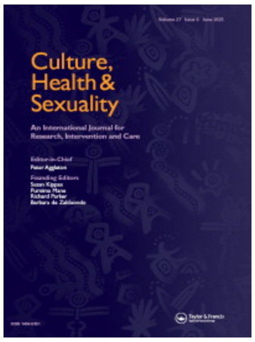

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Sexual healthcare to meet the needs of sexuality and gender diverse aboriginal young people: imagined possibilities

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ABSTRACT
In Australia, Aboriginal young people who are lesbian, gay, bisexual, trans, queer or otherwise sexuality and gender diverse (LGBTQ+) are recognised within several overlapping priority populations in state and federal sexually transmissible infection and HIV strategies. However, limited research has documented their unique sexual health experiences, needs and preferences. In this qualitative study, semi-structured interviews were conducted with 10 LGBTQ+ Aboriginal young people aged 16–24 years in New South Wales. Interviews incorporated questions about service access, positive and negative experiences and self-determined healthcare priorities. We conducted a strengths-based thematic analysis to understand the issues of greatest importance in sexual healthcare for participants. Using the framework of 'imaginaries', we explored how participants imagined sexual healthcare that would meet their individual and cultural needs. The dominant imaginary centred on respect, representation and the as-yet-unrealised possibility of sexual healthcare designed by and for people who shared the intersection of Aboriginal and LGBTQ+ experience. We identified individual-level, service-level and societal-level factors influencing this imaginary, including relationships, accessibility and experiences of racism. Analysing the imaginaries constructed by LGBTQ+ Aboriginal young people of empowering, culturally safe sexual healthcare that is 'for them' provides insight into potential service design to improve sexual health outcomes for this population.

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Introduction

In Australia, Aboriginal young people who are lesbian, gay, bisexual, trans, queer or otherwise sexuality and gender diverse (LGBTQ+) are recognised within several overlapping priority populations identified in state and federal sexually transmissible infection (STI) and HIV strategies as having distinct and important needs (Department of Health 2018a, 2018b, 2018c; NSW Ministry of Health 2021, 2022b). These populations include 'young people', 'men who have sex with men', 'trans and gender diverse people', 'Aboriginal and Torres Strait Islander people' and 'Sistergirls and Brotherboys' (a term used within the Aboriginal community to refer to culturally specific diverse genders). However, little research has documented the specific sexual health experiences, needs or preferences of young people at the intersection of both LGBTQ+ and Aboriginal populations.

A scoping review identified that limited qualitative research has examined sexual health among LGBTQ+ Aboriginal young people (Bell et al. 2017). Of the existing qualitative literature, most focuses on the experiences of Sistergirls and Brotherboys (K. Brown 2004; Kerry 2015; Riggs and Toone 2016) and gay and bisexual men (Hope and Haire 2019), with one mixed methods study exploring experiences of navigating health service access by LGBTQ+ Aboriginal people in Western Australia (Hill, Dodd, Uink, Bonson, and Bennett 2022; Hill, Dodd, Uink, Bonson, et al. 2022). Findings have included gaps in awareness and lack of cultural sensitivity among health professionals delivering sexual healthcare (Hope and Haire 2019; Mooney and Sariago 2015; Spurway et al. 2022; Stardust et al. 2017) and experiences of racism within wider Australian communities and transphobia and homophobia within Aboriginal communities (K. Brown 2004; Hill, Dodd, Uink, Bonson, and Bennett 2022; Kerry 2015; Mooney and Sariago 2015; Riggs and Toone 2016). More positive examples of community acceptance and support have also been documented, including affirmation and acceptance of the culturally female role occupied by Sistergirls (K. Brown 2004; Riggs and Toone 2016) and the protective role of family and kinship networks in safeguarding against homophobia or transphobia (Bennett and Gates 2019; Hill, Dodd, Uink, Bonson, and Bennett 2022; Riggs and Toone 2016). The limited research conducted with LGBTQ+ Aboriginal young people to date tends to have focused on social, cultural and emotional wellbeing (Soldatic et al. 2021, 2022). We identified only one previous qualitative study that explored experiences of accessing sexual healthcare (Spurway et al. 2022) and one that explored experiences of accessing healthcare services more broadly (Sullivan et al. 2022) among LGBTQ+ Aboriginal young people in NSW, despite several reports by Australian government and community organisations recommending improved understanding of healthcare experiences and access needs (Australian Human Rights Commission 2015; Dudgeon et al. 2015; National LGBTI Health Alliance 2021; Robinson et al. 2020).

The epidemiological context for this study is an expanding syphilis epidemic that has disproportionately affected Aboriginal communities in northern Australia (Australian Department of Health 2020). Young people aged 15–29 years record the highest incidence of notifiable STIs (Chlamydia, gonorrhoea and syphilis); higher in remote regions and higher in Aboriginal young people than in non-Indigenous young people (King et al. 2022). The HIV notification rate is roughly equivalent between Aboriginal and non-Indigenous populations, with male-to-male sex accounting for 50 per cent of known HIV transmissions in the Aboriginal population (King et al. 2022). However, most STI and HIV surveillance data specific to Aboriginal people is reported by age, gender and area of residence, with neither sexual orientation nor sex of recent partners included.

Experiencing racism is recognised as a significant determinant of ill-health both globally (Paradies 2006) and for Aboriginal people specifically (Priest, Paradies, Gunthorpe, et al. 2011; Priest, Paradies, Stewart, et al. 2011) and discrimination against LGBTQ+ people in healthcare settings has been widely documented (Ayhan et al. 2020). Individuals who are both ethnic minorities and LGBTQ+ have an increased likelihood of experiencing discrimination in a healthcare setting (Bastos, Harnois, and Paradies 2018; Kattari et al. 2015; Li et al. 2015). Despite the increased vulnerability of young people who experience intersecting marginalisations (Robards et al. 2020), little research on young people's access to healthcare adopts an intersectional approach that recognises the complexity of these experiences (Robards et al. 2018).

Conceptualising imaginaries

This study locates STIs and HIV within the World Health Organisation's (WHO) working definition of sexual health (WHO 2006), which centres physical, emotional, mental and social well-being in relation to sexuality, respect and the protection and fulfilment of sexual rights. We used the framework of 'imaginaries' (Taylor 2004) to analyse how LGBTQ+ Aboriginal young people conceptualise sexual healthcare that would meet their needs. This framework emphasises the shared accounts, values, social practices, norms and identities through which people imagine and construct their understandings of the world. An imaginary is described by Taylor (2004, 23) as incorporating:

> The ways people imagine their social existence, how they fit together with others, how things go on between them and their fellows, the expectations that are normally met, and the deeper normative notions and images that underlie these experiences… the social imaginary is that common understanding that makes possible common practices.

May (2015) uses the term 'resistant imaginary' to describe the disruption of dominant social norms by the alternative worldviews of those who live at the intersections of multiple identities and experiences. Imaginaries have been used in sexual health and blood-borne virus research to explore experiences of disclosing blood-borne viruses within families (Smith, Persson, et al. 2021), changing understandings of hepatitis C following the introduction of new treatments (Fomiatti et al. 2022) and clinician understandings of HIV positive patients (B. Brown and Jaspal 2022) and patients using HIV pre-exposure prophylaxis (PrEP) (Smith, Newman, et al. 2021). Research with LGBTQ+ populations has applied the framework in explorations of healthcare access (Baker and Beagan 2016) and sexual identity as expressed on dating apps (Ferris and Duguay 2019). In these examples, imaginaries function to provide insight into the beliefs and norms that both underpin social practice and make this social practice realisable (Taylor 2004).

Study aims

This study explored understandings of appropriate and accessible sexual healthcare that would meet the needs of LGBTQ+ Aboriginal young people to inform the development of age and culturally appropriate sexual health services.

Methods

Strengths-based approach

Historically, much sexual health research conducted with young people and with Aboriginal populations has adopted a deficit lens, viewing health through a lens of failure or inferiority and attributing responsibility for negative health outcomes to individuals and affected communities themselves (Bell et al. 2017; Fogarty et al. 2018). In contrast, our study explicitly adopted a strengths-based approach to its subject matter and study population, centring the factors that promote individual and community health, rather than focussing on problems and disadvantage (Bryant et al. 2021; Fogarty et al. 2018; Mooney-Somers et al. 2011).

Sampling

We recruited young people in New South Wales (NSW) using purposive sampling followed by snowball sampling (Guest, Namey, and Mitchell 2013). A webpage featuring study information and contact details was hosted on the UNSW Sydney Kirby Institute website, and the study was promoted *via* social media (Twitter and Facebook). We recruited from among the community networks of initial participants who responded to the advertisements, Aboriginal young people engaged as peer research assistants and the Aboriginal Youth Advisory Group. Inclusion criteria for the study were that participants identify as both LGBTQ+ and Aboriginal and/or Torres Strait Islander, be aged between 16 and 24 at the time of recruitment and be proficient in the English language.

Data collection

Two Aboriginal young people employed as peer research assistants (MG and TH) conducted eight interviews between them. An older male Aboriginal research assistant involved in the design of the study conducted one interview (BW) and a female non-Indigenous senior researcher (BH) conducted one final interview due to an existing relationship between the participant and the research assistants. BH and EM trained the research assistants on qualitative research methods over several weeks until all felt confident to conduct interviews independently. This training incorporated discussion of methods and models, role play and mock interviews. Interviews took place between April 2021 and December 2022 and were conducted *via* videoconference or telephone.

The discussion guides used to inform semi-structured interviews were informed by close consultation with the Aboriginal Youth Advisory Group overseeing the study, with priority topics for inclusion determined by consensus. Discussion guides incorporated questions on a range of socioecological influences on participants' sexual and reproductive health experiences, needs and desired improvements, including individual (eg knowledge, perception of risk), relational (eg peers, family), institutional (eg health services) and societal (eg cultural norms, policies) level factors (McLeroy et al. 1988).

Inductive thematic analysis

Interviews were audio-recorded, transcribed, and the transcripts were de-identified, verified for accuracy by the interviewer and reviewed by the participant if desired. Interview transcripts then underwent an inductive thematic analysis (Braun and Clarke 2019) aided by the use of QSR NVivo (version 12.6.1) by an Aboriginal woman (HM) with input from the full research team. The analysis involved systematically identifying and organising patterns of meaning within interview data. HM developed a coding framework based on research questions and interview summaries, then refined this through multiple rounds of inductive coding. Iterative generation and refinement of themes involved reviewing themes with the research team and revisiting interview transcripts to ensure alignment with participants' perspectives. To analyse the imaginary of sexual health services that would meet the needs of participants, we considered the individual, social and societal level factors that participants described as informing their understanding and experiences of sexual healthcare.

Governance, ethics approval and informed consent

Ethical approval for the project was received from the Aboriginal Health and Medical Research Council of NSW Human Research Ethics Committee (1687/20) and the UNSW Sydney Human Research Ethics Committee (HC200622). An Aboriginal Youth Advisory Group provided governance and advice to the study. Members were LGBTQ+ Aboriginal young people aged 18 – 28 years who responded to an expression of interest.

Findings

Ten LGBTQ+ Aboriginal young people were interviewed, representing Wodi Wodi, Gumbaynggirr, Wiradjuri, Wayilwan, Pakana and Kamilaroi nations, with none being Torres Strait Islander. All participants cited herein as referred to by pseudonyms. Self-identified cisgender bisexual women made up most of the sample ($n = 7$), with the remainder consisting of one cisgender gay man, one transgender heterosexual man and one non-binary person. Present within the dominant imaginary were three themes: respect, representation and the design of sexual healthcare 'with me in mind'.

Feeling respected

Participants imagined sexual healthcare that would meet their needs as rooted in respect. Connor (man) said that he needed to feel 'safe and respected' when accessing

STI testing because it was a 'vulnerable experience'. Other participants contrasted vulnerability with respectful care and feelings of safety. Angela (woman) situated the imaginary in opposition to an intersection of racism and sexism targeted at young Aboriginal women, which she described as 'it's just, like, "all they're good for is getting pregnant"' and recommended healthcare professionals help young people feel safe by communicating that talking about sex 'is an ok conversation to have' and that you 'don't have to be scared'. Eric (man) explained that 'as a kid I was brought up to think if you go to the clinic, you're dirty' and reflected on 'the stigma around it can be really damaging'. Vulnerability was also apparent in Belinda's (woman) description of a negative experience during her first cervical screen at age 18 (prior to changes to the National Cervical Screening Program in 2017 that raised the age of first screen to 25). Belinda described her experience as 'very confronting'. She felt 'quite vulnerable' because she wasn't given an adequate explanation of the procedure being conducted on her body and the clinician 'was just constantly being like "can you just breathe"'.

For other participants, respectful sexual healthcare – and specifically sexual healthcare that did not feel judgemental – was associated with feelings of empowerment and agency. Emily (woman) imagined sexual healthcare that would meet her needs as 'delivered in a safe, respectful way that doesn't feel like there's a kind of stigma behind it' and that 'doesn't feel judgemental… it's more positive and encouraging and kind of liberating'. She imagined young people like herself being encouraged to '[take] control of your own sex life and kind of feel like you're empowered to make your own decisions'. Angela also constructed her imaginary around feelings of autonomy and 'knowing that I have access to options'. She described a scenario in which 'if something goes wrong, or if something were to happen to me, that I have different avenues that I can go down, whether or not that's through family or friends or through health services'.

Bisexual women participants described a gendered gap in the sexual healthcare provided to them that did not respect or accommodate their bisexuality or the diversity of their sexual and relationship experiences. Belinda described a typical sexual health consultation as 'focused on my sex with men' and recognition of her bisexuality 'just wasn't there… I disclosed that I was bi, but they were just like "use condoms" and I was like "well what the fuck am I meant to do when I'm with a woman?"'. She felt clinicians looked 'at the statistics' and then made 'assumption[s] about you', which led to care informed by racist stereotypes about young Aboriginal women.

> I think it comes into all of those stereotypes of like you know, 'oh, we've gotta prevent Aboriginal communities from having kids too early and too young', and like 'slap 'em with whatever reproductive controls you've got'. – Belinda

In the light of these experiences, Belinda saw sexual healthcare that would meet her needs as requiring healthcare professionals to ask her explicitly what those needs were, in a manner that empowered her to take an active role in managing her sexual health.

> I think it would go a lot further to actually empower that person and educate that person and say 'hey, what do you want?' And I don't really think that happens in the Aboriginal and Torres Strait Islander sexual health space. I think in terms of the queer space I don't think they… really engage, and maybe that's because I'm bisexual and they're just more

> focused on pregnancy. I was getting tested… but they're a lot more cautious and lecturing about condoms but they never gave me lectures for sex when it was happening with women. – Belinda

The theme of respect was interwoven with descriptions of relationships with healthcare providers. Alex (non-binary) described accessing sexual healthcare from a new GP as 'not very comfortable', explaining the additional burden placed on gender diverse young people to receive appropriate care: 'If it's not your regular GP, then it's a lot to go in and see a new doctor 'cos you have to explain, you know, all the extra parts.' Hannah (woman) reported positive experiences accessing STI testing both at university health services and Aboriginal Community Controlled Health Services (ACCHS), but highlighted that in the ACCHS setting, the 'revolving doctors that they've got, you're never seeing just one person'. This meant that to discuss a sensitive issue relating to sexual health, she would 'be talking to multiple different people about it, [which] makes it really, really difficult to open up and feel comfortable'. Hannah further clarified that a good relationship with a healthcare professional led to more respectful care and acted as a mediator of shame and stigma:

> I still do regular STI checks, even in a relationship, just in case… But having a good rapport with your GP to make that experience normal and comfortable I think is a really big one, 'cos asking for an STI check, I think, no matter how many times I've done it, it still feels dirty. – Hannah

Female participants described disempowering experiences navigating hormonal contraception access, with several expressing that they had not been given adequate information to make informed decisions about commencing long-acting reversible contraception (LARC) and that their concerns about side effects were not taken seriously. Belinda explained that she 'felt really judged' and that healthcare professionals 'don't know what the fuck I've been through' after being told by a pharmacist that she 'should really be on something' following removal of her contraceptive implant due to side effects. She concluded that she 'just wish[ed] there was a lot more respect'. Belinda, Felicity (woman), Hannah and Louise (woman) described negative side effects from hormonal contraception. The side effects experienced by Louise had led her to request the removal of her LARC, following which she 'actually felt like a person, like myself again'. While several participants felt that LARCs were foisted upon them, they were not offered as an option for Hannah, who experienced a 'hormonal mess' on 'every different pill I tried'. No alternatives were suggested until she enquired about a LARC, but she then found that it 'made the biggest difference to my lifestyle, and to pain management and health in general'. For Hannah, a LARC 'wasn't something that was offered to me, it was something I had to ask them about' and she would have preferred 'the other way around, when I first presented with these problems'.

Hannah, in particular, imagined an alternative healthcare experience in which healthcare professionals provided her with the information that she needed to make an informed and autonomous decision about contraception. Felicity had tried 'a lot of different types' of hormonal contraception to manage heavy periods caused by endometriosis and 'felt like no one was listening to me' when she tried to self-advocate about side effects: 'My moods were all over the place. Some would make me bloat, some would make me put on weight, some would make me lose weight. Some would make me physically sick.' She was ultimately placed on an injectable LARC that had fewer side effects, but due to her young age and fears about long term impacts on bone density, her doctor discontinued the LARC, leaving her with no hormonal contraception at all.

Overall, negative experiences of the kind described above informed the construction of an imaginary of respectful, empowering sexual healthcare that recognised the unique experiences of LGBTQ+ Aboriginal young people, as explained by Belinda:

> Just be respectful, eh. No judgement. Mob don't react well to judgement and feeling shame. Like we clam up, you know. I think that means that people are less likely to engage, and you're already carrying around so much shame, probably because there are associations within community about identifying as queer, and then you add on top of that that people are judging you for your reproductive practices. It's a lot. So, I think being respectful and respecting that person's autonomy. – Belinda

Representation and visibility

Participants identified other LGBTQ+ Aboriginal people as a shared community that functioned as a source of strength, resilience and knowledge. Several participants imagined a future of increased visibility for LGBTQ+ Aboriginal people, in which communities would support members to access sexual healthcare. Felicity noted that 'the stronger my relationship with both my gender, or with all my gender, sexuality, and Aboriginality, the more secure I've been' and recognised that the connections she felt to both the LGBTQ+ and Aboriginal communities brought resilience and strength. She linked these connections to a shared understanding of intergenerational trauma, saying 'it's good to know that you're not alone, and that people understand and that we are all just going through it, and we are all still thriving… it's disheartening, but also gives you a bit of resilience seeing other people still fighting.'

Connor noted that the religious aspects of his family 'dominate the more cultural aspects when it comes to sexuality and things like that' but emphasised that, despite these influences, 'there is such a huge amount of community love and support'. He also identified his connections to 'queer First Nation communities' and the sense of belonging he felt with others at this intersection as a positive influence on his health and wellbeing.

Several participants noted a marked absence of representation of LGBTQ+ Aboriginal people in sexual health services, and that this led them to assume that the services would not meet their needs. Emily explained that:

> 'Being part of the Aboriginal community and the queer community, I don't see those things openly advertised already and represented, so I have this assumption… I'm not gonna have my needs met. So, I don't often go and ask, unless it's explicitly shown'.

Alex agreed that services that are 'specific to mob and LGBT' needed to be more visible because they did not feel comfortable in mainstream services. Louise reflected on the absence of representation in sexual health services she had used in the past:

> It's not like they've done anything specific that feels culturally unsafe or unsafe for the LGB community. But also, they haven't done anything to actively make those two

> communities comfortable either. Which is a bit of a problem because it's like there's very small things that you can do. Even just a little acknowledgement of the flags… it feels like it hasn't come from an Aboriginal Torres Strait Islander LGBT person because that would've happened already. – Louise

The LGBTQ+ and Aboriginal and Torres Strait Islander flags were raised by several participants as a positive indicator that a sexual health service might provide inclusive care. Reflecting on a positive experience with a sexual health service, Alex noted that 'they made me feel so comfortable and so welcome, and just made it all feel very normal', adding that the display of 'signs and posters and stuff up around, like LGBT stuff, and stuff for mob… just seeing those make[s] you feel a bit more comfortable'. Alex also imagined sexual healthcare being improved by the representation and inclusion of people who shared their lived experience, saying that 'I know we've got the sexual health clinic, but maybe they can advertise they've got a specific doctor or nurse that is mob also'. While Alex recognised the value of posters, flags and other symbols of inclusivity, they added 'but it's also nice to see someone like yourself there'. These feelings were shared by Felicity, who noted that:

> The non-specific places where I've been to, and that didn't even give recognition to LBGT safe spaces, or anything to do with Aboriginal and Torres Strait Islander, have always given the worst experiences. Either they're just very close minded or… almost business minded. Whereas the places that I've been with flags up for either the LGBTQIA + flag, or Aboriginal and Torres Strait Islander have just always seemed more people focused and more caring and open. And I think that honestly seeing them in a service immediately puts me at ease. – Felicity

Designed 'with me in mind'

When asked if they thought sexual healthcare services were set up with LGBTQ+ Aboriginal people in mind, every participant said no. Angela, who said some of the services she had experienced were 'absolutely trash', described how some healthcare professionals 'see you as just a task that needs to be done'. Angela imagined sexual healthcare that would meet her needs as something tailored to herself and her experiences:

> Like 'we just need to fix this', rather than actually taking proper care… 'oh, what birth control you get on', like 'hurry up, I'll just write the prescription out'. Rather than actually taking the time to sit down with you and see how like, 'oh, because your partners are different from heterosexual roles, how does that impact you?' Or because of your Indigenous heritage, does that have any factors in play [in] what sort of medications or what sort of like treatment you request, or like [just] the way that they speak to you. – Angela

Similar views were shared by Connor, who understood sexual healthcare as 'set up with the mindset of sexual health for all' but with minority populations such as Aboriginal people considered 'an afterthought', and Emily, who described her usual GP clinic as 'having very whitewashed ideas in the medical system, and not really accommodating for other sexualities or gender[s]'. Emily imagined seeking care in an environment that was both an 'LGBTQI safe space' and had staff who were knowledgeable about Aboriginal culture and health.

Accessibility of services was another issue for participants. Louise noted that 'there are these services available but having them all spread out really thinly over different areas, it's really hard to find anything'. She imagined increased accessibility *via* a shared online resource listing services for LGBTQ+ Aboriginal young people:

> They could say 'here's this link, or this inclusive information, and culturally inclusive information that's on this website', and then kind of all direct them to one kind of space. 'Cos having all these niche little bits, that's fine, sometimes, but for people to find that, they have to go searching. – Louise

Connor imagined accessible sexual healthcare for LGBTQ+ Aboriginal young people as meeting the needs of people living in remote communities, stating 'you put First Nations people and queer people in a remote environment, there is so much they're missing out on. He imagined a multipronged strategy to deliver sexual healthcare in remote communities: 'I would definitely focus on outreach there, if clinics could be set up, even just getting sexual health nurses out there to educate and talk about practising safe sex'.

Felicity imagined improving accessibility of sexual healthcare for LGBTQ+ Aboriginal young people as requiring a holistic approach that reached out into schools and other settings:

> We need to have better access in schools, and we need to have better education, and I think it mostly just comes down to accessibility. It can't just be online, or it can't just be in schools, or like it almost needs like a complete reshuffling of society and I don't know how else to make it any easier. Because to tackle one thing, you have to tackle another thing. And it's prioritising where to start. Like do you start with just Aboriginal sexual health, and then like now that we are getting into Aboriginal LGBTQIA+sexual health, like it is another step. – Felicity

Felicity and Louise imagined sexual healthcare that would meet their needs as being designed specifically for LGBTQ+ and Aboriginal young people. Felicity explained how until recently, she '[didn't] think I even knew that I could ask for a female doctor, or like, somewhere that was Aboriginal and Torres Strait Islander focused, or friendly'. She imagined a sexual healthcare service designed with her in mind as 'more in tune with what our mob needs specifically, compared to the general population… and LGBT as well'. She explained that 'I think it does make a difference when people understand… You feel a lot more supported and safe, and I guess you have a lot more trust in the services that you're getting'. Louise also imagined sexual healthcare that would meet her needs as designed by and for people who shared her lived experience in spaces dedicated to her community:

> Even just like having a space where those people can talk about their experiences, or like just seeing that there [are] also people like you as well… even just a space where it's, you know, related to Indigenous queer health. – Louise

Discussion

In this study, we analysed experiences of sexual healthcare described in interviews by LGBTQ+ Aboriginal young people in NSW. We explored the imaginaries they constructed of possible future sexual healthcare that would meet their needs. Common themes in the accounts given stressed the importance of feeling respected, representation and intentional design by and for people who are both LGBTQ+ and Aboriginal.

The young people in this study imagine sexual healthcare that is 'for them' as healthcare that treats them with respect and enables autonomy and control. Respectful care has been broadly recognised as a principle aligned with Aboriginal cultural values (Freeman et al. 2014; Liaw et al. 2015) and a strength of healthcare delivered through ACCHS specifically (Gomersall et al. 2017). While a small number of studies have highlighted the importance of respect and self-determination in enhancing access and acceptability of sexual healthcare to Aboriginal young people (Bryant et al. 2023; Graham et al. 2023; Mooney-Somers et al. 2009; Ubrihien et al. 2023), these have primarily focussed on heterosexual youth. Our findings reflect an imagined future sexual healthcare system underpinned by self-determination for LGBTQ+ young people, who are themselves imagined as empowered users through an Aboriginal lens. These findings support the commitment to Aboriginal community control and engagement embedded in the *Fifth National Aboriginal and Torres Strait Islander Blood-borne Virus and Sexually Transmissible Infections Strategy 2018–2022* (Department of Health 2018b), but require further development of tailored, collaborative approaches to design, implementation and delivery of sexual health services that are explicitly inclusive of LGBTQ+ concerns.

This study focused on participants who were both Aboriginal and LGBTQ+. This intersection was understood by participants to represent its own distinct community that functioned as a source of strength and resilience. Their desire for representation and normalisation of the LGBTQ+ Aboriginal experience in sexual healthcare reflects increased visibility of community members in media and online spaces (Hill, Dodd, Uink, Bonson, and Bennett 2022; Widders-Hunt 2020). Echoing previous research (Haire et al. 2021; Spurway et al. 2022), participants valued visible community symbols and healthcare professionals who shared a similar background. The imagined relationship between study participants and healthcare professionals with shared lived experience within a community-designed healthcare service reflects principles of ACCHS (National Aboriginal Community Controlled Health Organisation 2022) and peer-led HIV testing models for gay and bisexual men (Lee et al. 2020; Rees et al. 2022), but as yet lacking for individuals who are both LGBTQ+ and Aboriginal.

The need for evidence-based, culturally safe health services and prevention strategies to support the sexual health of young Aboriginal people has been recognised in Australian state and federal STI strategies (Department of Health 2018c; NSW Ministry of Health 2022a, 2022b). In this respect, cultural safety relates to environments free from assault, challenge or denial of identity and needs, in which services are provided on the basis of shared respect, meaning, knowledge and experience and where all people are listened to and treated with dignity (Williams 1999). Culturally safe healthcare should also respect cultural practices, communication styles, confidentiality and a holistic view of health that may contrast with biomedical approaches to service delivery (Department of Health 2018b; North Coast Area Health Service 2009). Participants in this study described having to navigate an intersectional 'matrix' of racism, sexism and homophobia in their everyday lives, as opposed to experiencing any of these forms of discrimination alone (May 2015). For LGBTQ+ Aboriginal young people, delivery of culturally safe sexual healthcare requires an intersectional understanding of the various forms of discrimination they may experience in accessing healthcare. Participants' past experiences with sexual healthcare were not often culturally safe, yet the possibilities that they imagined reflected that culturally safe healthcare that addresses age, gender and sexuality-specific needs is an important priority for this population.

This study makes an important contribution to the small body of literature documenting the experiences and needs of LGBTQ+ Aboriginal young people when accessing sexual healthcare. The involvement of peer research assistants and the use of a strengths-based, intersectional approach ensured the research experience was culturally safe and sensitive to participants' experiences. While the over-representation of cisgender bisexual women in our convenience sample is a potential limitation and restricts the generalisability of our findings, we note that among young people in Australia reporting non-heterosexual attraction, women attracted to both men and women make up a large majority (Fisher et al. 2019). Bisexual Aboriginal women, particularly, are a seriously underrepresented population in research and the experiences of this population are often absent from the peer reviewed literature (Henningham 2024).

Conclusion

By drawing on the concept of 'imaginaries', we have shown how LGBTQ+ Aboriginal young people conceive of sexual healthcare that would meet their needs. Our findings indicate the clear need for sexual health services that are not only culturally safe but gender and sexuality inclusive for LGBTQ+ Aboriginal youth. This study offers valuable insights for both policymakers and healthcare providers involved in the design of future sexual health services tailored to meet the needs of LGBTQ+ Aboriginal young people.

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