazel, 2016; Thomas et al., 2014). The establishment of the first Aboriginal Community Controlled Health Service in

1971—the Redfern Aboriginal Medical Service in Sydney, New South Wales—signaled a new approach to health care for Aboriginal people based on the principle of self-determination through “community control” (Foley, 1991; Mazel, 2016; Thomas et al., 2014). Here, Aboriginal communities claimed control over issues directly affecting their health, including determining the pace, shape, and manner of change and decision-making at local, regional, state, and national levels (K. Bell et al., 2000; National Aboriginal Community Controlled Health Organisation, 2019). In 1972, the Whitlam Government advanced self-determination as the principle underlying government policy-making in Aboriginal affairs (Mazel, 2016). However, this principle has not been consistently upheld by subsequent governments (Bond et al., 2019; Mazel, 2016; Sherwood & Geia, 2018).

As with health service delivery, self-determination and community control are the central principles of ethical, appropriate health research with Aboriginal peoples (National Health and Medical Research Council [NHMRC], 2018b). In 1983, John Liddle and Barbara Shaw—on behalf of the Central Australian Aboriginal Congress Aboriginal Corporation, which was established in 1973 and has provided health services and a platform for equity and social justice for Aboriginal people in Central Australia—took the first formal steps to gain community control in Aboriginal health research by drafting a series of “Research Guidelines” (Liddle & Shaw, 1983). These guidelines specified Aboriginal participation in and control of research of need and benefit to communities; the use of culturally sensitive methodologies; and full Aboriginal control over the dissemination of findings (Humphery, 2001). In 1986 and 1987, conferences in Alice Springs, Northern Territory, and in Camden, New South Wales, identified research priorities in Aboriginal health, developed research ethics guidelines, and advocated for Aboriginal supervision of health research and health research funding (K. Bell et al., 2000; Houston, 1987; Humphery, 2001; Johnstone, 2007). In 1991, the Australian NHMRC released the first set of national ethical guidelines for Aboriginal health research (NHMRC, 1991), most recently updated in 2018 (NHMRC, 2018a, 2018b).

Decolonizing Methodologies and Methods

In her book, *Decolonizing methodologies*, Linda Tuhiwai Smith (2012) argued that decolonized research can advance and develop Indigenous peoples’ aspirations if undertaken from within a framework of self-determination and social justice; when underpinned by values and principles that are consistent with those of Indigenous peoples; and if led by and with clear benefit for Indigenous peoples. Under such conditions, research can be an

important vehicle for change. To support principles of self-determination, a number of researchers have advocated a decolonizing approach to Aboriginal health research in Australia (Bainbridge et al., 2013; Bond, 2019; Clapham, 2011; Doyle et al., 2017; Humphery, 2001; E. Kendall et al., 2011; S. Kendall et al., 2019; Martin et al., 2019; Prior, 2007; Rigney, 1999; Rowe et al., 2015; Sherwood, 2010; Walker et al., 2014; West et al., 2012; Wilkin & Liamputtong, 2010), to redress long-standing power imbalances and ensure that colonized peoples have space to lead and communicate from their own perspectives.

It is important to differentiate between decolonizing methodologies (i.e., the approach underpinning how research should be done) and methods (i.e., the specific techniques used to gather data and analyze evidence; Tuhiwai Smith, 2012). Positivist approaches to research require researchers to investigate health issues through observation and discovery (S. Bell & Aggleton, 2016). Decolonizing methodologies seek to build on the interests and agendas of Aboriginal people in pursuit of social justice, by prioritizing subjectivity and privileging Indigenous peoples’ voices, knowledge, and worldviews, and ensuring that Aboriginal people lead as experts in making sense of their own lives and diverse lived experiences (Bainbridge et al., 2015; Prior, 2007; Rowe et al., 2015; Sherwood, 2010; Walker et al., 2014). Decolonizing methods often involve participatory and community-based techniques that seek “emic,” or insider, insight through conversation, listening, and understanding, privileging the interpretation of data by Aboriginal people and shifting decision-making power and control over the design and conduct of the research (Bainbridge et al., 2015; Dudgeon et al., 2010; Mazel, 2016; Mooney-Somers et al., 2011; Tuhiwai Smith, 2012; Wilkin & Liamputtong, 2010).

In its fullest manifestation, a decolonizing approach requires research relating to Aboriginal people to be initiated and led by Aboriginal people (Bond, 2019; Humphery, 2001; Johnstone, 2007; Rigney, 1999; Tuhiwai Smith, 2012), including the identification of research priorities, the distribution of funding, the conduct of the research itself, and dissemination. If non-Aboriginal people are involved, this should be on terms decided by Aboriginal people (J. Ward, personal communication, 9 October 2019). Importantly, Aboriginal leadership in Aboriginal health research does not mean non-Aboriginal researchers can abdicate their own responsibilities as part of the decolonizing process (Johnstone, 2007; Tuhiwai Smith, 2012). Instead, it requires non-Aboriginal researchers to work as trusted “accomplices” (Finlay, 2020), standing and acting with Aboriginal researchers, and to be committed to reflecting critically on their research practice and building partnerships with community benefit and

transformational impact (Clapham, 2011; Dudgeon et al., 2010; Humphery, 2001; NHMRC, 2018a; Prior, 2007; Tuhiwai Smith, 2012).

Peer Research Approaches

One promising way to move toward achieving these goals is through “peer research,” which positions local community members at the center of the research. Peer researchers are members of a community, kinship, or other social networks, who often with no prior research experience, undertake training in research methods, become trusted, equal members of a research team, and work as researchers within their own communities or networks (Price & Hawkins, 2002). They typically take responsibility for leading one or more parts of the research cycle including research question identification, study design, participant recruitment, data collection, data interpretation, and data analysis.

Peer research first emerged from the participatory research paradigm that started in the late 1970s (Chambers, 1983) and which called for grass roots, community-led problem identification, and planning to solve health problems, based on recognition that community members are experts on their own lives. An early example of peer research took the form of “lay researchers” conducting health research in rural communities in South India in 1979 (Nichter, 1984). Peer research has been used since then to explore a wide range of health and social issues including mental health (Di Lorito et al., 2017; Guta et al., 2013; Littlechild et al., 2015); sexual, reproductive, and maternal health (Burke et al., 2017; Elmusharaf et al., 2017; Hawkins et al., 2009; Longfield et al., 2007); HIV (Angotti & Sennott, 2015; Greene et al., 2009; Logie et al., 2012; Longfield et al., 2007); disability (Burke et al., 2017); drug use (Coupland & Maher, 2005); and aging (Littlechild et al., 2015; Porter, 2016). It has been used with marginalized or vulnerable people in diverse social and cultural communities in high- (Greene et al., 2009; Guta et al., 2013; Littlechild et al., 2015; Longfield et al., 2007) and low- and middle-income (Angotti & Sennott, 2015; Elmusharaf et al., 2017; Hawkins et al., 2009; Porter, 2016; Porter et al., 2010) countries.

Peer research offers several potential benefits. Peer researchers may access population groups—and their social and cultural knowledge and experience—that may be difficult to reach using conventional research methods (Angotti & Sennott, 2015; Coupland & Maher, 2005; Kilpatrick et al., 2007; Porter, 2016; Rewi, 2014). An enhanced understanding of health and social issues may arise through research practices that build on trust and use cultural protocols not available to outsiders (Angotti & Sennott, 2015; Coupland & Maher, 2005; Kilpatrick

et al., 2007; Porter, 2016; Rewi, 2014). Peer research can also be justice focused: offering meaningful employment and skills development opportunities and showing respect for the expertise and knowledge that community members bring to research (Guta et al., 2013; Logie et al., 2012). Through dialogue and the coproduction of knowledge (Guta et al., 2013; Porter, 2016), peer research can support the transition from a community member to a researcher, advocate, and changemaker in policy and practice.

Yet peer research is not without drawbacks. There are concerns about how peer researchers are selected and to what extent they are truly representative of the population under study (Angotti & Sennott, 2015; Di Lorito et al., 2017; Israel et al., 1998; Porter, 2016). Ethical questions may arise relating to how peer researchers choose their interviewees, relationships of trust between peers and interviewees, and the potential for misuse of knowledge gained about people’s private lives (Greene, 2013; Rewi, 2014). Peer researchers must manage the roles and responsibilities associated with multiple identities, which can include friend, family member, and confidante on top of being a researcher (Greene et al., 2009; Porter et al., 2010; Rewi, 2014). Paternalistic relationships between “skilled” academic researchers and “less skilled” community trainees may inhibit community control over research agendas (Di Lorito et al., 2017; Israel et al., 1998). Concern has also been expressed about the reliability, validity, and credibility of data collected and analyzed by people who are not formally qualified academically (Kilpatrick et al., 2007; Lushey & Munro, 2015), and the challenges associated with sustained support for peer researchers in research (Angotti & Sennott, 2015).

In our eyes, however, the benefits of such an approach outweigh its weaknesses, especially when considering research with Aboriginal peoples for whom issues of self-determination and community control are paramount. We therefore document the utilization and adaption of a specific peer research model that has been used in health research to centralize the voices of marginalized populations in diverse cultural settings (Elmusharaf et al., 2017; Hawkins et al., 2009; Price & Hawkins, 2002), reflecting on its potential as a decolonizing methodology and method.

Working With Aboriginal Young People as Peer Researchers

Prior to commencement of the MOST trial, in one remote community, we worked with Aboriginal young researchers in two ways: first, in formative peer research to better understand young people’s current and past experience accessing STI testing services; second, in workshops to review, validate, and advise on implementation of proposed strategies to be trialed during the MOST study.

The work was led by Stephen Bell (S.B.) and Andrew Lockyer (A.L.), with support from Tellisa Ferguson (T.F.) during the training stages of the study. Ethical approval for the study was granted by the Central Australian Human Remote Ethics Committee (HREC 15-314) and noted by the University of New South Wales (UNSW) Sydney Human Research Ethics Committee. Enhanced procedures to secure verbal and written voluntary informed consent covered the role and responsibility of peer researchers in training, data collection, and analysis, as well as in the recruitment and interviewing of peers. Permission was granted to pay peer researchers in cash at an entry-level rate for work in an Aboriginal Community Controlled Health Service. A step-by-step description of the work undertaken is as follows.

Formative Peer Research

Sampling and recruitment of peer researchers. Purposive sampling (Bryman, 2016) was used to identify eight peer researchers (aged 16–19 years; equal split by gender) who agreed to be trained to collect data relevant to the sexual health experiences of Aboriginal young people. Recruitment was guided by inclusion criteria based on age (16–19 years), self-identification as Aboriginal, residency within the remote location, availability for the 4- to 6-week period required to complete the research training and process, and willingness to contribute to the study. Eight peer researchers, each recruiting a further two participants into the study, would provide a total target sample of 24 young participants offering their perspectives and views on the study objectives in this small town. To ensure breadth of coverage, an additional requirement for the overall team was the inclusion of individuals from two or more kinship and friendship groups, as well as residency in two or more geographic locations within this setting.

A male Aboriginal research officer, A.L., at the local Aboriginal primary health care service worked with S.B. to recruit the peer researchers. At the time of the project, A.L. was in his 40s, a long-term local resident, a father and uncle to young people aged 16 to 21 years, and a sports coach with young people outside work. Recruitment took place by A.L. through existing sports, work, and extended family networks.

Participatory research training. The eight peer researchers attended a 4-day research training workshop to prepare them for their role. Training was completed with four male and two female peer researchers; two female peer researchers had to withdraw during the first training day for personal reasons.

Training consisted of participatory activities—including activities such as group discussion, brainstorming,

role play, and values clarification and visual methodology including community mapping and problem tree analyses—to support the peer researchers' practice-based learning and trust building among the research team. S.B. led the training with support from A.L. and another female Aboriginal research colleague, T.F., to enable same-sex group discussion when needed. Training took place in a basketball court complex known to young people, perceived as comfortable and safe by the peer researchers, and with audio-privacy.

The workshop was structured around four to five sessions each day to fulfill core objectives. These included explaining the purpose of the study and peer researcher responsibilities; developing “conversational” semi-structured in-depth interviewing skills; developing an understanding of the individual, interpersonal, community, institutional, and structural factors that influence young people's sexual health and access to sexual health services; learning about applied research ethics with a particular emphasis on confidentiality, anonymity, informed voluntary consent, and the use of participant information sheets and consent forms; reviewing, revising, piloting, and practicing interviews using the interview guides which had been drafted by study investigators in advance of submission for ethics review; the use of a digital recorder and data management; and the identification and recruitment of interviewees from within peer researchers' own social networks.

Interviews with peer researchers. As part of the training, in-depth semi-structured interviews were conducted with each of the six peer researchers by S.B., with support from A.L. and T.F. Interviews explored three themes relevant to the study: Aboriginal young people's sexual experiences and relationships (Theme 1); awareness of STIs and risk practices (Theme 2); and STI prevention, risk reduction, testing, and treatment (Theme 3). Interviews lasted between 28 and 53 minutes (average length 38 minutes) and were audio-recorded and conducted in audio-private settings. They took place during the afternoon and evening of the first day of peer researcher training to ensure that later discussions during peer researcher training did not influence the responses given.

There were four reasons for doing this. First, it enabled the piloting of draft topic guides that had been prepared. Second, it offered a “teaching” opportunity in which peer researchers could experience being interviewed about sensitive sexual health issues, as well as introducing two key ethical components of the study design. The interviews used “third person interviewing”—that is, eliciting accounts from interviewees about how they understand the practices, experiences, and perspectives of *other people* like themselves in their community, rather than themselves—to enable interviewees to talk about sensitive

issues without personal attribution (Price & Hawkins, 2002). Furthermore, a “no names rule”—whereby peer researchers and their interviewees are discouraged from using names of other young people discussed during data collection—was used to ensure that no identifying information arose in narratives during data collection. These learning experiences were later drawn on in training about interview techniques and the ethical conduct of research. Third, involvement of the two Aboriginal research officers (A.L. and T.F.) in the interview process supported institutional research training and trust building. Finally, the process provided data on the topics of interest from Aboriginal young people that could potentially be used as a fallback, should the peer research approach to be adopted later fail. Data from these interviews were included in the final study data set.

Peer interviews and interpretation. Subsequently, peer researchers were asked to recruit interviewees of the same gender and age, using snowball sampling (Bryman, 2016) from within their social networks. Three short interviews lasting between 10 and 30 minutes were conducted with each interviewee, each focused on one of the three themes noted above. A total of 14 participants were recruited by the six peer researchers, including 8 young men and 6 young women aged 16 to 21 years. All peer researchers conducted interviews with two peers, though one young woman went on to conduct two unsupported interviews with additional peers to increase the sample of young women involved in the study. In total, peer researchers conducted 14 in-depth interviews per theme.

Data collection proceeded in a cycle whereby each peer researcher conducted an interview on Theme 1 with each of their interviewees within a 48-hour period, and then immediately attended a debriefing interview with S.B. and A.L. The same process was then repeated for Themes 2 and 3. The use of three short interviews rather than one extended interview provided an opportunity for extra mentoring during the debrief that followed each cycle of interviews.

Debriefing fulfilled four functions. First, the digital audio files for peer researchers' interviews were transferred to a password-protected folder on S.B.'s computer and erased from the digital recorder. Second, at least one full interview recording was listened to jointly with the peer researcher, who was asked about words or phrases that were unclear and prompted for their expert understanding and interpretation of the issues and experiences discussed. Third, while listening to the recording, notes were made of the peer researcher's interviewing skills that were worthy of encouragement as well as improvement. These were discussed at the end of the interview with a focus on strengthening interview technique. Finally, debriefing interviews enabled the monitoring of

data collection; if information gaps were identified, peer interviewers were encouraged to develop follow-up questions to be asked subsequently. Debriefing discussions across all three themes lasted between 2 and 3 hours (average length: 156 minutes). The length of these discussions was dependent on the length of peer researcher interviews listened to during the process.

All interviews were conducted in audio-private spaces at home, in school, or in community settings chosen by peer researchers and their interviewees. Combined recordings for the three themes together lasted between 17 and 92 minutes (average length of 38 minutes). Typically, Theme 1 interviews were the shortest, but as peer researchers' skills and confidence improved, interviews became more detailed and longer.

Workshop Activities

After completing their interviews, the six peer researchers participated in workshops which involved activities with the specific aim of reviewing and adapting strategies that had been proposed for trial by study investigators in the MOST study. Two workshops were conducted, each lasting 3 hours: one was attended by three peer researchers in school (one young woman, two young men) and the other was attended by the peer researchers who were no longer in school (one young woman, two young men).

In preparation for these workshops, S.B. and A.L. reviewed the peer researcher and debriefing interviews and conducted an initial thematic analysis of data using inductive techniques (Strauss & Corbin, 1990). S.B. and A.L. identified first-level codes and supporting example quotes for each of the three themes to ensure strategy design was informed by the data peer researchers had collected. A presentation of this thematic data was prepared on A1 flipchart paper and placed around the room in which the workshops were conducted. Presentation of data in this way ensured that male and female peer researchers were aware of findings from the full data set, rather than only the interviews they conducted, and that the data could be referred to by peer researchers as required throughout workshop activities.

Each workshop consisted of three activities in sequence, led by S.B. and A.L. First, key findings from each of the three themes were presented via an interactive question-and-answer session whereby peer researchers were invited to reflect and provide feedback on the themes and quotes presented on the flipchart paper around the room. Second, problem-solving activities using a structured topic guide were undertaken to explore the utility and implementation of the two proposed intervention strategies for the MOST trial: (a) an incentive program to increase STI testing within Aboriginal primary health care settings and (b) the safe, confidential

provision of urine specimen for STI testing without having to attend a health clinic. Third, a brainstorming activity explored other possible ways of increasing STI testing.

All workshop discussions were audio-recorded and undertaken in an audio-private meeting room in the offices of the local Aboriginal primary health care service. The workshops were transcribed so that the data and conclusions from the workshops—that is, peer researchers' words, views, and opinions about the intervention strategies—could be used to inform the final design of the MOST trial protocol.

Learning From Experience— Aboriginal Young People's Research Practice

Enhancing self-determination and community control in health research studies such as this requires a commitment to building on the existing skills and strengths of young Aboriginal researchers to undertake high-quality research on issues of community concern (Clapham, 2011; Dudgeon et al., 2010; Prior, 2007; Tuhiwai Smith, 2012), recognizing that young Aboriginal people have expert knowledge about themselves, their circumstances, and the solutions to their needs and problems (Tuhiwai Smith, 2012). Here, we draw on data collected from peer researchers during debriefing interviews. We undertook an inductive thematic analysis (Strauss & Corbin, 1990) of data collected from the six peer researchers during the debriefing interviews, with a particular focus on discussion of their research practice and involvement in the study.

Interviewing About Difficult Topics

All the peer researchers were actively involved in training, peer interviews, debriefing, and the workshops. A crude indicator of their success is the average length of interviews with their peers (38 minutes) compared with that of the study investigators with the peer researchers (38 minutes). As would be expected, however, there was some variation in the interviews conducted. One peer researcher out of school and one in school considerably outperformed the other peer researchers in terms of their response to feedback during debriefing meetings, eliciting more detailed and more nuanced accounts as the interviews progressed, compared with the other peer researchers.

The average length of interviews was quite short, however, which illustrates the difficulties peer researchers and investigators experienced engaging young people in in-depth conversation about sensitive topics that some may never have talked about to anyone before. A

16-year-old peer researcher described how awkward he felt asking respondents about STIs and sexual health: "I felt rude asking about it." He also reflected on an interviewee's body language when talking about peer pressure to have sex at a party.

I think, just the look on his face, I think he was talking, thinking about what's happened with him . . . He's looking at the ground and looking really lost and stuff . . . Maybe he's got drunk and had sex, whatever, and it's happened to him. Maybe. (peer researcher, 16 years old)

This quote illustrates peer researchers' ability to reflect on and interpret the meaning of body language during their interviews, as well as the range of talents and skills they developed beyond asking questions. These challenges also point to value in exploring other qualitative techniques that could be used by peer researchers to engage young people in creative and perhaps less pressured forms of research interaction.

Navigating Complex Interactions

Peer researchers described diverse interactions with interviewees, the challenges this brought to conducting interviews, and the strategies they used to manage them. Another 16-year-old peer researcher explained how to begin with, one of his interviewees was "being a bit of an idiot . . . just giggling and being stupid, talking shit." As a researcher, he realised he had to let the interviewee "get it all out" before he was able to focus on the content of the interview. Another 16-year-old peer researcher explained that, to begin with, one of her interviewees "gave me closed answers" because they were "really nervous at the start, being interviewed [and] 'cos she didn't know what it was about'." As a researcher, she explained that by "keeping talking and asking more questions," interviews "got better" as interviewees became more familiar with the process.

A 19-year-old peer researcher explained that she had deliberately chosen interviewees with contrasting personalities to ensure she explored a range of different sexual health experiences. She said,

[Interviewee] was happy to share stories and talk about it all [. . .] I couldn't get her to stop talking! She was a good person to interview. I didn't even ask the question but at the end [talking about improving services for young people] she was like, "Oh, we need to improve on this and that" (peer researcher, 19 years old).

This peer researcher said her other interviewee was "shy," feeling "more shame" when sharing her thoughts about the interview topics. But the peer researcher explained, "that's just how she is all the time," and the

interview experience simply exacerbated the situation. She explained that she reassured the interviewee that it was okay “to speak the truth” and that the research was “to help young Indigenous people.” She realized she “had to be more patient and encouraging” and to let the interviewee “have space to answer.”

Developing Reflective Practice

Peer researchers felt a sense of achievement as they transitioned from feeling “really nervous” (peer researcher, 16 years old) to feeling “proud” (peer researcher, 16 years old) when listening to their interviews and realizing the value of their work. Data from the debriefing identified the particular interviewing skills developed, as well as peer researchers’ ability to reflect on their research practice. Several peer researchers reflected on how they might have taken a bit more time to interrogate interviewees’ initial responses using prompts and probing questions:

I should have slowed down a bit. I was just spitting the questions out. I could have asked for more when he gave me the answers, like “why is that?” or “how was that?” Um, I didn’t use all the prompts that were [in the topic guide] which I could have . . . With his answers about support and friends, I would ask more questions, “Can they always be trusted?” Um, “Are they always there for you?” Some question like that. (peer researcher, 16 years old)

Peer researchers also came to value the importance of silence as part of the research process. After listening to his first interviews, another 19-year-old researcher said, “listening to the answers, I think the main thing for me would be to just give them a bit more time.” When asked how he might do that, he said, “I should just relax in the process. If there’s silence, there’s silence. It doesn’t matter, you know? Let them fill it.” After practicing these skills during the second interview, he said, “It was much easier . . . It just felt like fluid and easy flowing stuff. It was more of a conversation rather than question and answer.”

The 19-year-old peer researcher, who went on to conduct a further two full interviews without support after completing the peer research process with her first two interviewees, reflected on how she just tried to “follow the conversation,” asking questions based on what the interviewee said, rather than simply moving through the list of questions in the topic guide:

S.B.: That was good! You’re a natural. You came up with questions that we’d not even thought of.

Peer researcher: I was like, oh, I don’t know if I’ll get into trouble [for not following the guide], but I just, I knew the

questions were related, like it was around [the issues in the guide] so I just asked anyway.

S.B.: Yeah, like I said, the questions that we’ve got here are just guides. The main themes, the main questions, they’re the topics we want interviewees to talk about. (peer researcher, 19 years old)

It Is a Two-Way Process—Advisory Support

In addition to acquiring new research skills, peer researchers fulfilled an advisory role. One way they did this was to help the lead author understand the content and narrative of some of the interviews. For example, they explained the meaning of local terms used by young people. The word “tracks” was used as slang for “disease,” and the terms “chore” and “albor” were used by young people to refer to the significant relationships of lifelong support—that is “brothers”—that develop between young men who go through cultural initiation processes (or “men’s business”) together.

Peer researchers also provided context to the recorded interviews that might otherwise have been missed. For example, during the playback of an interview conducted by an 18-year-old peer researcher, the interviewee gave a range of reasons why young men have sex. In addition to typical responses such as “for fun,” “because my friends are [doing it],” or “because this chick wanted to have sex with me,” the respondent paused and quietly added, “because of love, getting older together, having family and getting a house.” This response was rather different to the majority of data collected. After some probing by A.L., this peer researcher eventually explained that he knew his interviewee had “just met a chick” and “he might be thinking that she could be a girlfriend . . . ‘cos she’s pretty lovely’.” This prompted insight into a different vocabulary young men use to describe the young women they meet socially.

Finally, peer researcher involvement in the workshops helped shape the development of the two interventions proposed by study investigators during the grant writing process to enhance access to STI testing. The first of these—the use of direct incentives for STI testing—is currently being evaluated in the MOST trial. Peer researchers’ recommendations influenced the type (i.e., mobile phone credit) and value (i.e., AUD\$30) of a suitable incentive; the specific aspects of test, treat, and retest cycle that should be incentivized; and the clinical protocol regarding timing and location of the offer and distribution of incentives by a clinician to maintain client confidentiality. The involvement of peer researchers in the workshop led to the rejection of the other intervention which the research team had proposed—namely, the collection of urine specimens for STI testing without having to attend a clinic—due to concerns about establishing

safe, confidential mechanisms through which specimens can be collected and then transferred to clinics for testing.

Peer Research as a Decolonizing Practice?

This article reports on the processes and value of working with young Aboriginal community members as peer researchers in a study conducted in a remote Australian setting. In accordance with literature on decolonizing methodologies (Prior, 2007; Tuhiwai Smith, 2012), the study recognised the agency of young Aboriginal people and enhanced the skills, understandings, and cultural knowledge of both the Aboriginal and non-Aboriginal researchers. The insight gained from working with young peer researchers was invaluable in relation to the range of data collected (S. Bell, Aggleton, et al., 2020; S. Bell, Ward, et al., 2020), the depth of interpretation possible, and the shared decision-making in relation to potential interventions to be incorporated in the MOST trial. The prioritization of young Aboriginal people's sensemaking in research translation for health service practice is a key principle of decolonizing methodologies (Dudgeon et al., 2010; Mazel, 2016; Tuhiwai Smith, 2012; Wilkin & Liamputtong, 2010).

An 18-day training period, including follow-up support, enabled young Aboriginal researchers to undertake high-quality research on issues central to their lives (Clapham, 2011; Dudgeon et al., 2010; Prior, 2007; Tuhiwai Smith, 2012). Debriefing interviews revealed that peer researchers enjoyed the work, felt they had grown in confidence during the study, learned new skills, were proud of their achievements, and were happy to be paid for their expertise for the first time. As seen in other peer research studies (Angotti & Sennott, 2015; Kilpatrick et al., 2007; Logie et al., 2012; Porter, 2016), they developed existing and acquired new skills and expertise in research itself with a particular focus on communication, interviewing, and body language, and all took their involvement in the work seriously. They were paid at the recommended rate for 19-year-olds undertaking an entry-level administrative role in accordance with the Australian Government Fair Work Commission's "Aboriginal Community Controlled Health Services Award 2010," as approved by the Board at the local Aboriginal primary health care service. They also received a certificate of attendance outlining the work they had done.

The use of a peer research technique facilitated a close to the ground, emic understanding of young people's lives, in ways that privileged Aboriginal young people's perspectives and experiences. This is another key principle of decolonizing methodologies (Prior,

2007; Rowe et al., 2015; Sherwood, 2010; Walker et al., 2014). Our sampling approach—facilitated by A.L., an Aboriginal research officer with local social and cultural knowledge, networks, and expertise—ensured a reasonably diverse sample of peer researchers. The six peer researchers included young people in (two young men, one young woman) and out of school (two young men and one young woman), with representation from five family networks, four friendship networks, two schools, and four different suburbs in the setting. As a result, broad insight was gained into strategies and approaches to enhance STI testing and health service utilization in a way that was responsive to different young people's circumstances and needs.

Despite these achievements, there is still much to be done to develop research approaches that are initiated, designed, implemented, and led by Aboriginal young people in pursuit of decolonizing (Sherwood, 2010; Tuhiwai Smith, 2012) or Indigenist (Bond, 2019; Rigney, 1999) research agendas. A limitation in this case was that the engagement of Aboriginal young people as coinvestigators representing their Aboriginal communities in a peer research approach was introduced into the study design after the MOST trial had received funding from the Australian NHMRC. As such, input from peer researchers was sought into the implementation and feedback on trial strategies that had already been defined by an investigator group comprising a mix of adult Aboriginal and non-Aboriginal academic researchers, policy makers, and health service practitioners. A major shift is required if young people are to be involved as key actors in decolonizing research processes, whereby their skills, expertise, and ideas trigger the need for research and young community members are integrated as coinvestigators to lead research in the earliest stages of research codesign.

With regard to method, as evidenced by some peer researchers' discomfort in undertaking one-to-one in-depth interviews with people they already knew and trusted about sensitive sexual health issues, we caution against privileging any one model of peer research. Alternative approaches—including yarning (Walker et al., 2014), photovoice and photo elicitation techniques (Wilkin & Liamputtong, 2010), participatory video (Schwab-Cartas & Mitchell, 2015), and art (Flicker et al., 2014), for example—hold the potential to engage young people in culturally appropriate research processes and interactions. Ways of supporting young people to conduct research using such techniques should be further explored.

Another limitation derives from the lack of sustained opportunities for peer researchers to be involved in dissemination of research findings from this study, to conduct research beyond the activities in this study, or indeed to find pathways to further career development in this area. All too often in peer research (Kilpatrick et al.,

2007) and Aboriginal health research (Humphery, 2001), there exist few employment opportunities for community researchers beyond the initial project cycle, mitigating against the development of a professional research career (Greene et al., 2009; Guta et al., 2013; Littlechild et al., 2015). Since the work described here took place, there has been staff turnover in the local Aboriginal primary health care service, with the two Aboriginal research officers based there moving on to other jobs. There is also no ongoing direct contact between the peer researchers and the MOST investigator team. This means we were not able to involve them in further analyses of the data beyond their engagement in the peer research cycle described above, nor the resulting publications (S. Bell, Aggleton, et al., 2020; S. Bell, Ward, et al., 2020). There are also no further support or training opportunities for them.

Much work is required to ensure these limitations do not occur in future peer research studies with Aboriginal peoples in Australia. As a future priority, we must try to ensure employment opportunities for Aboriginal young people to continue to acquire and practice research skills. To support future employability, we should commit to support—offered flexibly in safe spaces both within and beyond university settings (Elston et al., 2013)—to gain the formal qualifications that provide evidence of young Aboriginal researchers' skills. A starting point could be a system for peer researchers to be registered and supported to proceed to a nationally accredited certificate program in community health research. Supporting the careers of younger Aboriginal researchers and the systemic use of decolonizing methods are essential for decolonizing health research in this national setting.

In Conclusion

Decolonizing methodologies seek to reposition those who have hitherto been the objects of research as experts, leaders, critics, theorists, knowers, and communicators (Ndlovu-Gatsheni, 2017). In so doing, they seek to bring the agency and experience of colonized and subjugated peoples to the fore (Tuhiwai Smith, 2012). With a commitment to self-determination and community control of research processes (Johnstone, 2007)—and working in partnership with Aboriginal and non-Aboriginal representatives of academic research institutions and an Aboriginal Community Controlled Health Service, as well as young Aboriginal community members—this qualitative study sought to put Aboriginal young people and their experiences at the heart of sexual health research in one remote Australian setting. While meeting these objectives within the context of this study, much more remains to be done. In particular, action is needed to ensure young Aboriginal researchers lead future research on the sexual health inequities that persist in Australian society.

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