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Community-Based Sexual and Reproductive Health Promotion and Services for First Nations People in Urban Australia

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Context: Little is known about sexual and reproductive health (SRH) access and health promotion for First Nations peoples in Australia. This study aimed to better understand community preferences, knowledge and access to contraception and SRH services, and use this understanding to make recommendations which support approaches led by local Aboriginal community-controlled health organisations (ACCHOs).

Methods: Qualitative First Nations-led yarning circles were conducted with 55 community members and health service providers using and/or working at ACCHOs in urban South East Queensland. Cultural protocols ensured women's and men's interviews were separately collected and analysed. Thematic analysis was conducted by multiple coders, privileging interpretations by First Nations researchers.

Results: Family, kin and friends were described as key knowledge holders and ACCHOs as knowledge spaces for sharing information about maintaining positive SRH and wellbeing for First Nations people. Interviewees wanted accurate and timely information in an accessible, culturally appropriate way. Making informed choices about family planning was described as an important process of agency and self-determination for First Nations people, and contextualized within broader aspirations for growing strong families and healthy relationships.

Conclusion: Understanding SRH through the concept of "knowledge spaces" and "knowledge holders" highlights the collective importance of community relationality to support individual agency and informed SRH decision-making. ACCHOs appear to be acceptable knowledge spaces for SRH information; and evidence-based recommendations may increase their reach. Health services should consider upskilling community SRH knowledge holders to share consistent, accurate and accessible SRH information.

Keywords: Indigenous, community-based health promotion, sexual and reproductive health, contraception, strength-based

Introduction

The collective historical experiences of sexual and reproductive health (SRH) are different for Aboriginal and Torres Strait Islander (herein First Nations) peoples. Their reproductive rights and sexual wellbeing have been subject to colonial control,¹ with early colonizers using sexual violence to debilitate First Nations communities in Australia.¹ Institutionalized assimilation practices saw state control of marriages and infant removals under the White Australia policy.^{1,2} First Nations women were fallaciously imagined as "highly sexualized or sexually deprived"¹ and misrepresented as a source of sexually transmitted infections to further justify their

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segregation from colonial settlers.³ Today, First Nations people experience sexual and reproductive health inequities with higher prevalence of sexually transmissible infections (STIs), maternal mortality and infant deaths.⁴ We acknowledge this historical context that has enabled current inequities to occur as we advocate for positive SRH and wellbeing for First Nations peoples.

The World Health Organisation⁵ defines SRH as “a state of physical, emotional, mental and social wellbeing” implying

that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.⁵

This holistic approach to health is compatible with First Nations worldviews.⁶

There remains a research gap about the experiences and attitudes towards SRH services for First Nations peoples – beyond just STIs and contraceptive usage rates;⁷ as well as ways that First Nations-specific health services can best support First Nations peoples to make informed decisions about their SRH and wellbeing.^{8–10} Even less is known about the experiences and preferences of First Nations men,¹¹ and First Nations people living in urban areas (now the majority) who remain largely underrepresented in health research.¹² Torres Strait Islander people are often excluded from studies conducted on mainland Australia (eg⁸), and there has been limited comparison of the experiences of different age groups¹³ or clinicians’ perspectives within studies.¹⁴ Much of the existing work on contraception, fertility rates and perceptions of family sizes was conducted in the 1970–1980s^{15–17} in a rural setting^{18,19} or focuses on STIs and blood borne viruses.^{9,20} More recent qualitative studies about First Nations peoples’ experiences and preferences for contraception and SRH are small and not generalizable to urban settings. Aboriginal Community Controlled Health Organizations (ACCHO), non-government organizations governed by community elected boards, have been found to be leaders in culturally safe primary health care provision in Australia, including SRH promotion,^{18,19,21–29} though there is limited evidence about the effectiveness of sexual and reproductive health education (SRE) with First Nations peoples.²⁰ This fragmented evidence-base is not sufficient to inform urban health services how they can best respond to their local First Nations community needs.

Our First Nations-led study responds to a request by an urban ACCHO to better understand how they could

provide more relevant and accessible contraception information and services within a broader primary health network (20+ clinics) in South East Queensland.³⁰ This region is home to one of the largest and fastest growing First Nations populations in Australia,³¹ and is a historical and culturally significant gathering place for people from numerous local Nations (including Yuggera, Turrball, Quandamooka, Yugambeh, Munanjahli, Gubbi Gubbi, Jinibara), as well as Aboriginal and Torres Strait Islander people from across Australia. Specifically, this study aimed to: better understand community preferences, access to and decision-making regarding information about contraception and SRH services; and use this understanding to make recommendations to support ACCHOs to provide SRH information and services to First Nations people.

Methods

Methodological Approach

Indigenous research methodologies^{32,33} were used to undertake this work, informed by an Indigenist research approach.³⁴ Indigenous research methodologies utilize methods that privilege the distinct worldviews, knowledges and realities of Indigenous peoples that vital to their survival and thriving, honor Indigenous ways of doing, being and knowing and emphasize influence of context on individual and collective experiences.³³ An Indigenist research approach aims for research with Indigenous peoples to be emancipatory, have political integrity and privilege Indigenous voices.³⁴

Participant Recruitment

Fifty-five participants were recruited from urban South East Queensland ACCHO clinics and programs via posters and invitations from clinic and health promotion staff. Snowballing and purposive sampling was used to recruit ACCHO staff and First Nations clients to ensure representation of men and women across different generational groups, with and without children (see [Table 1](#)).

Data Collection

First Nations-led yarning circles³² ensured an engaging environment for participants to share their experiences. Yarning builds relationships in a respectful and meaningful way; using storytelling to gather information.³² Yarns focused on participants’ understanding of family planning, contraceptive methods and their needs and preferences for information to make informed choices about their fertility.

Table 1 Study Participants

Yarning Circle Groups	N=55
First Nations Elder women (Aunties)	5
First Nations postnatal mothers (baby less than 6 months)	5
First Nations young women, over 18 years (no children)	4
First Nations young women, under 16 years (no children)	4
First Nations young men, over 18 years (with children)	1
First Nations young men, 16–18 years (no children)	19
First Nations women staff	6
First Nations men staff	4
Health service clinicians (First Nations and non-Indigenous) – Group 1	4
Health service clinicians (First Nations and non-Indigenous) – Group 2	3

This included discussions about information and services currently available, considerations for different age groups and genders, and recommendations on what ACCHOs could do to produce timely, accessible and trustworthy resources and services to support decision-making. The yarning circles were hosted by ACCHOS and held between December 2017 to August 2018 at these community locations: an ACCHO maternity service, a young men's camp, two clinics and the head office.

Yarning circles averaged 55 minutes (from 14 to 80 minutes). Parental consent was provided for participants under 16 years (age of sexual consent in Queensland), and written informed consent was obtained from all participants prior to commencing the yarning circle, including for the publication of anonymised responses. Facilitators of yarning groups were First Nations (YR, BB and IF) and the same gender as group participants. Catering and refreshments were provided to all participants and community member participants received a gift-card (AU\$20).

Data Analysis

Yarns were audio recorded and transcribed verbatim by an external transcription service, then reviewed for accuracy by facilitators. Names or personal information were de-identified; NVivoPro 12 Software³⁵ was used for data management. Braun and Clarke's³⁶ recommended steps were used for thematic analysis: data familiarisation, generating initial codes, searching for themes, reviewing themes, defining and naming themes and ongoing reflexivity. To respect the cultural significance and gendered nature of SRH for First Nations people, women researchers read the women's data, and men researchers the men's data during analysis. Four women researchers (two First Nations) separately coded the women's data and came to a consensus on the final themes,

with two male researchers (one First Nations) separately coding the men's data and coming to a consensus on final themes. Where coding differed, interpretations by First Nations researchers were privileged in the findings and consensus reached. Men's and women's findings were then integrated for the final manuscript, with consensus from both groups. To preserve participant confidentiality, quotes are attributed only to the yarning circle group (see Table 1).

Ethics

The study was approved by the University of Queensland Human Research Ethics Committee (#2018000915). This study was conducted in accordance with the Declaration of Helsinki.

Results

Key themes from the yarns included: 1) accessing SRH knowledge from preferred knowledge holders and spaces; 2) SRH knowledge improving life agency; and 3) healthy relationships and strong families promote SRH and wellbeing. All participants spoke of the importance of accurate and timely information about SRH, delivered in an accessible and culturally appropriate way. Community members discussed the importance of non-judgmental and safe environments where they could feel confident to share knowledge in a culturally safe and strength-based way. Staff suggested areas for ACCHOs to improve to ensure a more consistent and accessible approach to SRH services and resources (Figure 1).

Knowledge Holders

Family, Kin and Friends

Most community members cited family, kin and friends as the primary knowledge holders they would go to for

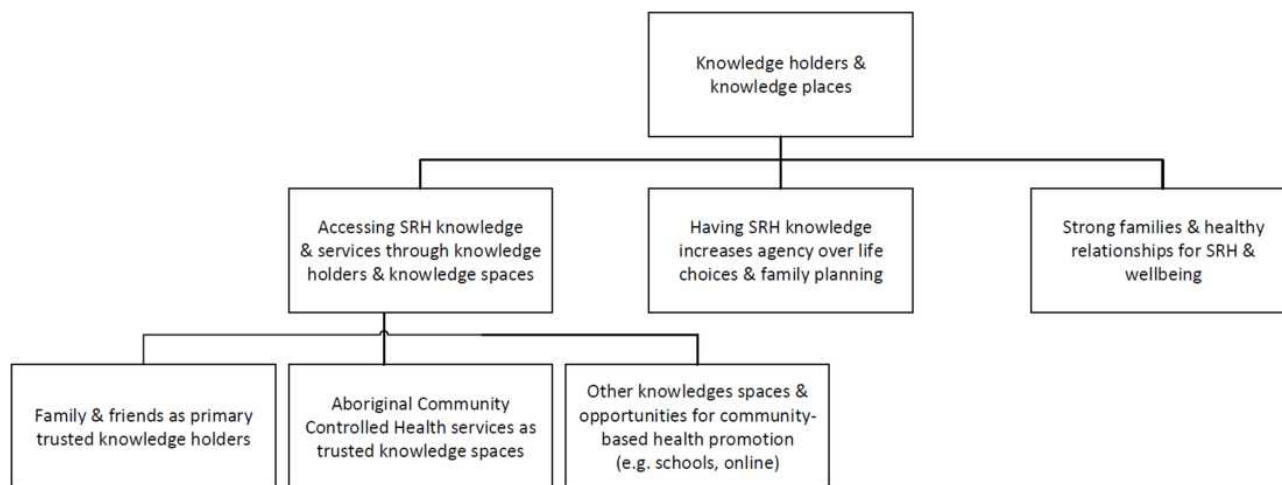


Figure 1 Thematic analysis of First Nations-led SRH yarning circles.

trusted, culturally safe advice about SRH and family planning.

I would talk to a friend, [...] an older sistergirl, or one of my mates [...] 'cause that's more comfortable. [Young woman]

Older women (Aunties/Elders and also postnatal women) all expressed the desire and commitment to support young men and women in determining healthy choices, through the sharing of their own life experiences:

I've made sure with my kids—I never got told anything—then they got told everything because I didn't wanna put them in the same position that I got and the way how it felt. [Aunty]

It's about, I think, too, breaking the barrier, making it where it's not shameful for people to talk. [Aunty]

It was considered important to support their grandchildren, children, nieces and nephews to make informed decisions about contraception.

It's about being a mother and an aunty and now to just support them young girls. Hopefully they'll learn from it and they'll pass it down. [Aunty]

Some female staff discussed how they had conversations about sex with their children that was gender and age-appropriate. It was important to be open and honest and answer any questions about contraception.

I know it's still a long way off, but I know [partner's name] has spoken that he feels that's his responsibility for our son. And he said my responsibility is the girls. [First nations woman, staff]

Whilst community members said they usually feel most comfortable talking about SRH with people of the same gender, Women's and Men's business was not always exclusive; and also relied on closeness of existing relationships.

My dad [...] made sure we knew everything [...] Me [...] and my dad have a close relationship. [Young Woman]

my mum was pretty open with me and, I guess, wanted to make sure I did the right thing. She said, 'once you're sexually active, let me know and I'll get you condoms.' Of course I didn't let her know, but she still gave me that education. [First Nations man, staff]

Key reasons for men seeking SRH knowledge from kin and friends were they were sexually active and a desire to do the right thing by their partner. Other reasons were exposure to school based sexual education and their partner initiating discussions about SRH.

Knowledge Spaces

Aboriginal Community Controlled Health Organisations

ACCHOs were spaces cited where they could access accurate information, in a safe environment.

I think Mum just assumed that I wasn't gonna have sex so she didn't [chuckles] talk to be about contraceptives. I think it was the [ACCHO staff member] who sat me down. I was just getting a regular health check and they said 'Are you sexually active?' ... They told me all the risks and stuff, and why I should be using protection [...] I knew that doctors were confidential and stuff, but I just

didn't know that's a conversation you can sit there and have with your doctor. [Young woman]

As specialized services, ACCHOs made it a priority for staff to facilitate spaces (including outside clinical settings) to make clients feel safe and comfortable to share information:

I've found people are engaged more that way [using yarnning groups] and they ask questions [...] if you feel unsafe, you don't have to talk. This is an opportunity for us to talk together in a safe place, so we've created a safe place to discuss. [...] being able to speak whatever comes to mind, whether it's funny and being able to laugh helps with engagement. [First Nations man, staff]

ACCHOs were seen as providing trustworthy and reliable information through a holistic approach; this is in contrast to the biomedical approach of non-ACCHO providers:

I went to the [non-ACCHO] doctor to talk about contraceptive, because I don't live close to the [ACCHO], and he [the non-ACCHO doctor] gave me a big sheet [contraception pamphlet]. [...] I don't really trust [the non-ACCHO] doctor because he's very ... He's a man for starters, but he's so medically driven. [Postnatal woman]

The First Nations women interviewed described preference for female health professionals to discuss their family planning options:

I trust a female doctor a lot more to talk about that kind of stuff. [...] Even the [female] nurse is a big help for me. [Young woman]

Female clinicians reported they felt they had more positive experiences when discussing family planning with clients compared with their male colleagues; though one postnatal woman did describe a positive experience with a male doctor from an ACCHO:

I had an unplanned pregnancy [...] he printed out lots of information for me [...] to weigh up [my] decision [of whether I] wanted to keep the baby or not keep it, and he was really open to me about it. He didn't pressure me into either way. He's like, 'It's your decision. You need time to think. [Postnatal woman]

Clinicians agreed that they needed to be mindful of striking a balance between worldviews, un/conscious bias about contraception and health advice when engaging with clients. They also felt that life experiences influenced how receptive women were to receiving SRH advice; for

example, clinicians suggested mothers in their twenties are possibly more receptive to contraceptive advice than teenagers.

Although clinicians had provided contraception advice to many clients, they felt that clients were sometimes reluctant to follow the advice, suggesting knowledge from family, kin and friends was not always the in alignment with current evidence-based biomedical knowledge, particularly for the more recent contraceptive innovations:

... we will be so much more successful as clinicians if the community conversations are alongside us. [Clinician]

Men did not commonly access the ACCHO specifically for SRH. Rather SRH care and promotion was opportunistically provided during their attendance for acute illness or an adult health check:

I suppose back then, when I was around 16, 15, the only time I really went to the doctor was when I was sick. I don't think I really had a stable doctor to be able to talk about that stuff with. [Young man]

Clinicians also reported they had few discussions with men regarding vasectomies due to lack of clients requesting, or seeking information about the procedure.

Men were more likely to seek SRH information from family, kin and friends than a doctor. Young men were generally reluctant to discuss sexual health, including accepting or receiving a test for sexually transmitted infections. A common reason for this reluctance among young men was that they did not have a stable doctor with whom to build a trusting relationship.

they're very reluctant to discuss it even to another male. [Male clinician]

The young men interviewed were not very familiar with the First Nations health worker role at ACCHOs yet liked the idea of a community-based sexual health worker to assist with simplifying and contextualizing SRH information, through the use of real life scenarios or through peers with lived experiences.

Affordability of some forms of contraception was cited as a barrier to access:

I've had a few conversations about [vasectomies] but cost is always the biggest factor. [Clinician]

That's not something that I think in the forefront of my head, okay vasectomy is an option to discuss because it's sort of out of the reach of our clients. [Male clinician]

Timely access to clinicians when information was needed and was also cited as a barrier to SRH services:

Waiting at the clinic is too long. You might turn up at the doctors to talk about women's stuff [contraception, women's problems etc] but you get turned away because there is no appointment times [available] and [you] have to wait 3 weeks [to get an appointment]. [First Nations woman, staff]

The timing of conversations about contraception was questioned by postnatal women who thought the conversation at the six-week postnatal check-up was too soon after the birth:

I didn't wanna have the contraception talk when they [maternity care providers] were coming out to the home visits 'cause I was like trust me, I'm not having sex. [Postnatal mother]

Like it was the last thing on my mind, but now that she's [her child] 16 weeks, now I'm ready to kind of think ... Now I'm ready to have that conversation ... 'Cause my body's starting to feel normal again. Maybe I'll let my partner touch me. [Postnatal woman]

Clinicians recognised a need to increase workforce capacity at the ACCHOs to continue to respond to community need and aspirations for positive SRH and wellbeing.

There's a lot of work that we can do in terms of raising the bar across our own suite of providers. So really making the best use of the whole workforce. Not just relying on clinicians but actually the whole workforce. Then for clinicians I think there are definitely gaps in knowledge, some preconceived ideas and understanding. [Clinician]

Other Spaces

School was sometimes described as a site for SRE but on the whole, participant consensus was that one-off sessions by external providers were not particularly helpful:

It was just one day, the sexual education people came in and the boys went to one room, we went to another [...] it was basically just putting a condom on a banana [...] I don't remember them talking about contraceptive [...] I guess whatever they did speak about, nothing sunk in apart from yeah, how to put a condom on! [Young woman]

Men reported wanting to receive information in a setting and format that facilitates safe, open, and interactive communication. Recreational, cultural and physical activities were identified as necessary ice breakers for making men feel safe and comfortable enough to talk openly about SRH.

A suggestion was made for the ACCHOs general health promotion teams that worked with young people to make SRH education more fun and engaging, and to take the "shame" (Aboriginal English for stigma, embarrassment, reluctance) out of talking about SRH.

... something that will make them laugh. In circumstances that they might actually be in, if that type of video. Something that they can laugh and relate to, I think is the best way. [First Nations man, staff]

Yarning groups, gender-mixed or gender-specific depending on client preferences, were considered a culturally safe way to have conversations about SRH with young men and women.

It might be uncomfortable for some of them to all be in the same room together and talk about it. But it's probably a good thing because they're exposed to it together, the same education, they can relate a little bit better if the opposite sex is in that room. But then again, some stuff has to be gender-specific. [First Nations man, staff]

The participation of First Nations health workers, peers and elders in yarning groups was considered important for discussing real scenarios and the lived experiences of peers.

Women across every yarning circle shared that they went online to search for contraception information rather than any specific online website; which could lead to unwanted sexually explicit content, misinformation and advertisements on their computers. Women described their uncertainty about the trustworthiness of online information as a source of contraception information:

I think going online too also gives me a bit of anxiety. I freak out a little when I read [SRH] information and it's in front of me on the screen. I'm just like, "oh you can't take this [morning after pill] so many days after. It's not going to work. I'm just like shit! [Young woman]

When you read a lot of [the comments] online, like [from] other mums with their experiences. And then you think, "Oh no, is that good for me?" Or, "What if that happens to me?" Or, you hear stories like, shock-stories, about certain contraception's, like I have and it turned me off a lot, and then I tried it myself and it didn't happen to me. [Postnatal woman]

The experience of one male worker was that males accessed online content for information on the treatment of STIs, but not for general SRH information.

There is no attraction to jump on the web, unless you think you've got something, to find out a bit more about. What do I do? [First Nations man, staff]

Is it around contraception and sexual health, because I know they won't get on there [the web] and do that stuff? [First Nations man, staff]

Unmediated information searching online made judging the credibility of online information challenging:

Facilitator: How do you filter out good information versus rubbish information?

Young woman: I don't even know, hey. I feel like I just do a lot of research, like when I want to know something. I just research everything, and what's more out there, I guess. I don't know. Yeah. And doctors. What doctors say.

Clients were more likely to trust SRH information when it is provided through health services and/or by providers with whom they have a strong positive relationship:

I need to have a relationship with someone before I trust them [and the information they give], like I can see doctor for the first time, [but] I'd probably be more inclined to listen to the midwife that went through my whole pregnancy than to listen to, a doctor that I was seeing [once]. [Postnatal woman]

It doesn't have to be a clinic. You just need to ask a few questions [...] So maybe if you were able to just call someone. [Postnatal woman]

An opportunity was identified for the ACCHO to create or moderate an online portal or app via their website that would contain up-to-date, evidence-based SRH information, that would be accessible as needed including after hours and importantly presented in an engaging, easy to understand and culturally safe way.

I just lose attention span when I watch videos. So it's just easier and it's more engaging, if you're doing quizzes. [Young man]

There was also support for a telephone support hotline that would not only provide information but emotional counselling by an experienced, respected and knowledgeable community Elder. Participants from all age groups supported this idea.

Agency and Life Choices

Contrary to common deficit lenses of dysfunction and stigma of teenage pregnancies, older women spoke at length of their own resilient stories of being young First Nations mothers and some of the hardships they had overcome and importantly, the need to support younger girls who were having a baby:

If she wanted to have that baby, it's up to her. She's a young girl, she's a child. We know that, but at the end of the day, she wants to have that baby. She's got plenty of support there. [Postnatal woman]

Family planning was considered by women as part of having control over one's life choices:

I think having a kid would be really stressful, and I'm not ready for that just yet. I just wanna be young and [...] chase some goals [...] I like being young and in control of my life. [Young woman]

They're [young women] pushing their babies around [...] my sister's 19 and she's got a child and that's the lifestyle she wants, whereas I want the lifestyle of working and then might have kids. [Young woman]

That's the main thing I think of when I think of contraceptive. I have control when I wanna have a kid. What's happening to my body. [Young woman]

This extended to having choices about different contraceptive options as people had different preferences:

... one of my mates in school, she was sexually active and I started talking about [Implanon] with her, and I said "How do they put it in?" And she told me to feel it and I could feel this little object under the skin. I had this visual image just like them injecting a massive bar and creating a big hole just shoving it in. So, I just went for the needle, but I would recommend the other two [Mirena and Depo provera] just because I was scared of the bar. [Young woman]

But everything [contraception] affected me, all of it, differently too, and I'm glad I tried it all, 'cause I know, but I'm just gonna stick ... After trying everything, and making my body go through all of that crap, I'm just happy to stick to condoms, go back to basics. [Postnatal woman]

I don't like putting artificial things in my body. [First Nations woman, staff]

Postnatal women also yarned about how they would appreciate support on how to plan for another baby:

I would love a family planning day that could just explain to me how my life would look with another baby. I've already got one but what would my life look like with a toddler and a baby in daycare and expenses and sports and schools and stuff, that would be really helpful to me.
[Postnatal mother]

This mirrored the approach by some clinicians to include the conversation as part of general life coaching and planning.

So talking to young people about what do you want to do when you leave school, what are your plans, what are you studying at the moment. Then using that as an entrée to talk about family planning, about the contraception you're using and how would having a baby affect your plan.
[Clinician]

For the First Nations men interviewed, it was also important to contextualise family planning information into their everyday life, roles and responsibilities and embed family planning messages into the social and cultural aspects of being a First Nations man.

Because I know us as older men, we have, just in the room, the self-confidence in here is low when it says, go get an STI check-up, how often you should do it. How do you expect a 13-year-old boy to lead the way when us as men don't even do it? [Older First Nations man, staff]

Healthy Relationships, Strong Families

Similar to the WHO holistic definition of SRH,⁵ participants emphasized that SRH could not be considered in isolation and that healthy relationships were essential to ensuring positive wellbeing and strong First Nations families.

... there needs to be more [about] the relationship itself, it's not all about sex. It's about respect and strengths ...
[First Nations woman, staff]

Participants suggested this was something that could be incorporated more into SRE.

... even when they [schools] teach [sexual health education], it's only like anatomy. They don't actually talk about relationships and what to expect ... [Postnatal mother]

One participant suggested that relationship counselling is important part of SRH services that could be provided by the ACCHO:

... there needs to be more ... the relationship itself, it's not all about sex. It's about respect and strengths and the woman as well. [First Nations woman, staff]

Similarly, a clinician spoke about the integration and expansion of yarns about health relationship into existing health promotion programs:

I think our [community-based health] programs really need - we need to be more involved about - and we don't even know what they say around contraception and healthy relationships and how comfortable they are at having that kind of conversation or being a foot soldier.
[Clinician]

This was considered part of building strong families and empowered communities:

They [young women] need somebody they can say, to look up to say, "Well this is a strong black woman ... She's proud of herself, [and of] what she does. [Aunty]

Discussion

Colonial attempts to control the sexual and reproductive health of First Nations peoples has resulted in SRH disparities and fragmented access to culturally safe information and support.^{1,37} Yarning with an intergenerational mix of First Nations men and women who attend ACCHOs, as well as First Nations and non-Indigenous health professionals, we found that family, kin and friends were seen as primary trusted knowledge holders for accessing SRH information, with ACCHOs viewed as trusted knowledge spaces. Other knowledges spaces and opportunities for community-based health promotion included online and schools but were less preferred. Community members approached SRH as part of broader holistic health and wellbeing, emphasizing the importance of reproductive autonomy for First Nations peoples. They believed it was important to have strong, healthy and empowered First Nations people making informed decisions about family planning, with family, kin, friends and ACCHOs being key facilitators of this. These findings reiterate the importance of First Nations-led initiatives that celebrate First Nations ways of knowing, being and doing, to counter to deficit-based colonial narratives about SRH behaviours for First Nations peoples and promote positive SRH and wellbeing.³⁷⁻³⁹ Recommendations on how to support knowledge holders (family, kin, friends, community) and how to support knowledges spaces (ACCHOs) are now provided. They come with the important caveat that

service responses should be customized to reflect the needs and aspirations of the local demographic and client group, taking into consideration culture, gender and age.

How to Support Knowledge Holders Recruit and Support Family, Kin and Friends as Community-Based SRH Champions

The results suggest ACCHOs should prioritise community health promotion that builds Elders, peers and family capacity to be involved in providing and supporting access to SRH and increasing general community knowledge about SRH and accessible contraceptive options. Similar to previous studies from regional and remote areas, the older women interviewed did not cast moral judgements on the sexual behaviours and choices of young people instead they offered support¹⁸ and wanted to build resilience and self-esteem in younger generations.¹³ These Aunties were enthusiastic to learn more about the effectiveness of different types of contraception to be able to better support younger people in their families and communities; this should be encouraged given the influential role of women in First Nations communities as formal and informal leaders.¹³ ACCHOs are well-placed to facilitate this, as trusted knowledge spaces. We recommend considering employing community champions who can assist with promoting positive, accessible and accurate SRH information in the community; this should include a diverse cross section of the population, including young people, Elders, and sexually diverse and gender diverse peers. The Deadly Choices program, now widely used across Australian ACCHOs and includes some SRE in their school-based program, provides a structure that would support further inclusion of SRH champions in these services.²² Previous studies suggest strong engagement in SRH promotion programs happens when they are designed by and for the community themselves,^{39,40} when the workforce includes peers such as family, Elders and community members in delivering support^{1,39,41} and uses innovative and creative strategies to engage young people in SRE;⁴² however the effectiveness of peer-led education among young First Nations people is currently unknown and further research is needed.⁴³

How to Support Knowledge Spaces Consistent Messaging Across the Organisation That SRH is Everyone's Responsibility

There is a need to harmonize SRH messaging across the workforce to improve client access to, and community

demand for, SRH services including contraceptive provision. With over 1400 staff employed by across the region, over half being First Nations people, this could represent considerable knowledge gain throughout the community. SRH as everyone's responsibility should be prioritised as an area for strategic action and integrated into all routine care through a positive, strengths-based approach.³⁸ A multi-disciplinary team approach involving nurses, midwives, health workers, family support workers; not just medical doctors, could optimise opportunities to talk about SRH with clients.

Incorporate SRH and SRE into Everyday Discussions About Healthy Lifestyles and Strong Relationships

Participants wanted to receive SRH information in a way that took into account their everyday life and aspirations, that focused on establishing trusting relationships first (whether with a health professional or their partner) and was based in community. Community members prioritised healthy relationships and building strong families, explaining that with robust foundations in communication in trusting relationships, conversations about sensitive topics such as safe sex and family planning can occur.⁴⁴ We recommend health services integrate family planning into conversations about life plans and goals to normalise SRH and engage clients at different life stages and in different settings. Health professionals should set the scene (and schedule enough time) to prepare patients for routine questions within the annual Health Assessment Item 715,⁴⁵ including prompting discussions about life goals in the context of building a healthy community and the social and cultural aspects of being a strong First Nations person. Other opportunistic touch-points in the system of care pathway include chronic disease management for men, and women of child-bearing age, maternal and antenatal care visits, six-week postpartum checks, unplanned pregnancy consultations, presentations for family violence or assault, and before and after termination of pregnancy. The aim is to educate and empower First Nations men and women to exercise autonomy over their choices and SRH, and address negative stories and stigma influencing perceptions of SRH through strength-based approaches that centre positive relationships. ACCHOs could provide these conversations in a culturally safe way.²¹

Provide Regular Contraceptive Training and Education to All Staff

As reported by a recent study,⁴⁶ most health professionals believed they would benefit from further training about contraception specifically (effectiveness of different

methods, including new methods, and skills for implant procedures), as well as more general counselling skills about how to approach these conversations with their First Nations clients. We recommend all staff to undergo mandatory basic training to assist with harmonizing the organisation's SRH response; with specialised supervised training for staff involved directly with contraception information counselling and administration, including the insertion of contraceptive devices (eg implants and intrauterine devices), management of unplanned pregnancies and emergency contraception. Should expertise or resourcing not be available internally, ACCHOs could consider developing sustainable training partnerships, relationships and referral pathways with relevant local, statewide or national SRH organizations such Children by Choice or state-based Family Planning organisations. Investment in building these relationships between ACCHO and external partners would be critical for this arrangement to work;⁴⁷ with staff turnover and changing workforce composition for both the ACCHO and partner organisations to be factored into this two-way capacity building initiative.

Creatively Engage Community in SRE Activities

Creative ways to engage community in SRE activities that address gender sensitivities should be considered. This is particularly important for younger (and often healthier) clients who may not be in contact with a regular healthcare provider. Younger community members (men and women) preferred interactive learning opportunities such as yarning circles or in a digital format (eg ACCHO website or application). Health promotion initiatives such as using technology and music have been found to raise awareness and knowledge of health education,^{20,42} though in of itself may not result in behavior change.^{48,49} Appropriate resources should be allocated to implement these community initiatives. Deadly Choices provides an ideal platform to expand the existing highly effective health promotion activities to incorporate more targeted SRH messaging and education, delivered by their young First Nations workforce.

Incorporate SRH into Continuous Quality Improvement Activities

Our results suggest that SRH education and services should be included in routine health care provision and health promotion across services; an activity that would be enhanced through integration with routine continuous quality improvement programs.⁵⁰ This data monitoring

could be used to understand use and access to different methods of contraception (including long-acting reversible and irreversible contraceptive options), timely treatment of STIs and provide ongoing support for staff and clients.

Strengths and Limitations

Participants were recruited solely from the ACCHOs in South East Queensland, therefore are to some degree already engaged in health services. Their experiences and preference may differ for First Nations people accessing private or public health services and those who have little or no engagement with health services. Yarning with community members of different ages was a key strength of this study. Further research to understand how health services can better support the distinct and diverse needs of First Nations LGBTQI+ peoples is needed. The findings from the young women's yarning circle (under 16 years) were limited and data saturation was not reached with this group. This may be due to the sensitivity of discussing contraception among peers or not being sexually active as only one young woman stated she used contraception.

Conclusion

Historical trauma that First Nations have endured in relation to SRH is important when applying key learnings in going forward; particularly, the need to focus on strength-based, community-led services and health promotion.^{38,44} Our study found ACCHOs can be exemplars for other health services on how to make First Nations people feel comfortable when having seeking access to SRH care and knowledge, and harness the roles of community SRH knowledge holders within these knowledge sharing spaces, to ensure First Nations people have consistent and accurate SRH information and equitable access to contraception for general health and wellbeing.

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Disclosure

The authors report no conflicts of interest in this work.

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