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Sexual agency, risk and vulnerability: a scoping review of young Indigenous Australians’ sexual health

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\textbf{ABSTRACT}
This review of qualitative research examining young Indigenous Australians’ sexual health highlights the profoundly social nature of young people’s sexual lives. Nineteen peer reviewed published papers were identified for inclusion. Findings reveal efforts made by some young Indigenous Australians to control their sexual lives, mitigate risk and maintain their sexual health. The review identified factors which are conducive to sexual health risks and vulnerability, including incomplete knowledge about STIs and safer sexual practices; gossip and ridicule concerning sexual activity and its consequences; damaging expectations about male prerogatives with respect to sexual relationships; limited inter-generational communication about sexual health issues; inadequate school-based sexual health education; and tensions between Indigenous and biomedical explanations of sexual health issues. Future research priorities include a focus on young Indigenous people in cities and towns across Australia, and in regional and remote settings in New South Wales and Victoria; understanding how Indigenous cultural values support young people’s sexual health; young men’s sexual and service-based practices; and the experiences of same-sex attracted and gender diverse youth. This research would inform the design and delivery of culturally safe and acceptable sexual health services and programmes, underpinned by an understanding of factors in young Indigenous Australians’ everyday sexual lives.

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\textbf{KEYWORDS}
Sexual health; STIs; pregnancy; young people; Indigenous people; Australia

\textbf{Introduction}

Research reveals that young Indigenous (Aboriginal and Torres Strait Islander) people in Australia are more likely than their non-Indigenous counterparts to experience unexpected or unwanted sexual health outcomes, including sexually transmitted infections (STIs) and pregnancy. Surveillance data from 2015 document higher notification rates of Chlamydia, infectious syphilis and gonorrhoea among Indigenous young people aged 15–29 years compared to older Indigenous people and non-Indigenous age peers (Kirby Institute 2016). In 2013, national perinatal data indicates that Indigenous mothers (17.8\%) were almost seven times more likely than non-Indigenous mothers (2.7\%) to be teenagers (AIHW 2016).
However, in relation to STIs and blood-borne viral infections, behavioural data from a national survey of 2877 Indigenous Australian aged 16–29 years during 2011–2013 (Ward et al. 2014) provides a more optimistic assessment of young Indigenous Australians’ sexual health. For example, 69% of respondents were able to correctly answer at least three quarters of a set of twelve questions concerning the prevention and treatment of STIs and blood-borne viral infections. The vast majority (95%) of respondents reported that their last sex had been ‘wanted’, and over 90% of participants reported positive feelings – such as feeling ‘good’, ‘happy’ and ‘loved’ – about their last sexual encounter. Nearly three quarters (74%) of 16–19 year olds and 67% of 20–24 year olds indicated that their last sex partner was in the same age category, and over two thirds (68%) of respondents aged 16–19 years reported using condoms during their last sex. Finally, 61% of this sample reported that they had ever been tested for STIs, and 42% of the sample had been tested in the previous year. These findings suggest that, while sexual health problems persist in communities of high STI prevalence, some young Indigenous people already adopt risk reduction strategies that can help to prevent STIs and unwanted pregnancies.

Qualitative research on young people’s sexuality and sexual health complements surveillance and survey data by examining the reasons young Indigenous people are at increased risk of negative sexual health outcomes (MacPhail and McKay 2016, 2), and the range of strategies they utilise to reduce sexual health risks and vulnerabilities in their everyday lives. Drawing on the social science concepts of sexual agency, risk and vulnerability, this paper reviews the published qualitative literature focussing on young Indigenous people’s experiences of sexual health in Australia. To our knowledge, such a review has not been conducted previously and results from it have the potential to inform the design and implementation of sexual health programmes and services that are perceived by this population as acceptable, relevant and culturally safe.

Scoping review methodology

A scoping review is a transparent, rigorous and structured method used to synthesise and analyse published literature and to identify knowledge and research gaps (Arksey and O’Malley 2005). It may be the precursor to a systematic review of one kind or another, but usually consists of the following stages: identifying a research question or topic; identifying relevant studies; study selection; synthesising and interpreting qualitative data; summarising and reporting on the results (Arksey and O’Malley 2005). Scoping reviews do not generally seek to assess the quality of evidence presented (Arksey and O’Malley 2005). Given the relatively small number of papers on sexual health and Indigenous Australian youth, our aim therefore was to undertake a comprehensive review of available published qualitative research.

Definitions and concepts

For the purposes of the review, we adopted the World Health Organisation’s (WHO) (2006, 5) working definition of sexual health. This definition highlights the importance of physical, emotional, mental and social well-being in relation to sexuality, a positive and respectful approach to sexuality and sexual relationships, the possibility of pleasurable and safe sexual experiences, and the protection and fulfilment of people’s sexual rights. Key
elements of sexual health embraced by this definition include STIs, unintended pregnancy and safe abortion, sexual and gender-based violence, sexual health education, sexual orientation and gender identity (WHO 2010, 6).

A number of key social science concepts relevant to young people and sexual health also informed the review process. This included the concepts of individual risk and social vulnerability, which have been identified as contributing to negative sexual health outcomes across a range of populations and settings (Aggleton 2004; WHO/DfID 2004). Individual risk can be defined as the probability that a person will experience an adverse sexual health event, and is characterised by what individuals know and do in relation to their sexual health (Melendez and Tolman 2006). Social vulnerability arises from a constellation of social, cultural, economic, legal and health system-related factors that affect people’s opportunities to keep themselves safe sexually (Melendez and Tolman 2006). Such factors are sometimes separated into proximal (e.g. interpersonal relationships, access to health services) and distal (e.g. cultural beliefs, poverty) categories (Eaton, Flisher, and Aaro 2003). Finally, the notion of sexual agency describes the process by which people forge their own sexual trajectories, by initiating sexual relationships while navigating broader social expectations and influences, often, but not always in ways that are satisfying and relatively free of risk (Bell 2012). In this paper, we use this term to emphasise the importance of a strengths-based approach that seeks to understand what young Indigenous people do to maintain control over their health as they begin living their lives sexually (Mooney-Somers et al. 2012).

Identification of studies

The following databases were searched to identify relevant peer-reviewed papers: Scopus, PubMed, Applied Social Sciences Index and Abstracts (ASSIA), Education Resources Information Centre (ERIC). Various combinations of the following search terms were used during the search: ['Aborigi*' or 'Indig*'] AND ['sex*' or 'pregnan*'] AND ['young people' or 'youth' or 'adoles*']. The publication period included all years in each database until the end of 2015. The study population comprised young Indigenous Australians. The age range was determined by the research under review, and included young people aged 13–34 years. Papers were excluded if the research was not conducted in Australia; was not published in English; reported solely on quantitative data; was not peer reviewed; and did not contain primary data. We also excluded media articles, conference abstracts, conference reports or unpublished grey literature. Finally, we excluded articles not accompanied by a full description of the research study in question. Further searches were made using the reference lists of each paper, at the UNSW Sydney university library and using Google Scholar. Two specialist journals chosen for their coverage of Indigenous Australian health issues – the Australian and New Zealand Journal of Public Health and the Aboriginal and Islander Health Worker Journal – were hand searched. A total of 1534 unique references were identified. After screening for the above characteristics, 19 peer-reviewed papers were retained for review. This process is illustrated in Figure 1.

Data extraction and synthesis

The final 19 papers were reviewed independently by Bell and Maher using a standardised data extraction tool – in the form of a Word document specifically designed by the authors.
for this review. Two types of information were collected. The first included referencing information, study population, location of study, and a description of the research methods and analysis processes. The second extracted findings deductively from each paper in relation to four main themes – young people’s sexual agency, individual risk, and proximal and distal factors affecting social vulnerability – in line with the conceptual framework underpinning the analysis. Further inductive synthesis of data extracted from each paper followed a thematic analysis approach within each of the four themes following Strauss and Corbin’s (1990) system of ‘open’ and ‘axial’ coding. Open coding involves reading through the narrative data to increase familiarity with the material and to prepare ‘theoretical memos’ (Strauss and Corbin 1990) as analytical reminders for generating ideas and making links between different findings. Axial coding describes the later process of linking or organising open codes into themes and sub-themes, and providing evidence to support thematic findings.

Findings

The characteristics of the final 19 papers are summarised in Table 1. Collectively, these papers reported on data collected during ten research projects: two separate anthropological studies, in Arnhem Land in the Northern Territory (Burbank 1987, 1995; Burbank, Senior, and McMullen 2015) and southeast Arnhem Land, Northern Territory (Senior and Chenhall 2008, 2012, 2013; Burbank, Senior, and McMullen 2015); the ‘Our Lives’ study
<table>
<thead>
<tr>
<th>Citation</th>
<th>Focus of paper</th>
<th>Research design</th>
<th>Study population</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burbank (1987)</td>
<td>Pre-marital sex norms</td>
<td>Anthropological fieldwork</td>
<td>55 ‘adolescent’ girls’ (no age range specified) in a remote community</td>
<td>Remote, Arnhem Land, NT</td>
</tr>
<tr>
<td>Burbank (1995)</td>
<td>Adolescent sexuality and female reproduction</td>
<td>Anthropological fieldwork</td>
<td>59 ‘adolescent’ mothers (no age range specified) with children up to 5 years</td>
<td>Remote, Arnhem Land, NT</td>
</tr>
<tr>
<td>Lockyer and Kite (2006)</td>
<td>Teenage pregnancy, contraception and health service access</td>
<td>Semi-structured interviews</td>
<td>9 young women (&lt;25 yrs) who had fallen pregnant during their teenage years (no age range specified)</td>
<td>Remote, East Pilbara, WA</td>
</tr>
<tr>
<td>Kelly and Luxford (2007)</td>
<td>Sexual health service provision</td>
<td>Focus groups</td>
<td>Young Aboriginal women (no age range specified)</td>
<td>Urban, Adelaide, SA</td>
</tr>
<tr>
<td>Larkins et al. (2007)</td>
<td>Relationships, sex and contraception</td>
<td>Mixed methods – survey and focus groups</td>
<td>Focus groups with 41 female and 18 male students in Years 9–12 (no age range specified)</td>
<td>Urban, Townsville, QLD</td>
</tr>
<tr>
<td>Stark and Hope (2007)</td>
<td>STIs and condom use</td>
<td>Semi-structured interviews</td>
<td>24 Aboriginal women, aged 19–34</td>
<td>Remote, Central Australia, NT</td>
</tr>
<tr>
<td>Senior and Chenhall (2008)</td>
<td>Sexual activity and teenage pregnancy</td>
<td>Observation, group discussions</td>
<td>Young women in school, Young mothers (no age range specified)</td>
<td>Remote, Arnhem Land, NT</td>
</tr>
<tr>
<td>Mooney-Somers et al. (2009)</td>
<td>Resilience to STIs and BBVs</td>
<td>Peer-led interviews</td>
<td>17 men and 28 women, aged 17–26</td>
<td>Urban, Townsville, QLD</td>
</tr>
<tr>
<td>Larkins et al. (2011)</td>
<td>Young motherhood</td>
<td>Focus groups and semi-structured interviews</td>
<td>41 female and 18 male students (14–18 yrs); 10 young pregnant or parenting women (no age range specified)</td>
<td>Urban, Townsville, QLD</td>
</tr>
<tr>
<td>Mooney-Somers et al. (2011)</td>
<td>STIs and BBVs</td>
<td>Peer-led interviews</td>
<td>17 men and 28 women, aged 17–26</td>
<td>Urban, Townsville, QLD</td>
</tr>
<tr>
<td>Mooney-Somers et al. (2012)</td>
<td>Young people’s STI prevention practices</td>
<td>Peer-leading interviews</td>
<td>17 men and 28 women, aged 17–26</td>
<td>Urban, Townsville, QLD</td>
</tr>
<tr>
<td>Senior and Chenhall (2012)</td>
<td>Boyfriends and babies, now and future</td>
<td>Observation, group discussions</td>
<td>Approx. 59 young women aged 13–23</td>
<td>Remote, Arnhem Land, NT</td>
</tr>
<tr>
<td>Chenhall et al. (2013)</td>
<td>Youth-friendly sexual health research</td>
<td>Observation, group discussions, body mapping</td>
<td>118 young people, aged 16–25</td>
<td>Regional, rural and remote: NT, WA and SA</td>
</tr>
<tr>
<td>Senior and Chenhall (2013)</td>
<td>Health beliefs and behaviours</td>
<td>Observation, interviews</td>
<td>Approx. 150 people, general population, including some young people (no age range specified)</td>
<td>Remote, Arnhem Land, NT</td>
</tr>
<tr>
<td>Senior et al. 2014</td>
<td>Perceptions of risk from STIs</td>
<td>Observation, group discussions, body mapping</td>
<td>88 Indigenous and 83 non-Indigenous young people, aged 16–25</td>
<td>Regional, rural and remote: NT, WA and SA</td>
</tr>
</tbody>
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(Continued)
which investigated young people’s sexual behaviour and decision making in the Northern Territory, Western Australia and South Australia (Chenhall et al. 2013; Senior et al. 2014; Helmer et al. 2015); ‘The Indigenous Resilience Project’ in Townsville, Queensland, which used qualitative methods to explore young Indigenous people’s views of blood-borne viral and sexually transmitted infections affecting their communities (Mooney-Somers et al. 2009, 2011, 2012); the ‘U mob Yar Up’ project in Townsville, Queensland which used qualitative research within a mixed methods study to explore attitudes and behaviours towards relationships, contraception, safe sex, pregnancy and parenthood (Larkins et al. 2007, 2011); one study in South Australia (Kelly and Luxford 2007); two separate studies conducted in Western Australia (Lockyer and Kite 2006; Reibel et al. 2015); and two separate studies in the Northern Territory (Stark and Hope 2007; Ireland et al. 2015).

The papers focus overwhelmingly on young Indigenous research participants’ heterosexual sexual experiences and relationships. Only one study in a remote community in the Northern Territory discussed same-sex attraction and gender diversity, reporting briefly that some young research participants were aware of same-sex attracted and gender diverse young Indigenous people, but perceived them as residing in urban centres (Ireland et al. 2015). This review therefore reports only on heterosexually active young Indigenous people.

**Table 1. Continued.**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Focus of paper</th>
<th>Research design</th>
<th>Study population</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helmer et al. (2015)</td>
<td>Sexuality education amongst young people</td>
<td>Observation, group discussions, workshops, body mapping</td>
<td>88 Indigenous and 83 non-Indigenous young people, aged 16–25</td>
<td>Regional, rural and remote: NT, WA and SA</td>
</tr>
<tr>
<td>Ireland et al. (2015)</td>
<td>Young women’s sexual health behaviour and knowledge</td>
<td>Participant observation, interviews, ethno-physiology drawing, focus groups</td>
<td>12 women, aged 16–33</td>
<td>Remote, NT</td>
</tr>
<tr>
<td>Riebel et al. (2015)</td>
<td>Pregnancy care, antenatal engagement</td>
<td>Semi-structured interviews</td>
<td>28 pregnant Aboriginal women, aged 16–21</td>
<td>Rural, remote and metropolitan, WA</td>
</tr>
</tbody>
</table>

**Young Indigenous people’s sexual agency**

**Reducing the chance of adverse consequences**

Three papers from The Indigenous Resilience Project in Townsville describe ways in which young Indigenous research participants act to avoid adverse outcomes through their own sexual agency (Mooney-Somers et al. 2009, 2011, 2012). These findings document some of the harm reduction measures and peer support systems used by young Indigenous people to protect their sexual health (Mooney-Somers et al. 2009, 2012). These strategies and systems benefit individuals as well as their sexual partners and other peers. They include: monitoring STI status through regular testing at health services (Mooney-Somers et al. 2009, 2011, 2012); carrying and using condoms (Mooney-Somers et al. 2009, 2011, 2012); attempting to anticipate when a condom might be needed.
sharing condoms with friends who need them (Mooney-Somers et al. 2012); conversations with partners and peers about preventing STIs (Mooney-Somers et al. 2011); insisting partners have STI checks prior to sex (Mooney-Somers et al. 2012); choosing to be in trusting, committed relationships (Mooney-Somers et al. 2011, 2012); vouching for specific health services (Mooney-Somers et al. 2011); and accompanying friends during health service visits (Mooney-Somers et al. 2009, 2011).

Peer support processes enabled young Indigenous people to exert agency over their sexual lives. For example, young female research participants in Arnhem Land explained that they reported back to one another on the faithfulness of friends’ boyfriends within the local community (Senior and Chenhall 2008). Through such means, young women were able to identify the sexual networks within which they were enmeshed through their boyfriends’ sexual practices. Same-sex friends were reported as discussing sexual health issues with one another in a study in Arnhem Land (Burbank 1987) and in the Our Lives study (Chenhall et al. 2013); in a further study in Townsville young Indigenous people shared sexual health information with one another (Larkins et al. 2007). Such informal information sharing among peers may contribute to the variety of trusted, though not necessarily factually correct, sources of support in social settings that are not typically encouraging of young Indigenous people talking openly about their sexual activity and concerns.

**Gaining greater control over life**

There is clear evidence that young Indigenous research participants make efforts to gain control over particular aspects of their lives. These findings are important for sexual health as they illustrate how young people engage with and rework community values, what motivates them to act in particular ways, and where, when and how young people find time and feel comfortable talking about gender and sexuality. In Townsville, such practices took the form of rejecting specific age-related social values, stigma and stereotypes. Young men and women in school rejected the idea that having a child at the age of 16 was acceptable, with most indicating a preference to start a family between the ages of 20–25 (Larkins et al. 2011). In the same study, young women out of school, who were already parents, actively constructed themselves as ‘good mothers’ and spoke of motherhood as a positive transformative event and a reason to make something of their lives (Larkins et al. 2011). This illustrates attempts to build self-esteem and a sense of control in response to the challenge of looking after their children, and the stigma felt from health service providers and members of the wider community who may have negatively judged their parenting skills.

Other examples of agentive action were identified in research with young Indigenous women in Arnhem Land, which illustrated deliberate efforts to become pregnant with a man they wanted to marry (Burbank, Senior, and McMullen 2015) and their resistance to traditional practices of arranged marriage (Burbank 1987, 1995; Senior and Chenhall 2012). For some of these young women, marrying a partner of their own choice and becoming pregnant was reported as an area of life over which they had some control, and this was reported to increase their self-esteem (Senior and Chenhall 2008). Young female participants in this setting also reported supporting one another when out seeking boyfriends, pregnancy and marriage. This took the form of sending messages
to boys to arrange covert meetings, or walking around in groups at night as a form of camouflage to reduce parental suspicion that a girl was intending to meet a boy (Burbank 1987; Senior and Chenhall 2008).

Finally, young women in Arnhem Land reported trying to create space away from adults and families, outside school and home environments, so that they could spend time with each other to talk about their lives, and discuss ideas and aspirations. This occurred while spending time socialising with friends and peers whilst moving around the community at night (Senior and Chenhall 2008), and at a less intensely surveilled local basketball club (Senior and Chenhall 2012).

Key influences on young Indigenous people’s sexual health

Individual factors
Knowledge and understanding about the transmission and prevention of STIs is reported as incomplete or limited (Larkins et al. 2007; Stark and Hope 2007; Senior et al. 2014; Helmer et al. 2015; Ireland et al. 2015). Most studies grouped these infections collectively by referring to STIs as ‘sex infections’ (Ireland et al. 2015) or ‘sex diseases’ (Stark and Hope 2007). However, when asked in three research projects, respondents were often able to differentiate between one or more of the following infections: Chlamydia, gonorrhoea, pediculosis pubis (pubic lice), syphilis and trichomoniasis (Stark and Hope 2007; Mooney-Somers et al. 2009, 2011; Senior et al. 2014; Helmer et al. 2015). Young Indigenous women in two studies in remote communities in the Northern Territory were able to identify a range of symptoms associated with STIs (Stark and Hope 2007; Ireland et al. 2015).

Young people tended to be more aware of and concerned about pregnancy rather than STIs (Larkins et al. 2007; Senior and Chenhall 2012; Senior et al. 2014). With regard to STIs, both young men and women in the Our Lives study believed that people who experienced STIs were older and lived far away, and that acquiring an STI was associated with having sex with these ‘others’ (Senior et al. 2014). These young participants perceived themselves as being at low risk of contracting STIs because they were having sex with familiar young people, a practice that was equated with safer sexual choices (Senior et al. 2014). Young women, in particular, were more concerned about pregnancy. In a different study conducted in rural, remote and metropolitan parts of Western Australia, young female research participants were reported as being aware that unprotected sex could lead to pregnancy, but lacked understanding of how pregnancy affects the body (Reibel et al. 2015).

There was little discussion about abortion in the papers reviewed. However, young female research participants in one study in remote parts of East Pilbara, Western Australia, reported experiencing difficulties making informed choices about termination (Lockyer and Kite 2006), and in another study in Townsville, most young female participants indicated they were opposed to abortion (Larkins et al. 2011). Young women’s personal experiences of abortion were reported only in this same study (Larkins et al. 2011).

Knowledge of STI and pregnancy prevention among young Indigenous research participants was mixed. There was more information about awareness of these issues among young women than young men. Studies in a range of settings reported poor biomedical knowledge about how to prevent STIs (Larkins et al. 2007; Stark and Hope 2007; Ireland et al. 2015), and limited knowledge about family planning among both young women and young men (Helmer et al. 2015). Young women in studies in Townsville and remote
Northern Territory reported awareness about the use of different types of contraception to prevent pregnancy (Larkins et al. 2011; Ireland et al. 2015). In a study in a remote Northern Territory community, young women knew about condoms and some long-acting reversible contraceptive methods (injection and subdermal implants), but were not aware of emergency contraception, oral contraceptive pills, diaphragms, vaginal hormonal rings or inter-uterine devices (Ireland et al. 2015, 5). The Indigenous Resilience Project in Townsville revealed higher levels of understanding about the transmission and prevention of STIs among participants with personal experience of STIs (Mooney-Somers et al. 2009, 2011, 2012).

Sexual activity among young Indigenous people has been documented in the context of casual sexual encounters and multiple sexual partnering (Larkins et al. 2007; Ireland et al. 2015), the use of contraception or STI testing services (Larkins et al. 2007, 2011; Stark and Hope 2007; Mooney-Somers et al. 2009, 2011, 2012; Senior et al. 2014), the effect of alcohol consumption on sexual risk practices (Larkins et al. 2007; Stark and Hope 2007; Mooney-Somers et al. 2011, 2012; Chenhall et al. 2013; Senior et al. 2014), young women’s search for boyfriends and the maintenance of relationships (Senior and Chenhall 2008, 2012; Mooney-Somers et al. 2012; Burbank, Senior, and McMullen 2015), premarital sex and pregnancy (Burbank 1987, 1995), planned and unplanned pregnancies (Burbank 1987, 1995; Senior and Chenhall 2008, 2012; Larkins et al. 2011; Chenhall et al. 2013; Burbank, Senior, and McMullen 2015; Reibel et al. 2015), and personal experiences of STIs (Stark and Hope 2007; Mooney-Somers et al. 2011, 2012; Chenhall et al. 2013; Senior et al. 2014).

Limited, inconsistent contraceptive use was reported to be common among young Indigenous research participants in a wide range of settings (Larkins et al. 2007, 2011; Stark and Hope 2007; Mooney-Somers et al. 2011, 2012; Chenhall et al. 2013; Ireland et al. 2015; Reibel et al. 2015). Subdermal contraceptive implants were preferred by young women in a study in East Pilbara (Lockyer and Kite 2006), but young women in a study in remote Northern Territory were discouraged by the ongoing side effects of hormonal implant and injection contraception (Ireland et al. 2015). Use of condoms and uptake of STI testing increased among young people in the Indigenous Resilience Project after personal experience of STIs (Mooney-Somers et al. 2009, 2011, 2012).

**Proximal elements of social vulnerability**

*Peer influences:* Whilst positive examples of peer influence have already been discussed, the negative influences of peers on gender and sexuality norms was extensively documented in the studies reviewed. Young men’s dominance in heterosexual sexual relationships took various forms, including swearing, bullying and being violent towards young women (Larkins et al. 2011; Senior and Chenhall 2012; Chenhall et al. 2013; Senior et al. 2014; Burbank, Senior, and McMullen 2015; Helmer et al. 2015; Ireland et al. 2015). Physical and emotional coercion by young men to have sex was reported in two studies (Larkins et al. 2007; Burbank, Senior, and McMullen 2015) and young men’s dominant, controlling influence over sexual negotiation and decision making was reported in another (Senior and Chenhall 2008, 2012).

In studies in remote Northern Territory and Townsville, young women experienced difficulty negotiating the use of contraception (Larkins et al. 2011; Ireland et al. 2015) if male partners were reluctant and preferred not to use, or refused to use, condoms (Mooney-
Somers et al. 2011, 2012; Ireland et al. 2015). In a study in Arnhem Land, young men reportedly encouraged young women to remove contraceptive implants (Burbank, Senior, and McMullen 2015). Across a range of settings, young Indigenous research participants reported that sexual communication and negotiation were more difficult under the influence of alcohol (Larkins et al. 2007; Stark and Hope 2007; Senior et al. 2014) or absent in the moment of sexual activity (Mooney-Somers et al. 2012). Communication could also be hampered by a sense of shame and unwillingness to talk freely about sexual issues in relationships (Larkins et al. 2007; Stark and Hope 2007), as well as by mistrust or experience of partner unfaithfulness (Burbank 1995; Mooney-Somers et al. 2012; Burbank, Senior, and McMullen 2015).

Gender norms and social expectations were reported as rendering young Indigenous women vulnerable to reputational damage in regional, rural and remote parts of the Northern Territory (Chenhall et al. 2013; Senior et al. 2014; Burbank, Senior, and McMullen 2015; Helmer et al. 2015), Western Australia and South Australia (Chenhall et al. 2013; Senior et al. 2014; Helmer et al. 2015), and in Townsville (Larkins et al. 2007; Mooney-Somers et al. 2009, 2012). In two papers, young women reported that sexual activity was required in relationships to keep young men happy and stop them from getting bored and moving on (Senior and Chenhall 2008; Burbank, Senior, and McMullen 2015). Young men were typically expected to have multiple sexual partners if given sufficient opportunity, while there were pressures on young women to be seen as loyal and monogamous (Helmer et al. 2015). While sexually active young women were judged negatively by their peers, sexually active young men were perceived as ‘cool’ (Larkins et al. 2007; Chenhall et al. 2013; Senior et al. 2014; Helmer et al. 2015).

Normative practices of gossip, ridicule and violence were widely reported as occurring within peer networks when a young Indigenous person was associated with sexual health outcomes that indicated sexual activity. For example, research participants in Townsville reported that stigma and shame were associated with young people having STIs (Mooney-Somers et al. 2009). Young people from diverse settings in the Our Lives study explained that if a young person was thought to have an STI, peer ridicule might occur through gossip and name-calling via social media and in person, although this was often based on rumour rather than fact (Chenhall et al. 2013; Senior et al. 2014). Young women in the Our Lives study were perceived as being more vulnerable to reputational damage associated with sexual activity than men (Senior et al. 2014). Studies in Arnhem Land reported that jealousy and violence occurred between young women who were associated sexually with the same young man (Burbank 1995; Senior and Chenhall 2008; Burbank, Senior, and McMullen 2015).

Influence of Indigenous adults: The papers reviewed provided numerous examples of strong, positive family influences on young Indigenous people. Examples included older women taking daughters and granddaughters for contraceptive implants in Arnhem Land (Burbank, Senior, and McMullen 2015); grandmothers encouraging young people to use sexual health services for STI testing in Townsville (Mooney-Somers et al. 2009), antenatal care in a range of settings (Ireland et al. 2015; Reibel et al. 2015); and the provision of support through extended kinship networks during childbirth in rural, remote and metropolitan settings in Western Australia (Reibel et al. 2015) and with childcare in remote communities in the Northern Territory (Burbank, Senior, and McMullen 2015; Ireland et al. 2015).
However, there was evidence of less positive influences by adults. For example, there was limited communication between parents and young Indigenous people about sexual health issues in Townsville (Larkins et al. 2007; Mooney-Somers et al. 2011). While community suspicion and gossip about young people’s sexual activity was reported to occur amongst adults in Arnhem Land (Burbank 1987) and in another remote setting in the Northern Territory (Ireland et al. 2015), there was little adult intervention that aimed to change behaviours (Senior and Chenhall 2008; Burbank, Senior, and McMullen 2015). In anthropological studies in Arnhem Land, young people reported replicating adult behaviours they had observed amongst parents, extended family members, and the local community, such as male control and aggression in relationships, and public fighting among women due to jealousy (Burbank 1995).

**Influence of schools:** Five papers described young people’s perceptions of sexual health education in schools (Larkins et al. 2007, 2011; Senior and Chenhall 2008; Senior et al. 2014; Helmer et al. 2015). In each of these papers, the influence of schools on young Indigenous people’s sexual health was limited to a critique of the inadequate provision of sexual health education (Larkins et al. 2007, 2011; Senior and Chenhall 2008). Research participants stated that school-based sex education was largely irrelevant to their needs (Senior et al. 2014; Helmer et al. 2015), didactic and unengaging, and too clinical (Helmer et al. 2015).

**Influence of health services:** Young Indigenous participants in several settings felt reluctant to use health services due to shyness, embarrassment and shame (Larkins et al. 2011; Ireland et al. 2015), and fear of reputational damage associated with being seen accessing services for sexual health needs (Helmer et al. 2015). Young women in Townsville reported that the cost of hormonal contraception inhibited use (Larkins et al. 2007). Young people expressed concerns about confidentiality in a remote Northern Territory community (Reibel et al. 2015), in Adelaide (Kelly and Luxford 2007) and across different settings in the Our Lives study (Chenhall et al. 2013; Senior and Chenhall 2013).

A minority of the papers reviewed provided evidence of the positive influence of health services on young people’s sexual health. These included wide availability of condoms at Aboriginal Community Controlled Health Services, sexual health centres, hospitals and youth support services in Townsville (Mooney-Somers et al. 2012), and the promotion of contraception by health workers in a remote setting in the Northern Territory (Ireland et al. 2015). The acceptability of Aboriginal Community Controlled Health Services for STI diagnosis and care among young Indigenous people in Townsville was enhanced by a feeling that the health provider cared, took time, provided information and prioritised individual concerns (Mooney-Somers et al. 2009). For some participants in Townsville, the presence of an Indigenous health care provider was important (Mooney-Somers et al. 2009), whilst in Adelaide, young Indigenous women preferred accessing sexual health services from non-Indigenous nurses who worked closely with Aboriginal health workers and elders (Kelly and Luxford 2007). Across Western Australia, pregnancy care was perceived to be enhanced by the availability of female staff, midwives, Aboriginal Health Workers or Grandmother Liaison Officers, and the provision of appointment reminders, accommodation and transport options (Reibel et al. 2015).

**Distal elements of social vulnerability**
A number of structural issues influence sexual health and service utilisation by Indigenous Australian young people. One of the papers reviewed identified how overcrowding at
home in a remote Northern Territory community encouraged sex outdoors and the low use of contraception (Ireland et al. 2015), while a study in Townsville illustrated how homelessness and residential lability inhibited young women’s ability to make and keep clinic appointments (Mooney-Somers et al. 2009). Intergenerational patterns of teenage motherhood, limited access to condoms outside health clinics, and restricted educational and employment opportunities were seen as increasing the chance of teenage pregnancy in a variety of settings (Stark and Hope 2007; Senior and Chenhall 2012; Reibel et al. 2015). With regard to pregnancy, the remoteness of communities was linked to a lack of culturally safe, acceptable and accessible maternal health services in East Pilbara (Lockyer and Kite 2006) and in a remote community in the Northern Territory (Reibel et al. 2015).

Several papers documented the effects of historical and contemporary practices of Western religious, health and educational institutions on young Indigenous people’s sexual health. For example, research in Arnhem Land suggested that the movement of Indigenous people to settlements increased the interaction between young people in school and social settings (Burbank 1987; Senior and Chenhall 2012; Burbank, Senior, and McMullen 2015). In a remote mission setting in the Northern Territory, the influence of Catholic teachings in the school curriculum was seen as conflicting with public health messages about contraception and safe sex (Ireland et al. 2015). Research in Western Australia found that distrustful interaction between Indigenous community members and local health service staff was related to models of health service delivery that consistently failed to provide culturally appropriate health services (Reibel et al. 2015).

Indigenous values, languages and interpretations also influence young Indigenous people’s sexual relationships and sexual health. For example, a Northern Territory study explained that local beliefs about the body, and the manner in which different body parts are named and described, differ from Western biomedical explanations (Ireland et al. 2015). Three studies reported how Indigenous values in Arnhem Land and in another remote setting in the Northern Territory link perceptions about sexual maturation to fertility, sexuality, pregnancy and marriage at particular ‘age grades’ (Burbank 1987, 1995; Senior and Chenhall 2008; Burbank, Senior, and McMullen 2015; Ireland et al. 2015) which correspond to changes to the body during puberty (Burbank 1995). These explanations relating to the perceived social acceptability of young people’s involvement in sexual intercourse, pregnancy and marriage at different ages differ from explanations based around biomedical concepts of risk, health and wellbeing.

**Discussion**

Findings from this review point to the limited but growing qualitative evidence that, despite often adverse circumstances, young Indigenous people act to limit sexual health problems and build sexual and reproductive resilience. As documented in Townsville (Mooney-Somers et al. 2009, 2011, 2012), many young Indigenous people are capable of looking after themselves and each other and utilise peer support and networks (e.g. supporting friends having STI checks and helping each other with condom access) in order to do so.

The review identified diverse individual influences and social vulnerabilities that impact young Indigenous Australians’ sexual health, and their abilities to act in ways that challenge these vulnerabilities. At an individual level, the papers reviewed reported
incomplete knowledge about the transmission and prevention of STIs, a concern to prevent pregnancy rather than STIs, and limited knowledge of safer sex practices (particularly in remote settings). Such issues impact on young people’s perceptions of risk, their awareness of the consequences of sexual activity, and the need to take action to prevent pregnancy or the transmission of STIs.

Social vulnerability arising from both proximal and distal influences affects young Indigenous people’s sexual lives. For example, proximal influences such as the strong negative effects of peer relationships – whether sexual or relationship partners, friends and acquaintances – on sexual health are evident. Risk of reputational damage to young women involved in sexual activity, together with gossip and ridicule, can create a culture of personal silence around sexual health. Vulnerabilities arise due to feelings of shame when attending STI testing and treatment (Chenhall et al. 2013; Helmer et al. 2015). Shame may also encourage young women to keep pregnancies hidden (Chenhall et al. 2013), and makes communication about STI risk reduction difficult, be this between young people (Larkins et al. 2007; Stark and Hope 2007) or with informed adults (Senior et al. 2014).

Other forms of vulnerability arise from male prerogatives with respect to sexual intimacy and relationships. These may be tolerated by some young women in order to maintain relationships (Helmer et al. 2015), but can inhibit their ability to negotiate safer sex or contraceptive use (Larkins et al. 2007, 2011; Stark and Hope 2007; Senior and Chenhall 2008, 2012; Mooney-Somers et al. 2011; Burbank, Senior, and McMullen 2015; Ireland et al. 2015). Our review identifies a conflict between young men’s expectations that young women are responsible for initiating conversations about condoms and safe sex (Helmer et al. 2015), and wider social beliefs that young women who carry condoms are sexually experienced and ‘slutty’ (Senior et al. 2014). This further constrains conversations about safe sexual practices.

Despite occasional reports of support from grandparents and other family members for accessing services for STI testing and contraception (Mooney-Somers et al. 2009; Burbank, Senior, and McMullen 2015) and pregnancy (Chenhall et al. 2013; Ireland et al. 2015; Reibel et al. 2015), the papers reviewed provide evidence of limited inter-generational communication about sexual health issues (Larkins et al. 2007; Mooney-Somers et al. 2011). This extends to support from local institutions – for example, the perceived inadequacy of current school-based sexual health education for Indigenous young people is clear in the reviewed papers (Larkins et al. 2007, 2011; Senior and Chenhall 2008; Senior et al. 2014; Helmer et al. 2015). Study participants described mixed perceptions about the guarantees of confidentiality given by health service providers (Kelly and Luxford 2007; Chenhall et al. 2013; Senior and Chenhall 2013; Reibel et al. 2015), and variable access to condoms and other forms of contraception, as well as antenatal care (Larkins et al. 2007; Reibel et al. 2015).

Social vulnerability to sexual health problems may also be the result of more distal factors. For example, the clash between Indigenous and Western biomedical understandings of the body can cause confusion between health service providers and Indigenous community members when trying to discuss, explore and treat sexual and reproductive health issues (Ireland et al. 2015). Distrustful interactions between service providers and community members based on Indigenous perceptions about the lack of culturally appropriate services (Reibel et al. 2015) can discourage use of sexual health services. Indigenous
values relating to early pregnancy and marriage often exist in tension with Western values that view adolescent pregnancy as a social and clinical problem (Reibel et al. 2015), and potentially impact the nature and quality of the services young people seek and receive from providers. However, the strengths of Indigenous values are also evident, particularly in relation to the support young women receive from other women in relation to pregnancy and reproductive health issues.

**Future research**

Findings identify clear priorities for future qualitative research. First, most existing qualitative studies with young Indigenous Australians have been limited to one large regional setting in Queensland, and a small number of remote settings in the Northern Territory and Western Australia. There is a need for qualitative, experiential data concerning the sexual lives and socio-sexual networks of young Indigenous people in cities and towns across Australia, as well as in regional and remote settings in New South Wales and Victoria.

Second, there is a scarcity of in-depth research examining Indigenous resilience in the face of sexual health risk and vulnerability. To date, only one qualitative study has examined young Indigenous people’s agency in relation to sexual health (Mooney-Somers et al. 2009, 2011, 2012). There exists a major gap in understanding how Indigenous cultural values and practices support, rather than inhibit, young people’s sexual health and promote, rather than constrain, practices of harm reduction. Culturally respectful research in both of these areas is urgently required. This would usefully be complemented by qualitative research that focuses on young Indigenous people’s sexuality, frames young Indigenous people’s sexual experiences and sexuality in a positive manner, and explores how Indigenous Australian understandings of the body can be integrated into sexual health. A more unequivocal adoption of the WHO (2006) definition of sexual health, which encourages an analysis of the influence of political, legal and cultural factors on the ways in which sexual health is experienced, would be one way of securing this.

Third, much qualitative research to date has focussed on young Indigenous women. While it remains important to examine young women’s perspectives and experiences, efforts to improve sexual health services and programmes will benefit from greater insights into young men’s sexual, relational and service-based practices.

Fourth, allied to this, there is also major need to undertake sexual health and sexuality research among same-sex attracted and gender diverse young Indigenous people across a wide range of settings.

Finally, our review points to knowledge gaps in relation to the delivery of sexual health services and programmes. To date, there has been no qualitative research that examines what the term ‘youth-friendly sexual health services’ (WHO 2010, 38) might mean for young Indigenous Australians. Only five papers so far have documented young people’s perceptions of sexual health education in schools (Larkins et al. 2007, 2011; Senior and Chenhall 2008; Senior et al. 2014; Helmer et al. 2015). More detailed qualitative investigations might focus on understanding how to improve the delivery of good quality relationships, sex and sexuality education with young Indigenous people in school and community settings, starting with emic constructions of sexuality and sexual health (Ireland et al. 2015) and acknowledging that young people’s health literacy, and constructs of ‘risk’ and ‘safety’, may differ
from how these terms are used in health promotion (Senior et al. 2014). Future research might also explore the value of peer support systems and youth-centred harm reduction programmes (Mooney-Somers et al. 2009, 2012) that deal honestly with young Indigenous Australian’s everyday experiences and social realities.

**Limitations**

There are some limitations to this review. We report on 19 qualitative papers, which is a limited resource base. We have only reported on studies published in peer-reviewed journals and excluded grey literature including government and community reports. Finally, the aim of this review was not to assess the quality of the research involved, but to identify and summarise key themes. However, we have focussed on themes that are common across studies as well as ideas reported in fewer papers, in an attempt to cover both typical experiences and pay attention to the complexity of individual views and experiences.

**Conclusions**

Our findings highlight the interconnected and social nature of young Indigenous people’s sexual lives, and the very real efforts made by young Indigenous people to try to reduce risk and gain a sense of control over their sexual health. We hope that the findings of this review will both stimulate further research and be of use to researchers and practitioners working to improve the sexual health of young Indigenous Australians. Together, the findings reported here emphasise the importance of qualitative research in informing the design and delivery of culturally appropriate sexual health services and programmes underpinned by in-depth understanding of young Indigenous Australians’ sexual lives.

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