Girinyalanha Giilang (Talking about a Story):

Enablers and barriers to sexual health resources among young Aboriginal and Torres Strait Islander people in Murrumbidgee Local Health District.

UNSW Kirby Institute

UNSW SYDNEY

NSW GOVERNMENT Health Murrumbidgee Local Health District

The investigators would like to acknowledge the Traditional Owners of this land and pay their respects to Elders past and present.

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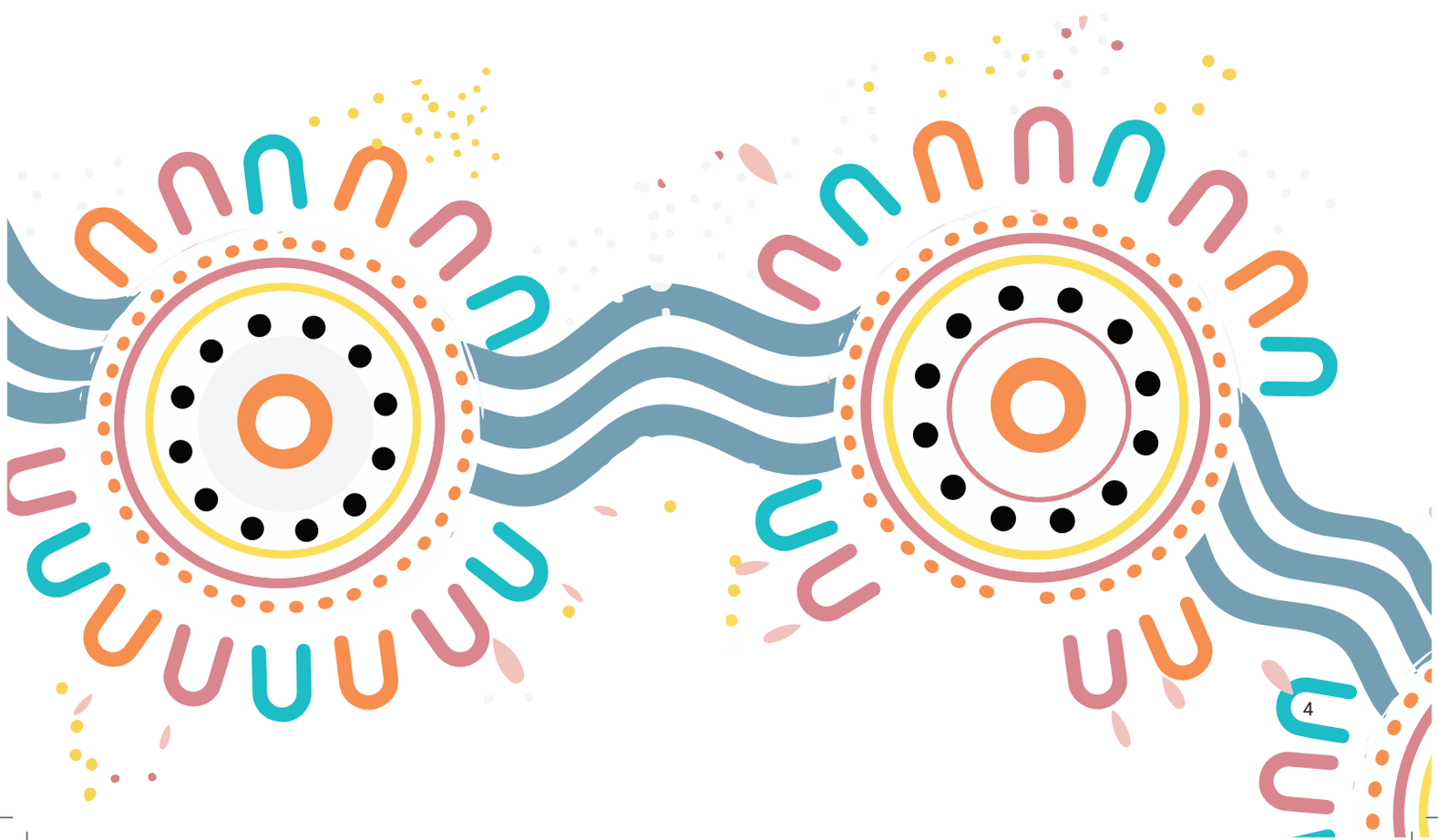


Where was this research done?

Girinyalanha Giilang means ‘talking about a story’ in Wiradjuri language.
The three sites in which the study took place – Griffith, Narrandera and Wagga Wagga – are on Wiradjuri country.

Why was this research done?

Young Aboriginal and Torres Strait Islander people are listed as priority groups in policy and strategy documents in Murrumbidgee Local Health District (MLHD), New South Wales, and Australia. Key recommendations across these strategies include:

- improving access to health services, including sexually transmissible infection (STI) testing and education;
- ensuring that STI data is informed by Aboriginal and Torres Strait Islander people's perspectives;
- development and delivery of culturally appropriate health services and programs;
- building partnerships and reducing stigma and discrimination related to STIs and HIV [1-4].

Overall, STI rates are higher among Aboriginal and Torres Strait Islander people living in regional and remote areas. This graph shows that rates of STIs among Aboriginal and Torres Strait Islander people living in remote or very remote areas are 4, 23 and 38 times higher for chlamydia, gonorrhoea and syphilis than non-Aboriginal people living in the same areas [5]. Prevalence, meaning the number of current infections, was higher for chlamydia in regional areas (17.1%) and for gonorrhoea in remote areas (12.6%) [6]. In general, we know that the risk of STIs increases the more remote the location, but we don't have specific information about this in young Aboriginal and Torres Strait Islander people.

Testing is an important strategy for reducing the harms of STIs, as it can lead to treatment and cure. Research shows that STI testing and retesting after STI treatment is more common among young Aboriginal and Torres Strait Islander women than young men [7-10]. The GOANNA Survey 2 [11], a survey of young Aboriginal and Torres Strait Islander people across Australia, shows that:

- only about half (52%) of sexually active young Aboriginal and Torres Strait Islander people had ever had an STI test
- men were less likely than women to be offered an STI check;
- young Aboriginal and Torres Strait Islander people in the 16-19 age group were least likely to be offered testing (42%) compared with those over the age of 20 (over 70%);
- living in a regional area reduced likelihood of being offered at STI check

Taken together, these statistics suggest there exist gaps to STI testing for young Aboriginal and Torres Strait Islander people, particularly those who are younger and living in regional areas.

Qualitative research often uses interviews, or talking, to better understand people's perspectives about issues and strengths in their own voice. This style of research can help to explain the numbers reported in survey findings, that is, interview participants can help shine a light on why these things are happening, or in what ways they are happening [12]. Yet, there is little talking research to understand from young Aboriginal and Torres Strait Islander people what they view could be done better to improve their sexual health [13]. Key qualitative research gaps – things we don't know – include:

- what influences young Aboriginal and Torres Strait Islander people's engagement with clinic-based STI testing;
- sexual health of young Aboriginal and Torres Strait Islander people in urban, regional and remote settings, specifically in New South Wales and Victoria;
- how Aboriginal and Torres Strait Islander cultural values support young people's sexual health;
- issues facing young men's access to sexual health services; and
- the experiences of same-sex attracted and gender diverse youth [13].

It is believed that a deeper understanding of these issues will improve delivery of sexual health care in a culturally safe way for young Aboriginal and Torres Strait Islander people [2].

Sexual health research with young people often fails to recognise what young people are doing well. Too often, research about sexual health in Aboriginal and Torres Strait Islander communities uses what's known as a 'deficit discourse' approach, meaning that research focuses on the negative experiences and describes them in a way that blames the community rather than recognising the failures, or shortcomings, of the broader policies and services in which people are accessing care [14].

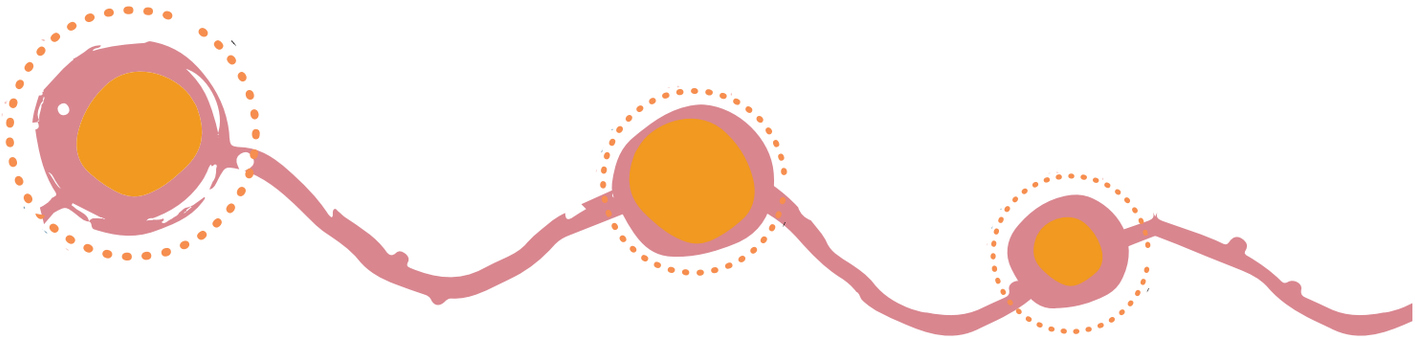
It is important to design research that seeks to understand what young Aboriginal and Torres Strait Islander people already do to maintain control over their health as they become sexually active [13]. Using a strengths-based approach, this study aims to provide much needed qualitative evidence to improve the design of appropriate health promotion programs and health service delivery aimed at reducing STIs among young Aboriginal and Torres Strait Islander people in regional settings, such as MLHD.

Specific objectives were to:

- Document young Aboriginal and Torres Strait Islander peoples' perceptions and experiences of sexual interactions and relationships;
- Examine young Aboriginal and Torres Strait Islander people's access to sexual health information in MLHD;
- Explore the social and cultural factors influencing young Aboriginal and Torres Strait Islander and Torres Strait Islander people's experiences of accessing services for their sexual health needs in MLHD;
- Identify and analyse the strategies young Aboriginal and Torres Strait Islander people are using to protect their sexual health and reduce potential risks; and
- Lay a groundwork of knowledge which may inform service development and delivery.

Who conducted the research?

Kate Whitford,
a non-Aboriginal woman



Bobby Whybrow,
a proud Wiradjuri man

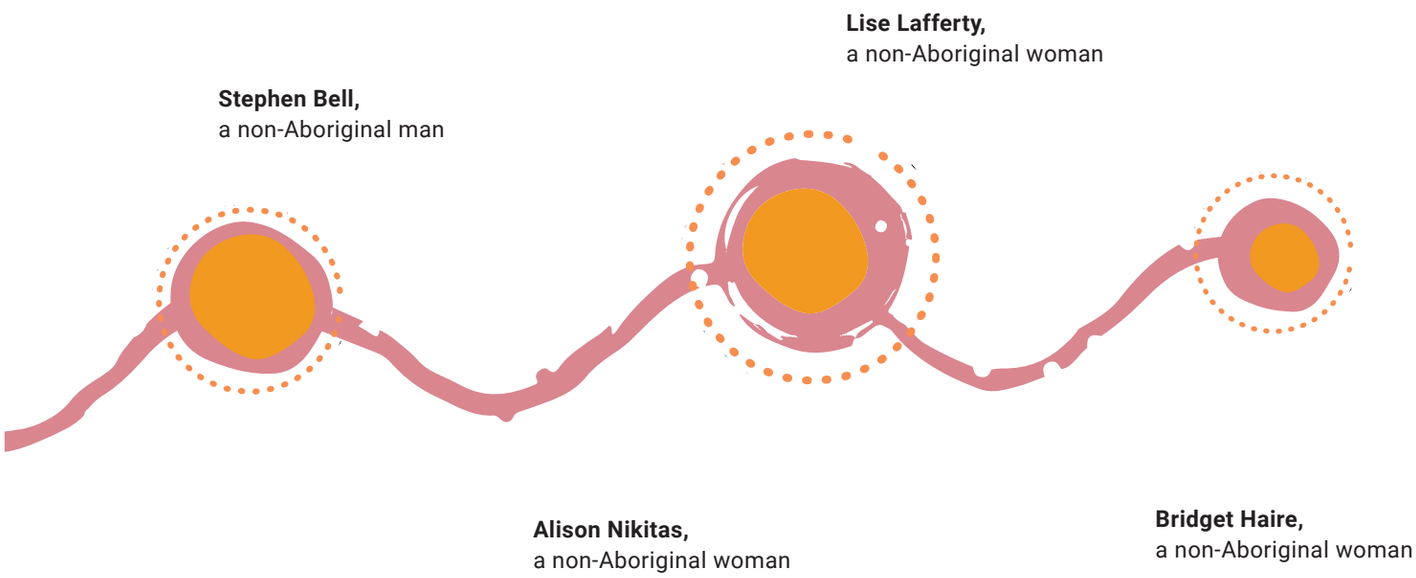
Samantha Williams,
a proud Wiradjuri woman

CO-DESIGN PROCESS

This project was proposed during a qualitative training workshop in Sydney in February 2019. In the initial investigator meetings, the three sites (Griffith, Narrandera and Wagga Wagga) were identified as places that would most benefit from this research project in MLHD. From 2019 to early 2020, Steve, Bobby, Alison and Kate conducted several visits to each of the three sites to meet with key stakeholders and community members to propose the research and assess community need for the project. The investigators had individual meetings with Aboriginal and Torres Strait Islander Elders, health workers, Aboriginal and Torres Strait Islander Medical Service (AMS) staff, youth organization workers, educators and community leaders; and also participated in some community meetings such as Aboriginal and Torres Strait Islander Women's Groups and research meetings.

These visits were key to the effective delivery of the project, as the community were able to highlight any potential issues and signify whether there was community desire for such a project; and the investigators were able to be informed on how to successfully and respectfully deliver the project in these communities.

This project is a collaboration between MLHD and The Kirby Institute, with funding provided by NSW Health. The study investigators are:



DATA COLLECTION AND ANALYSIS

Bobby and/or Kate conducted all the interviews, with Sammy and Steve supporting with some interviews. Interviews with young Aboriginal and Torres Strait Islander men were conducted by Bobby and interviews with young Aboriginal and Torres Strait Islander women were conducted by Kate. Interviews with other key community members, such as Elders, community leaders, health workers, and others were conducted by Bobby and/or Kate.

Alison Nikitas worked with the research team to develop the Talking Story project, Lise Lafferty led the analysis for this report, and Bridget Haire provided oversight of the project.

Who participated in the interviews?

Interviews were completed with young Aboriginal and Torres Strait Islander men and women and other key community members in Griffith, Narrandera, and Wagga Wagga. These communities are all within MLHD.

Narrandera: Twenty young Aboriginal and Torres Strait Islander people participated in interviews in Narrandera, including 10 young Aboriginal and Torres Strait Islander women aged 16-27 years, and 10 young Aboriginal and Torres Strait Islander men aged 15-29 years. Interviews in Narrendara predominantly occurred in February 2020, with the final two interviews with men being conducted at a later date.

Griffith: Twenty-three young Aboriginal and Torres Strait Islander people participated in an interview in Griffith, including 13 young Aboriginal and Torres Strait Islander women aged 15-29 years, and 10 young Aboriginal and Torres Strait Islander men aged 16-29 years. Interviews in Griffith took place in November-December 2020.

Wagga Wagga: Twenty-two young Aboriginal and Torres Strait Islander people participated in interviews, including 12 young Aboriginal and Torres Strait Islander women aged 15-28 years, and 10 young Aboriginal and Torres Strait Islander men aged 15-29 years. Interviews in Wagga Wagga took place in October 2020.

Key informants: Nineteen interviews were conducted with key informants, seven from Narrandera, and 6 each from Griffith and Wagga Wagga. Key informants were individuals who had a range of roles and experiences including Aboriginal Elders, teachers, school workers, youth workers, nurses, Aboriginal Medical Service (AMS) staff and community leaders.

Table 1. Interview participation in Narrandera, Wagga Wagga and Griffith

	Narrandera	Wagga Wagga	Griffith
When interviews were completed	February 2020	October 2020	November-December 2020
How many young people participated	10 young men and 10 young women	10 young men and 12 young women	10 young men and 13 young women
How many key informants participated	7 key informants January – February 2020	6 key informants from December 2019 – October 2020	6 key informants from February 2020 – December 2020

Key findings:

Note: We have changed participant names to protect identity.

1. SEXUAL HEALTH AND WELLBEING

Peer Pressure / Social influence: People across all three communities described peer pressure and social influence as shaping decisions to engage in sexual intercourse at what many described to be an early age. Feelings of shame were often entangled with the age of onset of sexual activity. For example, participants described shame being experienced by young people who had not 'lost their virginity' by the age of 16. However, in contrast to this, there was shame in actively seeking out and addressing one's sexual health. That is, it was perceived by young people that being sexually active was important for social acceptance among peers but accessing health services to address their sexual health was not socially acceptable.

Within the context of communities with limited resources, these social influences presented unique challenges for young Aboriginal and Torres Strait Islander people in MLHD in developing and navigating sexual health agency – that is, making decisions about sex they are comfortable with.

> I think if their friends and everyone else around them is doing it, they will feel like they have to do it. […] I reckon you feel pressure from your friends. Like, they don't actually pressure you, but you're like "oh, they're doing it, so, like why don't I?" (Sandra, 15-19yo, Narrandera)
>
> I remember when I was with my first partner, I was the one like putting the pressure on him. […] Because I felt like there was pressure on me, that I had to, because everyone around me was already doing it, so I felt like I had to do it as well. (Zoe, 25-29yo, Narrandera)

Despite this pressure, young people demonstrated the desire to manage these social pressures and assert agency. A young man in Narrandera said he felt that young people should be comfortable making decisions about sex that are best for them, rather than being influenced by social pressure. When asked what advice they would give their peers about having sex, several of the female participants highlighted the importance that young people should feel 'ready' before having sex, and making sure it's with the right person.

> ***So what, what, um, what advice would you give another young person to stay safe while having sex? Ah, don't be pressured. Don't be pressured?*** Don't be pressured into doing it, do it when you want you, like you don't have to be cool. ***Yeah.*** Like, do it when you want to. (Brent, 15-19yo, Narrandera)

Recommendation: Given the role of peer influence, and that many young people recommended personal decision making over peer pressure, sexual health education delivered to young people should also consider ways to support young people to feel empowered to not only assert their agency but also be able to self-navigate what they feel comfortable with.

Key Findings:

2. ACCESSING SEXUAL HEALTH INFORMATION

Shame: Shame was a recurrent theme among young Aboriginal and Torres Strait Islander people across the communities with regards to talking about sex, accessing sexual health information / education, and attending services to address any sexual health needs or concerns.

> ***Do you think that there's enough information about sexual health available for young people in this community?*** No. Because there's always that stigma of "it's shame". It's embarrassing, but it's not. Because like, I'd rather know about it than you know, end up with Chlamydia. (Holly, 20-24yo, Griffith)

Key informants also perceived shame as a substantial barrier for young Aboriginal and Torres Strait Islander people to access sexual health information and services.

> ***Or what are some of the typical issues that young people face with sexual health?*** Oh, I think the biggest one is, is the shame. I often hear that word come up. And if they're worried about coming to talk to someone about it, that word comes up quite a lot, "shame". (Key informant, Griffith)
>
> And that shame factor, and um, and then you've got parents as well that... don't want to acknowledge that their child's sexually active, or, or had that conversation with them about being sexually active (Key informant, Narrandera)

A young person indicated there existed a gap in services to aid in overcoming embarrassment about sexual health.

> ***Is there anything that you think's missing, that is needed? Sexual health services?*** […] There's just a lot of stuff that [young people] wanna talk about and that but they don't because there's not the right services out there, or the right people to talk about it to. (Tammy, 20-24yo, Griffith)

These experiences reflect a desire for better engagement in discussion of sexual health issues, but either a lack of appropriate pathways, or a lack of knowledge of the pathways that exists, to do so.

Recommendations: Participants perceived that increased education would reduce feelings of shame and better enable people to engage in conversations about sexual health.

> ***Do you think if there was more education and more people talked about it, do you think there'd be less stigma?*** […] Yes, one hundred. If people actually realised how common it was, and you know, it's actually not like you know, I don't think it's gonna kill you. You know, Chlamydia can make people infertile and stuff like that, like it can play a huge role like that. (Felicity, 25-29yo, Narrandera)

Key Findings:

Informal Resources: Family was often the primary resource for sexual health for both young women and young men in all three communities, with mums among the most frequent 'go-to' for sexual health information. Young women seemed more able to discuss sexual health with family than men could, suggesting that perhaps young men had fewer resources available to them for sexual health information.

> The first person I probably would tell would be my mum. […] Just cos like she's my mum, like she's not gonna judge me or anything. (Sandra, 15-19yo, Narrandera)

Formal Sources: Across all three communities, schools were regarded as a place to seek out sexual health information, either from individual teachers or other school personnel, and within Personal Development, Health and Physical Education (PDHPE) classes. However, young people conceded they didn't necessarily listen to or retain sexual health information obtained through school. Young people would perhaps be more likely to retain sexual health information if received via multiple sources, that is, if there were greater opportunity to reinforce what has been learned.

> I didn't really pay attention at school. It was more when the experience happened. (Joel, 25-29yo, Griffith)

Across all three communities, Clontarf Academy and Headspace were regarded as trusted places to access sexual health information. The AMS in both Griffith (GAMS) and Wagga (RivMed) were viewed by some young people in the respective communities as a resource for sexual health information. But in Narrandera, young people talked about the lack of an Aboriginal and Torres Strait Islander health service within their community.

> ***What would be good to have here, that other places have?*** Griffith AMS, that'd be good to have one of them here. ***Like Koori doctors?*** Yep. Someone that understands you know, young Aboriginal people. And, cos like… ***What's different about, like Griffith AMS to here?*** They've got like, you know, an Aboriginal... people and you know, you can.... not saying you can't talk to 'em, but you can talk to [Aboriginal doctors] about a lot more stuff than you can white, non-Indigenous people. (Brent, 15-19yo, Narrandera)

Recommendations: Culturally specific considerations for sexual health information dissemination included delivery of information through images or infographics, as "a lot of black people, we learn more by pictures" (Griffith young woman, 25-29yo), while other people suggested oral information sharing as culturally meaningful. It was mentioned by young women in Griffith that there was an absence of sexual information at GAMS, with several recommending the service should display fliers and brochures, indicating that visual displays might be beneficial to young people at that service.

Reflecting on a perceived gender imbalance of resources provided to young people, a young woman suggested distribution of a sexual health kit, inclusive of condoms and sexual health information and links to resources, to ensure access to appropriate resources and products for both young women and young men.

Key Findings:

> Giving the boys little packs, you know what I mean? ***And what would be good to have in the pack?*** Like condoms, and probably a little health, like a health kit, like a guiding book type thing. That'd be good. And like explain the STDs, like that'd be, cos I know like, us girls we get our little period package thing. […] At school, we get, I think you get tampons now, you get like liners, like three different type of pads, and also a little guiding book to tell you about your period, why you get it, what happens, and everything like that.
> (Thea, 15-19yo, Narrandera)

Online Resources: Online resources were also used, such as Google, "Ask Nurse Nettie" (a chat feature on the "Play Safe" and "Take Blaktion Play Safe" websites) and Flo (a menstruation tracking app with health articles available to app users). Google / the internet were other online resources accessed by young people, however, the ability to discreetly access online resources was variable.

Recommendation: Young people recommended age-appropriate dissemination strategies, including social media platforms such as Tik Tok and Snapchat.

LGBTIQ+ Information: In describing the sex education received during PDHPE in school, a participant reflected on the heterosexual focus presented in class. This had the consequence of marginalising the sexual health needs of young lesbian, gay, bisexual, transgender, intersex, queer (LGBTIQ+) people.

> I suppose touching upon like sexual intercourse in regards to LGB[TIQ+] people. But, because a lot of people might not identify as heterosexual. So it's important to touch on like gay, gay people, as well as being bisexual, things like that. (Tom, 20-24yo, Griffith)

Recommendation: These findings suggest that greater consideration of the sexual health of LGBTIQ+ young people should be integrated into any sexual health education or information distributed to young people.

Barriers and enablers to sexual health care

There were a number of factors which fostered service access by young Aboriginal and Torres Strait Islander men and women in relation to sexual health. These included:

Culturally safe (including Aboriginal and Torres Strait Islander staff and Aboriginal artwork)

Patient transport

No cost / bulk-billed services

Support from friends or family members to attend appointments

Trusted clinicians

Several barriers to accessing health services for sexual health were identified, including:

Poor service promotion / patient lack of awareness of services available

Lack of Aboriginal and Torres Strait Islander staff (receptionists and/or clinicians)

Lack of appointments / lengthy wait times

Lack of trust in healthcare workers

Shame

Lack of gender appropriate care

ENABLERS TO SERVICE ENGAGEMENT

Aboriginal and Torres Strait Islander personnel: Participants in all three communities identified it was important to them that the service they attend for sexual health care be Aboriginal and Torres Strait Islander-run, or at a minimum, employ Aboriginal and Torres Strait Islander staff members. For both a young person and a key informant, this was described as creating a culturally safe space in which young people can feel heard, as well as understood.

> So [RivMed's] a good one because it's an Aboriginal based health centre. […] A lot of [the health workers] are really understanding as well, they actually listen to you. RivMed, it's different, like I've been to all these other health places, and they don't really listen. (Natalia, 15-19yo, Wagga Wagga)

> Employing Aboriginal people to be there. Even if it's not the health professionals, at least it's someone they can talk to. You know, someone that they feel comfortable with. But they've gotta be Aboriginal. You can't have, I mean there is some nice non-Indigenous people that work really well with Aboriginal people, but at the end of the day, they're not Aboriginal. So they don't actually understand what Aboriginal people go through, and especially in the community. And they gotta be local. (Key informant, Narrandera)

Recommendations: In describing ideal services that should be implemented within their respective communities, trust consistently emerged as an important consideration in service development and delivery. It was suggested that trust would be more readily established with Aboriginal and Torres Strait Islander workers, than white or non-Aboriginal and Torres Strait Islander health or youth workers.

> I think [young Aboriginal people] need more people that they can trust, not just jump into something and say "oh, tell me this", or "give me", do you know what I mean? Or like, yeah, maybe, having a few sessions and get, win [young people's] trust. ***So like build a relationship?*** Yeah, so then they can feel comfortable enough to talk openly. (Eliza, 25-29yo, Griffith)

Young Aboriginal and Torres Strait Islander people believed that cultural connections to services would likely foster greater service engagement from young people.

> Say a blackfella's sitting there telling you something, you go "oh, yeah, yeah" you take it in, you know what I mean? ***Yeah, and it's private too.*** Yeah, but like you feel trusted as well, like you've told them, they've told you. Like, you know what I mean? (Toby, 15-19yo, Griffith)

Patient-clinician trust: Similar to accessing sexual health information, trust was a key facilitator to accessing sexual health services. As a young man from Griffith (20-24yo) describes, "They know my history". With regards to accessing STI testing, trust featured as an important aspect in whether or not young people felt safe in coming forward for testing.

> I won't do it with a random doctor, I'd do it with a doctor that I know. ***Someone that you trust? Eh?*** You gotta trust someone to do it, it if you know what I mean. Like I just won't turn up and see a doctor, you know, "I want this done". (Nathan, 15-19yo, Wagga Wagga)

A young male participant in Wagga Wagga relayed having recently accessed a health service for a sexual health checkup, and that trusting the healthcare workers was instrumental to him attending that service.

> ***Why did you use the service?*** Because I trusted [sexual health nurse] and the nurse there, and I know her well, and I just know that they're good there. (Alex, 25-29yo, Wagga Wagga)
>
> If you're just subjected to being there to support sexual health, people, if they don't, if people haven't established a relationship with you, then they're not gonna access you. Especially on the sexual health. You know, you can't just say "oh, here, I'm the sexual health worker, I'm here to help you". But then they're like, you know, most kids would be like "well I don't even know you, I'm not telling you my business". (Key informant, Griffith)

Recommendations: Key informants identified that any new employment or service program requires establishing rapport and relationship building with young Aboriginal and Torres Strait Islander people if they are to feel comfortable attending and engaging with the service. This corroborates the engagement recommendations made by young Aboriginal and Torres Strait Islander people that establishing a relationship is a priority for successful running of a sexual health information/ education program.

BARRIERS TO SERVICE ENGAGEMENT

Poor service promotion: A barrier to service engagement was the absence of knowledge among young Aboriginal and Torres Strait Islander people of services available, such as Community Health in Griffith, with many young people in the community unaware of this service.

> And I feel like if I would've known about community health, what, what… ***You would've used it?*** Yeah, I sort of wished I knew about them, or what they were doing to promote their stuff a little bit. (Joel, 25-29yo, Griffith)

Lack of appointments available: In Narrandera, people described the lack of appointments and long wait times at the doctor's surgery. Due to high patient loads, the medical centre would triage patients before arranging an appointment, which was a barrier for some young people who didn't want to disclose their reason for appointment to the reception staff. trust featured as an important aspect in whether or not young people felt safe in coming forward for testing.

> The wait [for an appointment] is beyond a joke. ***Yeah, ok, so how long do you have to wait?*** Lately it's been up to three to four weeks. ***So, that's three weeks for an appointment?*** To see a doctor. Unless you go and see the nurse and explain to the nurse what's wrong first. (Issy, 20-24yo, Narrandera)

Lack of gender appropriate care: Gender was consistently raised by key informants as being critical to successful sexual health care engagement among young people. There was a notable shortage of male health workers identified by key informants in Griffith. In reflecting on the outreach service provided by a previous male Aboriginal and Torres Strait Islander sexual health worker years prior, this community member identified that young men are particularly vulnerable to non-engagement in sexual health care and the valuable role a male health worker can have in influencing health care participation. There did not appear to be a comparable filled position within the community at the time of data collection.

> When there was an Aboriginal health worker here […] that was associated with sexual health a few years ago. […] He used to do a lot of outreach to all our areas. […] And he would come to each area, and, and, and initiate it and get things going, particularly for the boys. Because often the girls are more inclined to come, but the boys were less inclined. But having a male sexual health worker made a big difference, I think, to the boys. (Key informant, Griffith)

The gender of the clinician was raised as a consideration in accessing sexual health care. One young woman described silo-ing her sexual health care across different services, attending the AMS for a sexual health check but using a mainstream GP service – where a female nurse was employed - for a Pap Smear, while another suggested a lack of female doctors made her less comfortable to attend.

I've had a sexual health check. And a Pap Smear done. ***Yeah, ok. And where did you go for that?*** For my Pap Smear I want to [GP Clinic]. And for my sexual health I just went to GAMS. […] ***Yeah, and why did you choose to go there?*** That's where my doctors are. Well, I've, I used to go to [GP clinic] but I changed to GAMS, and the only reason why I went back to [GP clinic] for my Pap Smear is because they have a nurse, like lady nurses doing it to you. […] And I just felt more comfortable. (Bella, 25-29yo, Griffith)

No, I just don't really like going [to the GP clinic]. Because there's not a female doctor there. (Carly, 25-29yo, Narrandera)

Shame: While shame was identified as a barrier to sexual health care engagement, some participants described that familiar, non-judgmental services could aid in reducing young people's concerns about shame when presenting for STI testing.

RivMed is pretty good. Like I actually like RivMed, cos I can just go in there and they're actually understanding. And like if I'm like shame to like get a test done, or something, they just say "it's fine, we do this all the time". Like, you're not the only person.
(Melanie, 15-19yo, Wagga Wagga)

Summary recommendations

Young people consistently recommended greater visibility of services that provide sexual health care within each of the communities. In addition they requested more education available to young people, increased access to male and female healthcare workers, increased employment of Aboriginal and Torres Strait Islander personnel (including healthcare and administrative), and more youth-focused services. Each of these recommendations was generated from a number of themes in the research, including sexual health and wellbeing, access to sexual health information, and barriers and enablers to sexual health care. Collectively, they provide a wholistic overview of the current service deficits experienced by young Aboriginal and Torres Strait Islander people in Murrumbidgee and youth-led strategies for enhancing the sexual health of young people within these communities.

Acknowledgements

The Girinyalanha Giilang (Talking Story) research project was funded through the NSW Health Prevention Research Support Program (H17/22706). We wish to acknowledge Associate Professor Stephen Bell's contributions to this project. This research would not have been possible without the support of the Advisory Group and community leaders within each of the communities, who championed the project and whose networks were instrumental in connecting us with participants. We also wish to thank the key informants who generously provided their time and shared their observations of young people's navigation of sexual health and wellbeing and service availability within their respective communities. Special thanks to Aunty Joy O'Hara, Maydina Penrith, Aunty Colleen Ingram, Aunty Joy Ingram, and the many community champions that connected us with young people across the district. We are indebted to the young people who trusted us with their stories, sharing their personal experiences of sexual health, wellbeing and service engagement, as well as their perspectives and reflections of the service gaps and needs within their communities. Design of better services to meet the needs of young Aboriginal and Torres Strait Islander people requires input from young Aboriginal and Torres Strait Islander people. Thank you.

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Artist: Samantha Williams, a proud Wiradjuri woman.

Cover image credit and story: The three circles represent the three towns Griffith, Narrandera and Wagga where the research was conducted. The symbols around the outside represent the people/community that were involved in the research project. The blue lines joining them represents the Murrumbidgee River which links the towns. The white tracks are the tracks that were taken by people not from these communities but travelled to them to conduct the research or hold info days/ workshops. The four hands represent the four people who conducted the research on the ground in the communities.