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Research Article

Sexual and Reproductive Health Service Access among Aboriginal and Torres Strait Islander Young People in Regional NSW, Australia

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Owing to the historical and ongoing impacts of colonisation, there is a large health equity gap in sexual and reproductive health (SRH) outcomes between Aboriginal and Torres Strait Islander peoples and non-Indigenous populations. Whilst qualitative research has identified the barriers and enablers to sexual healthcare engagement among young Aboriginal and Torres Strait Islander people in remote settings, little is known about the ways in which young people navigate sexual healthcare in a regional setting. This study aims to address this gap. Sixty-five young (aged 15–29) Aboriginal and Torres Strait Islander people participated in semistructured interviews across three regional communities in New South Wales, Australia. The candidacy framework informed this analysis. A large proportion of participants expressed having agency and resources to attend health services for SRH needs (primarily STI testing and contraception). Women in particular described being supported by social networks to access SRH services. Male participants were less likely to identify their own candidacy for healthcare. Services that were culturally safe and had trustworthy, nonjudgemental staff and a feeling of community were easier to access (more permeable). Factors that decreased accessibility were confidentiality concerns, difficulty making appointments, and lack of visibility of services, or what they offer. Using the candidacy framework, this study identified the importance of culturally safe service provision, reducing barriers to accessing appointments and the provision of nonjudgemental care in engaging young Aboriginal and Torres Strait Islander people in SRH care. This study also highlighted the various strategies and actions that young Aboriginal and Torres Strait Islander people are already taking to protect their sexual health and that of their partners.

1. Introduction

Unprotected sexual activity can result in sexual ill-health, including sexually transmissible infections (STIs) and unplanned pregnancy. STIs such as chlamydia, gonorrhoea, and infectious syphilis are a cause of substantial disease burden, with more than one million infections acquired worldwide each day, most of which are asymptomatic [1, 2]. While these STIs are easily treatable with antibiotics, undiagnosed infection can result in pelvic inflammatory disease, infertility, and adverse pregnancy or birth outcomes [3–7]. The World Health Organization's *Global health sector strategies on, respectively, HIV, viral hepatitis, and sexually transmitted infections for the period 2022–2030* highlight priority populations that are most at risk of STIs, and include Aboriginal and Torres Strait Islander peoples [8].

In Australia, the disparity in STI disease burden between Aboriginal and Torres Strait Islander and non-Indigenous people is well-documented and attributable to the impacts of colonisation [9–11]. National surveillance data shows that Aboriginal and Torres Strait Islander people experience higher notification rates of chlamydia, gonorrhoea, and

syphilis compared to their non-Indigenous counterparts [12, 13]. Data point to ways that many Aboriginal and Torres Strait Islander young people are engaged with health services and STI testing. Recent behavioural data from a national survey (the GOANNA2 survey) of Aboriginal and Torres Strait Islander people aged 16–29 years showed that uptake of adult health checks was high in regional and remote areas (69% and 77% of respondents, respectively) [14]. The survey found that 70% of young Aboriginal and Torres Strait Islander participants who reported being sexually active had accessed at least one STI test in their lifetime, and 61% were offered an STI test in their most recent health check [14]. However, over the two time periods in which the GOANNA survey [14] was conducted, there is some suggestion that knowledge around sexual and reproductive health (SRH) has decreased such as knowledge of STIs and blood-borne viruses. It is important to note that higher notification rates may be indicative of the high service engagement among young Aboriginal and Torres Strait Islander people and not necessarily indicative of higher infection rates among this population compared to non-Aboriginal Australians [15]. These higher notification rates demonstrate the valuable role of service engagement and draw attention to the importance of identifying the accessibility of services. Ultimately, earlier service engagement may foster more timely access to STI testing and treatment, thereby reducing transmission and prevalence among this population group.

Qualitative research studies show that Aboriginal and Torres Strait Islander young people utilise a range of strategies to take control of their sexual health, including fostering healthy relationships based on respect and consent [16, 17], accessing sex education, utilising trusted social networks, and engaging with various types of sexual and reproductive health (SRH) services in line with their unique needs [18]. However, the literature suggests there are still individual, social, and structural barriers to accessing SRH services among this group such as embarrassment or shame about attending service, lack of available services (or service options), confidentiality concerns or lack of trust in providers, prohibitive cost, or location of services [19]. Owing to historical and contemporary legacies of colonisation [9, 10, 20], there remains a large health equity gap between health outcomes and health service use by Aboriginal and Torres Strait Islander versus non-Indigenous young people [13, 20–22]. Available qualitative research from national and international settings outlines factors that influence the SRH of young Aboriginal and Torres Strait Islander peoples. These include the ongoing impacts of colonisation [9–11]; experiences of institutional racism in government health systems [23, 24]; structural barriers to accessing services, including availability and timing of appointments [25], lack of transport, and prohibitive cost of services [26, 27]; interpersonal barriers created through service delivery by non-Indigenous providers, with associated language and cultural differences [28, 29]; and social problems arising from perceived or anticipated experiences of shame or stigma when seeking sexual health services [25, 28]. The ability to shape services which respond to these complex access barriers relies on high-quality granular research, inclusive of qualitative exploration of the social, environmental, and cultural factors that influence young people's engagement with SRH services [8].

There are three main types of primary health services available to Aboriginal and Torres Strait Islander people for the delivery of SRH care in Australia: mainstream general practitioner (GP) clinics, community sexual health services, and Aboriginal community controlled health services (ACCHSs). Typically, the main source of primary care is privately run mainstream GP clinics where a patient is seen by a GP or a practice nurse and is usually charged a fee for appointments, which is partially recoverable from Australia's universal healthcare system, Medicare. Government-run, community sexual health services offer a range of fully anonymous, free sexual health services including testing, treatment, and contraception. ACCHS play an important role in providing culturally appropriate services that are run by, and "tailored to the needs of local Aboriginal and Torres Strait Islander communities" [30]. These services deliver holistic care through offering a range of services in addition to GP or nurse appointments in line with local needs [31].

With regards to where young Aboriginal and Torres Strait Islander people are accessing healthcare, the GOANNA2 survey further demonstrated that utilisation of ACCHSs is high in remote areas in Australia, with 68% of people surveyed living in remote areas usually seeing an ACCHS-based GP, compared to just 29% in nonremote areas [32]. However, service provision in regional areas can be complicated, where towns vary in size, availability and choice of health service may be limited (i.e., many regional towns have no ACCHS), resulting in a lack of access to services that are culturally safe and align with young people's preferences or needs [33, 34]. A large proportion of the qualitative research exploring the sexual health of Aboriginal and Torres Strait Islander peoples focuses on those living in remote areas in Central Australia [25, 28, 35], however, New South Wales (NSW) is home to over one-third of the total Aboriginal and Torres Strait Islander population [36]. In the context of the disparity in STI notification rates between Aboriginal and Torres Strait Islander and non-Indigenous young people [12], and survey data hinting at ways in which young people engage with SRH services [14], there is a critical gap in in-depth qualitative research exploring the social, environmental, and structural factors which facilitate high uptake of SRH service access among young Aboriginal and Torres Strait Islander people living in regional areas of NSW.

The patient candidacy framework enables an understanding of the ways in which people navigate healthcare. Candidacy is defined as "the ways in which people's eligibility for medical attention and intervention is jointly negotiated between individuals and health services" [7, 37]. Specifically, candidacy is regarded as "a dynamic and contingent process, constantly being defined and redefined through interactions between individuals and professionals" [7, 37]. Candidacy centres the service user in its assessment of health service provision and not only explores engagement with the health service ("utilisation") but also highlights issues that arise prior to engaging with a health service,

by exploring the reasons *why* an individual may not present or engage with a health service at all [37].

Drawing on data collected during qualitative interviews with young Aboriginal and Torres Strait Islander people aged 15–29 years, this paper utilises the candidacy framework to explore the diverse influences on young people's health service engagement for SRH care in three communities across regional New South Wales, Australia. We adopted a strength-based [38–41] approach which recognised young people as experts in their own lives, and enabled analytical focus on the perspectives of the participants, generated through their lived experiences of engaging with health services in their local areas.

2. Methods

2.1. Study Setting. The setting of our study is a large, inland agricultural region in NSW, Australia. Three communities from this region were selected for the study based on the diversity of characteristics and perceived needs, as identified through consultation with local health district (LHD) representatives. The communities in our study ranged in population size from 6,000 to 70,000 people, with Aboriginal and Torres Strait Islander people comprising 6–12% of these communities [42]. Community 1 is a small town with one mainstream GP clinic, a small hospital, and community health service; community 2 is a provincial city with multiple GP services, a hospital, and an ACCHS; and community 3 is a large regional city with several health services, a large base hospital, and an ACCHS [42]. The study was carried out in partnership with the state health department's LHD, which oversees the communities where the research was conducted.

2.2. Community Consultation and Engagement. In keeping with the principles of community consultation and engagement when conducting research with Aboriginal and Torres Strait Islander communities [43], study investigators travelled to the three communities for preliminary in-person meetings with stakeholders, including Aboriginal elders, Aboriginal health workers, ACCHS staff, community health workers, community leaders, and policymakers. These meetings informed the design of the study and ensured that it was driven by locally-identified needs and expectations.

The study was overseen by an advisory group which was established following initial community visits and prior to data collection.

2.3. Participant Recruitment, Eligibility, and Sampling. The two study investigators who lived locally facilitated participant recruitment, following cultural protocols, through Aboriginal elders and key contacts at health services and tertiary education providers, all of whom became the study's "community champions." During the data collection phase, information about the study was circulated via flyers and social media. Study investigators and community champions approached potential participants who fit the study criteria and invited them to participate. Snowball sampling [44] was also employed through participants' networks.

Participants were eligible to participate in an interview if they identified as Aboriginal and/or Torres Strait Islander, were between the ages of 15–29 years, and live, or access services, in communities 1, 2 or 3. This age range was selected as it aligns with current guidelines which recommend regular STI testing for Aboriginal and Torres Strait Islander people under the age of 30 [45]. Participants were purposively sampled [44] to achieve maximum variation sampling and gain perspectives across diverse life stages (15–19 years, 20–24 years, and 25–29 years) and experiences such as at school/not at school; with/without children; and married, in a relationship, or single.

Participants were remunerated with a $30 voucher to a major supermarket as recognition of the contribution of their time and expertise. Community champions also received the $30 voucher for assisting with the recruitment of participants.

2.4. Data Collection. Interviews with young men were conducted by BW (a proud Wiradjuri man) with support in some interviews from SB (a non-Aboriginal man). Interviews with the young women were conducted by KW (a non-Aboriginal woman) with support in some interviews from SW (a proud Wiradjuri woman). Interviews lasted from 14 to 80 minutes and were conducted using semi-structured interview guides. Interviews took place in audio-private locations in a range of settings including community centres, technical colleges, schools, parks, and participants' homes. They were audio-recorded with a digital recorder, transcribed verbatim by a professional transcriber, and checked for accuracy by KW and BW.

The interview guides were developed among the authors and informed by a strength-based focus [38, 40, 41]. Research involving Aboriginal and Torres Strait Islander people peoples often follows a "deficit" discourse, which focuses on the problems, absences, or failures relating to health in those communities. This approach means that often, the blame for ill-health is placed on the individuals themselves, ignoring the structural or system-based contributors to these problems [20, 40]. Countering this, strength-based research looks to change this narrative and focus on the strengths, successes, and actions of Aboriginal and Torres Strait Islander people that enhance their health outcomes [38, 40]. Guided by the strength-based approach, interview topics included experiences of accessing sexual health services, sexual health information and education, sexual health practices and support, and demographics (Aboriginality, age, gender, sexuality, relationship status, attending school or not, and number of children).

Transcripts were deidentified, uploaded to NVivo 11 qualitative software (QSR International) [46], checked for accuracy, and coded thematically. KW inductively coded the dataset into nine overarching themes. Study investigators reviewed and discussed the overarching themes to ensure they agreed on the meaning and that the themes accurately represented the data [44]. Through this coding process, the

overarching theme of service access was identified as being aligned with the candidacy framework. Issues of candidacy and service accessibility were identified and discussed. A second round of deductive coding was conducted on the whole dataset, where data relating to service accessibility were coded under themes and subthemes informed by the candidacy framework [47]. Latent thematic analysis was undertaken to identify the ways in which the data were ascribed to the candidacy framework [48]. The candidacy framework includes four overarching themes: (1) identification of candidacy: whether or how an individual assesses their need or desire to engage with a health service; (2) operating conditions and the local production of candidacy: the locally specific context and how resource allocation impacts the production of candidacy in this setting; (3) navigation and permeability of health services: the ease with which an individual can motivate themselves to attend a health service, and how the service facilitates this; and (4) appearances, adjudications, and offers: the competencies, resources, and motivation required to make a "claim to candidacy," judgements made by healthcare providers, and what services are offered [2, 47].

Investigators returned to the community to present preliminary findings from the project back to young people in an interactive community feedback workshop. This process is detailed elsewhere (see [49]).

2.5. Ethics. Ethical approvals for this study were obtained from the Aboriginal Health and Medical Research Council of NSW (AH&MRC; HREC ref: 1535/19), Greater Western Human Research Ethics Committee (2019/ETH11719), and officially acknowledged by the UNSW Sydney Human Research Ethics Committee (15/09/2019).

Participant gender, age range (15–19, 20–24, and 25–29) and pseudonyms are presented alongside participant quotes.

2.6. Findings. Qualitative semistructured interviews were conducted with 65 young Aboriginal and Torres Strait Islander people between February 2020 and December 2021, in community 1 (10 women, 10 men), community 2 (13 women, 10 men), and community 3 (12 women, 10 men). Of those that reported being sexually active, almost three-quarters (70%) had accessed a service for SRH in their lifetime (see Table 1); this was much higher among women than men (74% vs 43% overall), particularly in communities 1 (80% vs 10%) and 2 (69% vs 40%). ACCHSs were the most commonly accessed service for SRH care: approximately half of the participants in communities 2 and 3 reported having ever accessed an ACCHS, compared to 20% of participants in community 1 where there is not currently an ACCHS operating.

2.7. Identification of Candidacy. Individuals make judgements about whether to seek healthcare based on their assessment of whether they need (e.g., experiencing symptoms or seeking a prescription for contraception) or are able to access healthcare (e.g., can afford an appointment or access a free one) [47]. Almost three-quarters of those who had reported being sexually active had ever engaged with a health service for SRH care (identified candidacy), and this was higher among women than men. This suggests a high level of competency in utilising healthcare among participants. The main reported reasons for attending a service for SRH care were for STI testing or to access contraception. Motivations for STI testing included regular screening, experiencing symptoms, a new relationship, or being notified of a possible exposure. This indicates that a large proportion of participants identified their own need, and ability to access healthcare, including possessing knowledge about the risks of sexual activity and where to access services.

> *I was using condoms, but then there was one time I didn't use it, so.* **Yeah, ok.** *So, like yeah, I was just, went for a check-up, just in case. [. . .] Cos like my partner was with people before. [. . .] And cos like he was my first, so I just wanted to make sure.* (Tyra, female, aged 15–19 years, community 3)

> **What service did you access? Like STI test, or contraception?** *Oh, practically like I go for blood tests every three months, it depends, yeah, I'll just get checked. My blood test, I'll get here and there, like I'll get urine tests and stuff.* **Yeah,** *if I'm not feeling right, but yeah.* **Is that just, you're just a regular thing, like you go regularly?** *Yeah.* (Tammy, female, aged 20-24 years, community 2)

Almost all sexually active female participants reported attending a service for SRH (primarily for contraception), compared to less than half of men (Table 1). Social networks were a common feature in facilitating young women to gain access to contraception or STI testing (that is, assert their candidacy), including parents, aunts, partners, older siblings, and friends: "*my mum actually told me that I needed to go on something (contraception*)" (Carly, female, aged 25–29 years, community 1). This suggests the importance of social networks in helping individuals identify their need for healthcare.

> *(My mum's) like really like, ok, as soon as you have sex, or you bleed, get "the rod" (contraceptive implant) straight in. [. . .]* **So how old were you when she did that?** *Oh, like thirteen or fourteen.* **Yep.** *When I started to bleed.* **Yeah, ok. And how did you find that? Were you happy to do that?** *Yeah, I was happy "cause I could understand where she was coming from." And it's just, it's smart, "cause it stops me from getting pregnant." [. . .] Mum knew not to put me on the pill because I would just forget to take it. So with the rod, it's in for three years, you don't have to worry about it.* (Melanie, female, aged 15–19 years, community 3)

Some young men were less inclined to access services, with some indicating that they "did not need to." For these participants, sexual health considerations were largely focused on unplanned pregnancy rather than exposure/transmission of STIs.

Table 1: Demographic characteristics of Aboriginal and Torres Strait Islander study participants, aged 15–29 years.

Community	1		2		3		Total	%
	Female	Male	Female	Male	Female	Male		
Total by sex/location	10	10	13	10	12	10	65	100
Sexually active (self-reported)	9	10	9	7	11	10	56	86
Ever accessed a service for SRH	8	1	9	4	9	8	39	60

So you said you've never had an STI test? *Nah.* **Ok. Can you tell me why some of the reasons why you haven't had one before? Have you not needed it?** *Yeah, I think I haven't, don't need it.* **You don't need it?** *I think my girlfriend's right (colloquialism for "all right" or "okay"; in this instance, meaning he perceives she does not have STIs).* (Dylan, male, aged 15–19 years, community 2)

Were you worried about STIs or getting anyone pregnant? *No, I actually was, like I was pretty confident, like I'd always have me game with me. I'd pull out (use the withdrawal method).* (Ian, male, aged 25–29 years, community 1)

This suggests that if a young person is unaware of the risks associated with unprotected sex, and the importance of STI testing, they may be less likely to identify their need (or assert their candidacy) for healthcare.

2.8. Operating Conditions and the Local Production of Candidacy. Operating conditions and local production of candidacy are defined as the "macrostructural influences" (that is, the culture and sociopolitical context) that impact the conditions under which health services operate, and an individuals' production of candidacy in that context [47]. Young people in each of the three communities identified challenges in accessing sexual health services, including limited availability of sexual health services and/or lack of choice of service (depending on the community), with the latter impacting access to culturally safe and appropriate sexual healthcare in the absence of a local ACCHS. Participants discussed several factors relating to enhanced cultural safety, particularly at ACCHS, and increased the likelihood of identifying and asserting their candidacy. These included feeling safe and comfortable and delivery of patient-centred care (whereby patients did not feel rushed through appointments).

ACCHS is a big one. Like one of my cousins lives here and we both go to that service, and I find it's pretty useful. Couple of services in one. [. . .] A lot of the (ACCHS) are though. Which I think's pretty good. So you don't have to go to ten different services to get your stuff sorted. [. . .] **What about (ACCHS) did you like?** *Um, think just the familiarity* (Cody, male, aged 15–19 years, community 3)

Like I'll mainly go to the (ACCHS) (for STI testing) because I like how you (can) get the (service-provided patient) transport there if you can't find a way, it's a lot easier. Not only that, it's like when you go there, and you're round that community, you feel like you belong, you don't feel like anyone's better than you and that. (Tammy, female, aged 20–24 years, community 2)

2.9. Navigation and Permeability of Health Services. Navigation of health services relates to an individual's ability to access a health service (after having identified health needs). The ease of accessing a health service is referred to as "permeability," whereby services that have few barriers are "porous" [7, 37] and those with barriers to care are considered less permeable [47]. Participants' understanding of what might happen whilst accessing a health service impacted their reported likelihood or desire to use a particular service (such as beliefs or perceptions of what an STI test entails, rather than fact-based knowledge). Facilitators and barriers to accessing services (porousness and permeability) were reported across the three locations.

Service accessibility (permeability) is impacted by the alignment of cultural values between the health service and the individual [37], such as the culturally safe environment provided by ACCHSs. Participants frequently reported that they were more likely to trust a culturally safe healthcare service than a mainstream service. Several young people spoke about the positive aspects of ACCHS such as familiar faces, a feeling of belonging and safety, being made to feel comfortable by the clinician, and the provision of transport, indicating high levels of trust in these organisations. This delivery of satisfactory care increases the accessibility (permeability) of the service, and therefore the likelihood that they will return for SRH care.

And did you get everything you needed when you were (at the ACCHS)? *Yep, so that, when you haven't had like an STI check or anything before, they will talk you through it, and they will say like what they do. And then how they would do it. And then they just, reassure you that you're not the only kid, or you're not the only person that's been here to do this. Like, "I see a lot of patients a day, like you're not the only one that like has to do this." So like you're fine, "cause like they just don't judge. Cos they see like a bunch of vaginas and dicks a day."* (Melanie, female, aged 15–19 years, community 3)

I'd rather go to the (ACCHS) than (mainstream GP clinic). Like I think the (ACCHS) and pretty much any (ACCHS) is actually a lot better than most services. [. . .] (ACCHS in other town), they take real good care of me, here they take pretty good care of me, and at (mainstream GP clinic) they seem to just rush you. Like the doctors rush you. While you go (to ACCHS), (the doctors there are) not even Aboriginal,

but they really do take their time, have a talk with you. (Liam, male, aged 15–19 years, community 2)

The availability of gender-appropriate clinicians was another key enabler for service access and is an important component of cultural safety among Aboriginal and Torres Strait Islander people [50]. Several female participants highlighted the importance they placed on the availability of a female clinician. Many discussed siloing their healthcare (i.e., attending different health services for different health needs) to ensure that they were able to see a female clinician for SRH checks. Others described being accompanied by a trusted family member to an appointment if they knew the clinician would be male. This highlights the key role staffing plays in enabling access to a service (i.e., enhancing permeability).

For my Pap smear I went to (GP service). And for my sexual health I just went to (ACCHS). [. . .] **why did you choose to go there?** *Um, that's where my doctors are. Well, I used to go to (GP service) but I changed to (ACCHS), [. . .] the only reason I went back to (GP service) for my Pap Smear is because they have a nurse, like lady nurses doing it to you. [. . .] I don't know who does the ones at (ACCHS). And I just felt more comfortable.* (Bella, female, aged 25–29 years, community 2)

So if you had a health problem, where would you go? *To the doctors. [. . .] I take my mum with me.* **And is that for support?** *No, I just don't really like going. Because there's not a female doctor there, I don't really like going to a male doctor.* (Carly, female, aged 25–29 years, community 1)

Despite the existence of dedicated sexual health services and ACCHSs in two communities, some participants simply didn't know what services were available locally for SRH care. Healthcare services are less accessible (porous) when their target client group is unaware of them.

I wish that I knew that places like community health had something like that (when I was younger), cos I would've used it (Joel, male, aged 25–29 years, community 2).

Participants in community 1 reported delays and difficulties in getting a medical appointment due to the limited availability of health services in their community, including waiting weeks for an appointment, or being triaged by reception or nursing staff about their medical issue, which may occur publicly in the waiting room. Overcoming these issues to gain access to medical appointments in this setting required more persistence and commitment from the young people, reflecting that the service had low permeability.

Um, are there any bad things about the health service? *They're just slow. Like you ring up and they're like "oh, book into (town half an hour away)."* **Oh, so they'll send you to another place?** *Yeah. Like it's so hard to get in here.* (Frankie, female, aged 15–19 years, community 1)

Several participants spoke about social or familial connections to ACCHS staff which impacted their sense of confidentiality. While this familiarity was sometimes described as positive, some participants reported fear of people within their networks knowing they were attending a service for SRH care. This can create a service barrier (i.e., making a service less permeable) and some participants said fear of being seen accessing SRH care by someone they know would stop them from using a particular service. However, among participants who anticipated confidentiality issues, many young people were often able to assert their candidacy and navigate access to other services that felt safe while addressing their needs.

Sometimes at (ACCHS), you'd run into your cousins and everything there, and you'd have to make out like "oh, I've got a cough," or something. (Rhys, male, aged 15–19 years, community 3)

I just don't wanna go to (local ACCHS). Like when I go to (another town), I'll go to the (ACCHS) up there because I don't know anyone, and I'll be happy to go there. **You don't go to** *(local ACCHS)* **anymore?** *No. "Cause like literally half my family work there. [. . .] so I only go there for certain things". So when I needed like immunisations to go on placement and stuff I went there cos it's just easy, but cos I'm on contraception, if I want a script or something I go to the other (health service. . .). "Cause I just don't want my whole family knowing my business."* (Vicky, female, aged 20–24 years, community 3)

2.10. Appearances at Health Services and Adjudications and Offers. Appearing at a health service, and interacting with the service provider to gain appropriate care, involves a set of skills and competencies [47]. Adjudications are the judgements made by health providers about the provision of care and offers (e.g., offering STI testing or contraception, rather than it being specifically requested) and describe whether, and what kind of care, is provided to the individual [47]. Participants described strategies to avoid feelings of shame or embarrassment around asking for an STI test by going for a general (nonsexual) health check, and "adding on" an STI test as a part of this. This reflects a high level of competency when appearing at and navigating health services, and avoiding potential perceived barriers (i.e., shame).

(The healthcare worker) just ask me what I'm here for, and I say "oh, just a check-up everywhere" [. . .] and then they go, "alright, so like an STI check and HIV check?" And I'll go "yep." (Melanie, female, aged 15–19 years, community 3)

Marcus (male, 25–29 years, community 2) spoke about his experience of getting a general health check and needing to know how to ask for STI testing when in the health service.

Where can young people access contraception or STI testing? *Yeah, I'm not too sure if there is, and I don't know. I mean I've gone to the (ACCHS) and stuff and done just*

general check-ups and stuff, so, you know, there's that option there. But I mean, I've never really seen anything like, advertised or anything. **So when you're talking about general check-ups, do they include STI testing?** *Oh, yeah, but you gotta ask for it. [. . .] I mean they've never suggested it before, or whatever.* **Ok.** *I've just gone in and said can I do a full health check, you know. Like test me for everything.* **Yep, and they've added (STI testing) on?** *Yeah.* (Marcus, male, aged 25–29 years, community 2)

This also suggests that some clinicians do not make "offers" of STI testing without being specifically requested.

3. Discussion

Our analysis explores the different factors impacting SRH service utilisation among young Aboriginal and Torres Strait Islander people from regional NSW through a candidacy lens. Our findings not only illustrate the strengths and agency that young Aboriginal and Torres Strait Islander participants demonstrated when asserting their candidacy for SRH care but also the various organisational and structural complexities faced by young people when attending these services, including lack of resources and culturally safe healthcare options in regional communities.

Similar to other findings [18, 28, 51], participants (particularly those in communities 2 and 3) used a range of opportunities to assert their candidacy, such as regular STI testing, STI testing at the beginning of a relationship with a new partner, or attending the health service when they experienced symptoms. This challenges the deficit model narrative [38, 40], and reflects that young Aboriginal and Torres Strait Islander people are empowered to access SRH care, especially when adequate services are available. The GOANNA2 survey showed that 37% of Aboriginal and Torres Strait Islander people aged 16–19 years had tested for STIs in their lifetime, compared to 15% of people aged 16–18 years in the mainstream National Survey of Secondary Students [52]. Government health data showed that 17% of mainstream GP clinic attendees aged 15–29 years had tested for STIs in the previous year [12], compared to 44% of Aboriginal and Torres Strait Islander people in the same age group [14]. Indeed, these figures show that young Aboriginal and Torres Strait Islander people are adept at identifying candidacy and navigating care. While disparities in STI disease notification rates exist between Aboriginal and Torres Strait Islander and non-Indigenous people [21], it is possible that higher rates of testing among Aboriginal and Torres Strait Islander people could be influencing the higher reported rates of notifications among this population [15].

Participant responses reflected the importance of cultural safety in accessing sexual healthcare. Cultural safety is a key concept that influences how Aboriginal and Torres Strait Islander people interact with health services [53], especially younger generations engaging with sexual healthcare. Cultural safety is defined as the provision of healthcare that is "safe" to "approach and use" from the perspective of the Aboriginal and/or Torres Strait Islander person receiving that care [6, 54]. Cultural safety aligns with the candidacy framework which states that individuals' health-seeking behaviours are influenced by cultural expectations [37]. Culturally safe healthcare aims to redress the power imbalance between healthcare providers and clients resulting from colonisation, by addressing the vulnerabilities that may occur in those settings [55]. Participant preferences for ACCHS (compared with attendance at mainstream services) illustrate that the local provision of these services facilitated the production of candidacy (through culturally safe healthcare within local operating conditions) among young Aboriginal and Torres Strait Islander people (in communities 2 and 3), a finding reflected elsewhere in the literature [18, 31, 56]. This directly relates to the concept of cultural alignment in candidacy theory, that if a service is culturally aligned, it is more accessible to prospective clients (more permeable, or porous). That young people repeatedly spoke about factors that increased their likelihood to use a culturally safe service (e.g., familiar and trustworthy clinicians and staff, feeling safe, and clinic-provided transport), even to the point of travelling to another town to attend a specific service, highlights that young Aboriginal and Torres Strait Islander people will overcome barriers to attending services that they feel meet their needs. Participants enacted various strategies to feel safe while accessing services that had barriers (i.e., no gender-appropriate clinician), by attending different services specifically to see a female clinician, or by bringing a family member to an appointment with a male clinician. These factors shed light on mechanisms that mainstream health services can implement to facilitate cultural alignment and engage young Aboriginal and Torres Strait Islander people in their care. Evidence from international settings suggests that cultural safety interventions that take a holistic, integrated approach, are more effective and impose fewer barriers [57, 58]. This highlights that health services of all types would benefit (i.e., enhance engagement with Aboriginal and Torres Strait Islander young people) by implementing strategies to improve cultural safety within their organisation.

The contrasting experiences in accessing healthcare across the three locations indicate that the types, and choice, of services available in a location have a strong impact on an individual's ability or willingness to assert their candidacy for healthcare. The importance of local production of resources in candidacy theory was demonstrated in community 1, where the long wait times and triaging system for appointments highlight an over-run system and lack of personnel resources. In Australia, there are fewer health workers relative to the population in regional areas [59] and the government runs various programs to attract health staff to these areas [60]. Inability to access a timely appointment, or feelings of being culturally unsafe, can be a barrier to accessing primary care, and may even result in avoidance of GP services altogether [61]. Strategies to address this could be more of sexual health outreach provided by the ACCHSs in nearby communities, or provision of transport between locations, to provide additional options for young people in places such as community 1 where there is no ACCHS available.

Several service access barriers were apparent in the navigation and permeability aspects within the candidacy framework. As reflected widely in the literature, shame and embarrassment are barriers to accessing sexual healthcare among young Aboriginal and Torres Strait Islander people [16, 28, 29, 33, 51, 62]. In our study, this is linked to both confidentiality concerns and the level of trust with the clinician. The issue of confidentiality is complex. While the benefit of ACCHSs is that they are community-run, this increases the likelihood that health service staff may be known to service users, which may result in a perceived lack of confidentiality. To address this, alternative options should be offered including the promotion of other, mainstream (culturally safe), anonymous health services. As noted among our participants, the provision of nonjudgemental care can reduce feelings of shame when accessing healthcare for an infectious disease [18]. Other research has demonstrated that integrating STI testing as part of routine, or opportunistic, care can aid in alleviating these barriers [62], a strategy supported by national STI management guidelines [45]. Health services should seek to normalise STI testing and SRH care into routine practice with young people. Some health services offer anonymous telehealth testing options which negate the need to physically attend a clinic [63, 64], and culturally safe education and messaging such as "Take Blaktion" [65] can ensure that young Aboriginal and Torres Strait Islander people have access to sexual health information and are aware of the range of services available to them. Trust, confidentiality, and continuity of care are demonstrated as key factors that minimise shame, and facilitate STI testing by increasing the permeability of, or engagement with, health services [66, 67].

Some gaps were identified that impacted young people's identification of candidacy and navigation, and permeability, of services, including not perceiving the need for STI testing (particularly among young men) and being unaware of available services. Female participants described greater engagement with health services than young men, reflecting findings from other studies whereby men were less likely to present to the clinic for STI testing than women [28, 33]. Indeed, in our study, female participants typically carried the burden of sexual healthcare due to contraception needs, and men who reported being sexually active were less likely to report attending a health service for SRH care, particularly in communities 1 and 2 (see Table 1). To address these barriers to sexual healthcare, jurisdictional health authorities and local health services should ensure adequate health messaging of service availability to priority populations within their respective population targets.

That our participants used all three types of health services shows that young Aboriginal and Torres Strait Islander people need a variety of options where they can retain some anonymity (mainstream GP services and accessible community services) in addition to ACCHS [18]. This will aid in increasing service accessibility (permeability) and ensure young people's capacity to assert agency (candidacy) in addressing their health needs [18]. The literature supports our finding that young people were able to navigate different services for different health needs [18, 68], the importance of continuity of care, social support [16, 69], and that ACCHSs are accessible (permeable) and deliver high-quality care [56]. Choice is an important component of ensuring patient agency in addressing healthcare needs [70].

4. Limitations

This study took place in three communities in regional NSW, and thus the experiences reported relate to a specific context and time. However, national and international studies exploring candidacy and cultural safety reflect similar findings to ours, such as that perceived stigma and embarrassment about STI testing [16, 62] and long wait times for an appointment were barriers to young people asserting their candidacy [68]. Nevertheless, we acknowledge that these findings may not be generalisable to other young Aboriginal and Torres Strait Islander people in Australia or First Nations people internationally due to their unique and nuanced lived experiences. While efforts were made to recruit participants across a breadth of life experiences, the method of recruitment through various community champions including elders, and personnel from health services, schools and youth centres, could mean that the participants in our study are more engaged with services, and this study may not reflect the experience of young people who are disconnected from services or their community.

5. Conclusion

This study used the candidacy framework, supported by a strengths-based approach [37, 38, 47], to highlight the main factors impacting access to SRH services among young Aboriginal and Torres Strait Islander people in regional NSW. Our findings demonstrate that many young people are adept at accessing and navigating sexual health services and that the culturally safe care provided by ACCHSs was highly valuable to young people asserting their candidacy for SRH care. Key barriers included cultural barriers, resourcing and staffing issues, long wait times for appointments, shame, and confidentiality concerns. Opportunities for improving engagement with young Aboriginal and Torres Strait Islander people should include the provision of free, anonymous sexual health services (or improved awareness of existing services); strategies to improve cultural safety in mainstream GP clinics; and ways to further encourage young Aboriginal and Torres Strait Islander men to assert their candidacy for SRH care (such as the provision of nonjudgemental care or targeted health messaging). This study has demonstrated that candidacy theory facilitates an understanding of service access by young Aboriginal and Torres Strait Islander people and can provide a framework to inform policy and practice around engaging young Aboriginal and Torres Strait Islander people in SRH care [47, 56]. However, further work is needed to explore the experiences of sexual health service access among young Aboriginal and Torres Strait Islander people living in urban areas in Australia.

Data Availability

This manuscript reports on qualitative data. To protect participant privacy, the data used to support the findings of

this study are restricted by the Aboriginal Health and Medical Research Council Human Research Ethics Committee, NSW, and the Greater Western Human Research Ethics Committee, NSW. As such, these data are not publicly available.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Authors' Contributions

The authors dedicate this paper to Samantha Williams, who sadly passed away in June 2023. Samantha, a proud Wiradjuri woman, was instrumental to the delivery of this project, and she will be dearly missed.

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