Sexual Health & Wellbeing Clinic

(For young people aged 12-25)

Evaluation

A partnership between The Northern Territory AIDS & Hepatitis Council, the Sexual Assault Referral Centre, headspace Darwin and headspace Katherine. Funded by Territory Families *Safe, Respected and Free from Violence* Prevention Grants.

Final Report

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Acknowledgements

The Sexual Health Clinic (Darwin and Katherine) operates through a partnership between the Northern Territory AIDS and Hepatitis Council, the Sexual Assault Referral Centre (NT Health) and headspace Darwin and Katherine. It is funded by the Northern Territory Government via the Territory Families *Safe, Respected and Free from Violence* Prevention Grant Program.

The initial stages of the evaluation of the Clinic involved multiple planning and evaluation development sessions, beginning in early 2021. The nature of Clinic and the topic of sexual health and wellbeing is sensitive, often stigmatised, in our communities and among young people. Given this context, the need for the careful, considered and highly professional engagement of all partners was critical to the evaluation processes from start to completion.

I would like to acknowledge each of the partner organisations and their staff who have embraced the evaluation as a tool for learning and growth, and generously participated in all aspects. Genevieve Dally (Executive Director, Northern Territory AIDS and Hepatitis Council), Julia Wormer, (Operations Manager, Primary Mental Health Services, headspace Darwin & Katherine), Prudence Boylan (Manager, Sexual Assault Referral Centre) and Megan Caffrey (Sexual Health Nurse, Youth Sexual Health Clinic).

Thank you to the headspace Darwin Youth Ambassador Group, who provided generous advice about engaging young people in the evaluation and shared their insights on the topic of sexual health and the Clinic in general. Thank you to Katie Murphy (School Counsellor, Student Wellbeing and Inclusion, Early Years and Education Services, Department of Education, Northern Territory Government) for facilitating linkages with participants in Katherine.

Finally, thank you to everyone who participated in an interview, discussion group or completed a survey. Your experience, views and ideas have helped to form a strong foundation for the Clinic which will help to grow this much-needed service into the future.

Acronyms & Abbreviations

Organisational
The Youth Sexual Health & Wellbeing Clinic (The 'Clinic' or SHC)
Northern Territory AIDS & Hepatitis Council (NTAHC)
Sexual Assault Referral Centre (SARC).

Other
Northern Territory (NT)
General Practitioner (GP)
Blood borne virus (BBV)
Did not attend (DNA)
Sexually transmitted infection (STI)

Executive Summary

The Sexual Health and Wellbeing Clinic provides much needed support, information and education to young people in the Darwin and Katherine regions. Most importantly, it does this in a safe and respectful way.

Sexual health can be a difficult topic for communities, particularly young people, to engage with. Fear, uncertainty, stigma, shame, cultural taboos, and misinformation can create barriers to the quality information and care needed to support young people in the development safe and respectful relationships with their own bodies and with others.

High rates of sexually transmitted infections, unplanned pregnancies, sexual and relationship violence in the Northern Territory demonstrate a need for youth access to quality information, holistic support and respectful advice. The Youth Sexual Health and Wellbeing Clinic ('the Clinic') was developed in 2019 to respond to this need. It is funded through *Territory Families - Safe, Respected and Free from Violence* Prevention Grants. The Northern Territory Government provides these grants to support primary prevention projects that challenge and change social and cultural attitudes, practices and structures that underpin domestic, family and sexual violence.

This evaluation has explored the work of the Clinic as it developed over 2021, its's strengths, challenges and ideas for the future. It includes the voices of 23 young people and 29 youth, community services, health and education providers. What quickly becomes clear is the need for this service, the importance of its holistic model, it's positive engagement with young people, and it's potential to grow into the future.

The clinic meets a need. It's great. It's really important.
(Medical Practitioner, Darwin)

Key Numbers

- The Clinic has operated for one afternoon each week from headspace Darwin since August 2019 and headspace Katherine since October 2021: Offering a free, confidential service, with a choice of qualified and experienced practitioners (nurse, counsellor, health worker).
- The Clinic has grown to provide a strong and consistent service to over 55 young people.
- The Clinic has provided over 80 face-to-face clinic sessions offering sexual health and relationship education and support, testing (for sexually transmitted infections and blood born viruses) contraception advice and referrals to further supports.
- In recent months, the Clinic Nurse has delivered 10 school-based education sessions to over 200 students and 16 school staff in Darwin & Katherine (October- December 2021).

It's great and I felt so, so respected and comfortable.
(Young Person, Darwin Clinic)

Strengths and Challenges

The evaluation has captured key learnings about the strengths and the challenges of the Clinic from the perspectives of young people, community, and associated organisations. Briefly, these include:

Strengths	Challenges
The Clinic responds to an acknowledged need for a youth-specific sexual health and wellbeing service	Stigma and 'shame' about sex and sexual health make it a difficult topic for young people and the community to engage with
It is holistic: The two-practitioner model works well for young people and staff (safety, different skill sets, wrap-around service)	Sexual health can be a low priority for young people until there is a crisis
Young people feel listened too, respected, and safe	Awareness of the Clinic in the community is limited
Young people get the support, education and information they need	The Clinic is limited in its ability to provide all types of contraception (referrals needed for prescription medications)
The Clinic is accessible to young people who need it: it is well located, after-school hours, and headspace is a place young people trust	Some access barriers remain. This includes limited hours (2.5 per week), no male practitioner (Darwin), lack of resources in diverse languages, and community misconceptions about organisations involved.
It is governed and operated by strong and committed organisational partnership	Staffing pressures (reliant on in-kind supports of all partners, drive-in, drive-out model sustainability issues for Katherine)
Education sessions in partnership with schools and school-based programs provide information, connections, and Clinic promotion	Limited ongoing/consistent youth input into Clinic planning and promotion

The Sexual Health and Wellbeing Clinic is meeting its aims.

1. Through its development as a holistic, safe, respectful and youth friendly service, the Clinic has increased sexual health screening and education for a cohort of vulnerable young people as identified by SARC, NTAHC, headspace, Territory Families and the Department of Health.

> *Staff went above and beyond to make me feel comfortable and do the testing I wanted…….The communication was really good. They were really reassuring.*
> *(Young Person)*

2. Referral pathways have been developed and strengthened to enhance young people's access to the Clinic.
3. Clinic sessions and group-based education sessions have improved access to protective behaviours and healthy relationships education that builds on the capacity and strengths young people identify within themselves and their communities.
4. The completion of this evaluation report evidences the final Clinic aim, which focused on the development of a report detailing the project and including quality improvement measures, evidence of project responsiveness and potential for replication and expansion.

The Clinic embodies the principles of Territory Families, *Safe, Respected and Free from Violence* Prevention Grants

The Clinic has worked to embrace and embody the principles of the Territory Families *Safe, Respected and Free from Violence* prevention grant program. The program supports local projects to challenge and change social and cultural attitudes, values and structures that underpin domestic, family, and sexual violence in the NT. The Sexual Health & Wellbeing Clinic has focused on embodying the following three principles specifically:

- educate the community about domestic, family, and sexual violence and develop the capacity of the community to respond to these types of violence.
- foster positive personal identities and challenge rigid gender roles, gender inequality, sexism, and discrimination
- encourage protective behaviours and support children and young people to exercise consent and engage in healthy and respectful relationships.

It wasn't a judgemental environment at all, and I felt safe saying what I was involved in to an adult, where in other circumstances it would have felt weird.

(Young Person, Darwin Clinic)

Introduction

This report details the evaluation of the Sexual Health & Wellbeing Clinic (referred to as 'the Clinic') for young people aged 12-25. Clinics have been operating in Darwin for two years and three months, and Katherine for just over three months. Gretchen Ennis from Useful Projects was commissioned to undertake this developmental evaluation between January and December 2021.

The report begins with a brief overview of the Clinic and the purpose of this evaluation. A summary of the existing research on the topic of young people and sexual health in Australia provides the context for the Clinic and the evaluation. Following this, the evaluation methods results are presented and these form the basis for conclusions and a set of recommendations.

Background: The Clinic

The Sexual Health & Wellbeing Clinic (The Clinic) is facilitated by the Northern Territory AIDS & Hepatitis Council (NTAHC) in partnership with headspace Darwin, headspace Katherine and the Sexual Assault Referral Centre (SARC). It is specifically for young people (12-25) and takes a whole of community approach to promoting respectful relationships, good sexual health, wellbeing, and the development of a strong empowered identity within the young person's unique circumstances. The Clinic began operating from headspace Darwin in August 2019, and more recently at headspace Katherine (October 2021). The Clinic seeks to engage vulnerable young people in mental health and sexual health services, taking a secondary health, preventative, and multifaceted approach to service delivery.

The Clinic is funded by the Northern Territory Government (Territory Families) as an underpinning clinical service of the *Safe Respected and Free from Violence: Domestic Family & Sexual Violence Reduction Framework 2018 -2028.* It offers sexual and reproductive health screening and education as well as school and community-based activities focused on consent and healthy relationships. It is an early intervention and prevention model using capacity building, harm reduction approaches to issues faced by young people not accessing mainstream services.

The Clinic model offers young people access to two health professionals and is staffed by both a nurse and a counsellor (in Darwin). In response to local needs, the Katherine Clinic is staffed by a nurse and an Indigenous health worker. This two-staff model provides a wellbeing focus and responsive care that is led by each individual young person, is culturally safe and celebrates diversity. Referrals can be made by any organisation or young person. Walk-ins are also encouraged, and young people do not have to provide identifying information if they don't wish to.

Current funding provides resources for one Clinic position (Nurse Coordinator). This is a three day per week position which covers both Darwin and Katherine Clinics. In practice this involves the Nurse being based in Darwin and driving to and from Katherine each week. This is supported by SARC, who provide resources for the second role (a counsellor in Darwin, and a health worker in Katherine). The Clinic consulting rooms are provided by headspace Darwin and Katherine. The in-kind support each partner provides is critical to Clinic operations and includes access to expertise (e.g., headspace Youth Ambassadors Advisory Group) and promotion via social media.

Stakeholder engagement is maintained through regular meetings as part of the Sexual Jealth Advisory Group (SHAG) and the headspace Consortium. Both networks involve representation from key Aboriginal Controlled services and mental health and sexual health services across the Northern Territory. The program aligns with the *Northern Territory Health Strategic Plan (2018-2022)* and the *Northern Territory Aboriginal Health Plan (2015 – 2018)* through a commitment to high quality care and the delivery of appropriate services to vulnerable people and populations. The program is underpinned by several other National and Territory focused strategies. *The National Council's Plan for Australia to Reduce*

Violence against Women and their Children (2009-2021) highlights the need for timely responsive services delivered to meet the diverse needs of women' and children affected by sexual and domestic violence.

Five months after beginning operations in Darwin, service provision was impacted by the first wave of the Covid-19 pandemic in the NT, with a range of lockdowns and restrictions impacting Clinic operations and attendance. Within weeks of opening in Katherine in October 2021, the town experienced a Covid -9 outbreak, and the town was subject to widespread lockdowns and ongoing restrictions. These events have undoubtedly impacted Clinic attendance. Even so, the feedback documented throughout this report highlights the importance of the Clinic (in both locations) and its potential to grow and evolve to become a key youth service in the Top End.

Clinic posters for Darwin and Katherine.

Purpose of this evaluation

The evaluation came at a time of change in terms of staffing and the planned expansion into the Katherine Clinic. As the evaluation has been taken place alongside Clinic operations for almost 12 months, it has been developmental in nature (Quinn Patton, 2010). The purpose of this evaluation is to provide solid foundation of knowledge about what has been learned so far, and to explore how best to move into the future. This has been broken down into three major foci:

- Progress towards meeting Clinic aims
- The strengths and challenges of delivering the Clinic service
- Recommendations for future service planning and delivery.

The evaluation will assist NTAHC, headspace Darwin & headspace Katherine and SARC to continue to build and strengthen the Sexual Health & Wellbeing Clinic for young people in the Top End.

Understanding the context: Learning from existing research

To begin the evaluation, an understanding of what is *already* known about youth sexual health and access to support, information and similar clinics in the Australian context was sought. A literature review was completed with a focus on exploring young people's access to, and experience of, relationship and sexual health information, education, support and care. A brief overview of key points from this review is presented here. A full version of the literature review can be found at Appendix 3.

What is known in broad terms about young people and their sexual health in Australia?

- Most high school aged students have engaged in some form of sexual activity (75%) (Fisher et al 2019).
- There is room to improve school-aged young people's knowledge about sexual health (for example, in a recent national sexual health survey, students answered an average of 56% of sexual knowledge questions correctly) (Fisher et al 2019).
- Improved sexual health knowledge does not increase sexual risk taking (Helmer 2015).
- There is widespread marginalisation of same sex attracted young people and very high levels of stigma and discrimination for young LGBTQI people (Hill et al. 2021).
- Rural and remote young people have higher rates of STI's than the general population (Edwards et al 2014) and their knowledge of STI's is lower than their metropolitan counterparts (Senior et al 2014). Rural and remote LGBTQI young people face very significant challenges (Hill et al. 2021).
- Aboriginal and Torres Strait Islander people in remote and very remote communities experience high rates of STI's, 4 to 29-fold the rates reported for non-Aboriginal people living in remote areas. With young people (16-29) being particularly vulnerable (Lobo et al 2020).

Sexual health and young people 'at-risk'.

Young people in the following demographic groups often experience high levels of risk in terms of sexual health for a range of reasons, often linked to structural disadvantage and discrimination.

- Aboriginal and Torres Strait Islander young people (MacPhail and McKay, 2018)
- LGBTQI young people (Hill et al., 2019)
- Rural and remotely located young people (Ming et al., 2021)
- Young people in contact with justice or child protection systems (Janssen & Davis, 2009)
- Young people with refugee backgrounds (McMichael & Gifford, 2010).

The links between Mental Health and Sexual Health

- The links between young people's mental health and sexual health are complex, however integrated services are a good idea (Fernandez, 2009; Edwards et al 2014; Carrotte et al , 2016).
- There are very high rates of mental health issues among LGBTQI young people in Australia (Hill et al 2021).

Where Young People Get Information About Sexual Health

- Schools (as part of relationship/sex education classes)
- Friends
- Social media
- Web sites (a particularly good source for LGBTQI specific information)
- General Practitioners and other health professionals
- Parents

(Hill et al., 2021; Fisher et al., 2019; Byron, 2017; Gabarron & Wynn, 2016; Evers et al., 2019).

Access to Care, Education and Support: Enablers & Barriers

The ability to provide relevant and engaging sexual health promotion, relationships and sexuality education and support is influenced by a range of political, social, and cultural factors. The following things are considered helpful:

- Visual signs of LGBTQI inclusivity in clinics (pamphlets, posters, other materials that include representation of all young people)
- Practitioner attitudes (preference for practitioners who make meaningful efforts to be inclusive and take a non-judgmental approach to sexual health care)
- Use of inclusive, non-judgemental, welcoming and gender-neutral language by all staff (not only practitioners)
- Relevant and credible sexual health education
- Make it easy for the young person to be in the room
- Discreet condom supply
- Appreciating the complexities of cultural diversity and going beyond simple translation of information.
- Recognising structural barriers and disincentives to engagement across diverse cultural groups
- Normalising sexual health

(Hill et al., 2021; Fisher et al., 2019; Grant & Nash 2019; Botfield et at., 2017).

As will become evident in the following sections of this report, these key ideas from the literature resonate well with the views of the young people, as well as Clinic, partner and associated organisation staff who engaged in the evaluation interviews.

Clinic Room at headspace Darwin (Photo by Megan Caffrey)

Evaluation Aims & Methods

The aims of this project

1. To evaluate the extent to which the Sexual Health & Wellbeing Clinic is meeting its stated objectives. These are:

    - Increased sexual health screening and education for a cohort of vulnerable young people as identified by SARC, NTAHC, headspace, Territory Families and the Department of Health.
    - Formalised referral pathways between agencies for young people accessing sexual health and wellbeing clinic
    - Improved access to protective behaviours and healthy relationships education that builds on the capacity and strengths young people identify within themselves and their communities.
    - Development of a formal report detailing the project and including quality improvement measures, evidence of project responsiveness and potential for replication and expansion.

2 To explore the strengths and challenges of the service.

3. To make recommendations for future service planning and delivery.

Evaluation Design & Methods

This is a mixed method, developmental evaluation project focusing on exploring Clinic development and processes. It involves the following elements:

1. Literature review
2. Interviews with Clinic partner organisations, referring organisation staff, and young people who attend the Clinic
3. Web-based survey of young people who have attended the Clinic (clients) and other young people in the Darwin& Katherine regions.
4. Review of Clinic documentation: meeting minutes and agendas, funding and acquittal documents, policy and planning documents.
5. Review of anonymised Clinic case files.

Together these elements provide a well-rounded understanding of the Clinic strengths and challenges and allow for evidence-informed planning for the future.

The evaluation proposal received Human Research Ethics approval from Menzies School of Health Research Human Research Ethics Committee. A copy of this approval is located at Appendix 1. A copy of the evaluation protocol is included at Appendix 2. The evaluation proposal and protocol was also approved by headspace National and all partner organisations involved.

Evaluation Results

The evaluation results have been organised into the following sections:

- Young people's case file review (Darwin)
- Young people's case file review (Katherine)
- Education sessions overview
- The views of young people
- Feedback from partner and associated organisations (Darwin)
- Feedback from partner and associated organisations (Katherine).

Following the evaluation results, the conclusion brings all the results together to reflect upon the Clinic, and evaluation aims. The strengths and limitations are considered, and a set of recommendations is provided.

Case file review: Young people attending Darwin Clinic

A total of 51 young people's Clinic files were reviewed during the last week of December 2021. They were analysed using a descriptive quantitative method focused on understanding demographics, presenting issues, services provided, referrals to and from the Clinic, and young people presenting over time (new and ongoing).

Table 1: Darwin Clinic demographics (Aug 2019 to December 2021)

Darwin Clinic Demographics	
Average age	15 years 8 months
Age range	12 to 26 years
Age median	15 years
Age mode	15 years
Males	13
Females	38
Aboriginal & Torres Strait Islander identifying	14
Born outside Australia	4

Table 2: Darwin Clinic attendance overview (Aug 2019 to Dec 2021)

Overview of attendance at Darwin Clinic	
Number of Clinic attendances documented in case notes	80
Average session per young person	2
Average sessions young person (excluding non-attendances)	1.5
Range of sessions per young person	1 to 12 sessions
Number of DNA's documented in case notes	24
Phone calls and texts to young people documented in case notes	51
Phone calls to carers and other services documented in case notes	44

Table 1 demonstrates that an 'average' young person attending the Clinic is a 15-year-old female. This table also provides evidence of strong engagement with Aboriginal and Torres Strait Islander young people. Table 2 (previous page) demonstrates that on average each young person attends between one and two Clinic sessions. However, some young people have attended many times, with 12 being the most. There have been a high number of appointments made (often by a referring service) but not attended by the young person. These 'DNA's' generate follow up contacts (with the referrer and young person via phone, text or email) in an attempt to engage the young person with the Clinic.

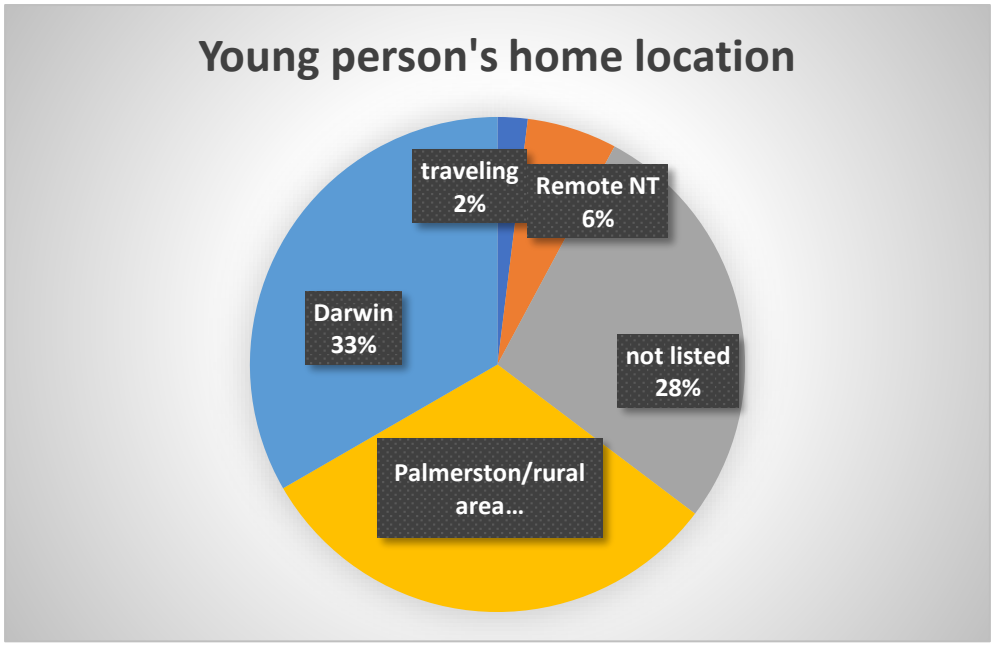


Figure 1: Darwin young people's home location

Of those files which contained a home address, Figure 1 demonstrates that clients are predominantly from the Darwin area, however an almost equal number come from the Palmerston and rural area. A small number of young people are based in remote communities, with just a handful having 'no current address' as they were travelling.

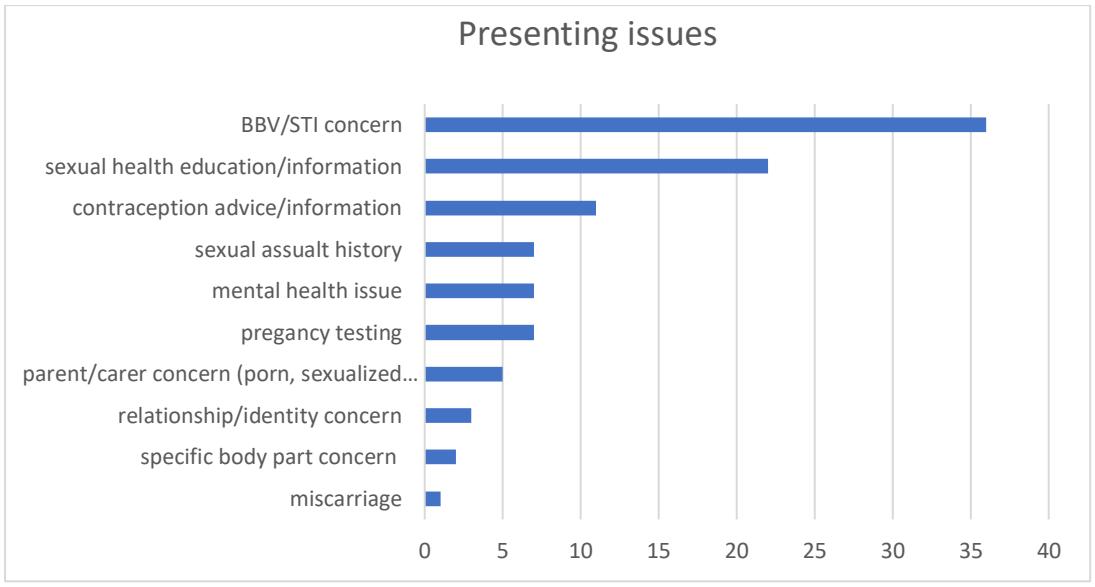


Figure 2: Darwin young people's presenting issues

Young people often attend the Clinic for multiple reasons; however, the majority are seeking BBV/STI testing and sexual health information (see Figure 2).

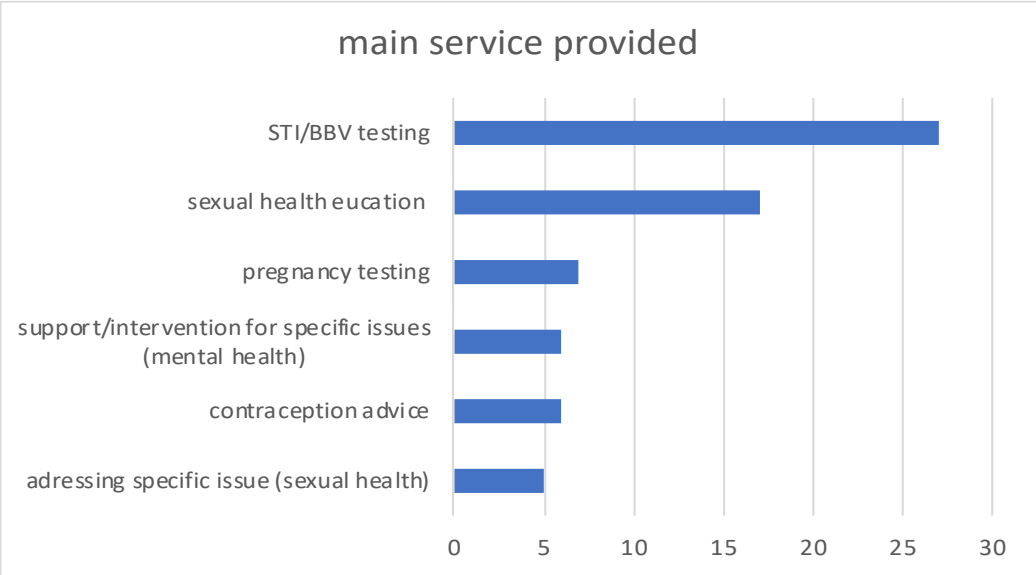


Figure 3: Main services provided (Darwin Clinic)

As most young people attend the Clinic seeking testing, it follows that the main service provided is testing. Figure 3 provides an overview of services provided as recorded in Darwin Clinic case files. Sexual health and wellbeing education also forms a significant aspect of Clinic service. Subsequent interviews with Clinic staff reveal that this aspect of service is not always documented as a separate element, as it generally forms part of the information that is shared around testing and any other issues raised. As such, the numbers in Figure 3 are likely to be far less than what has occurred in terms of information sharing and sexual health education. In addition to these services, the Clinic nurse also attends to any NT government mandatory reporting requirements that arise.

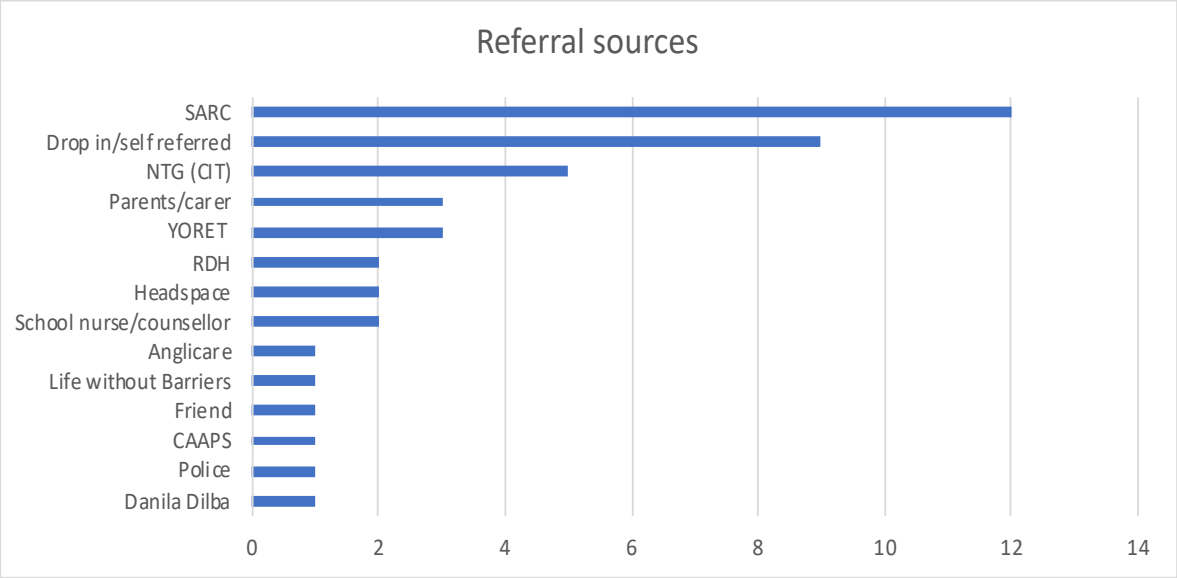


Figure 4: Referral sources (Darwin Clinic)

The majority of referrals to the Clinic come from the Sexual Assault Referral Centre, followed by those who have self-referred. Interviews with Clinic staff highlighted that those listed as 'self-referrals' or 'drop-in's in the case files have often been informally referred by another service. These referral sources reflect the aims of the Clinic.

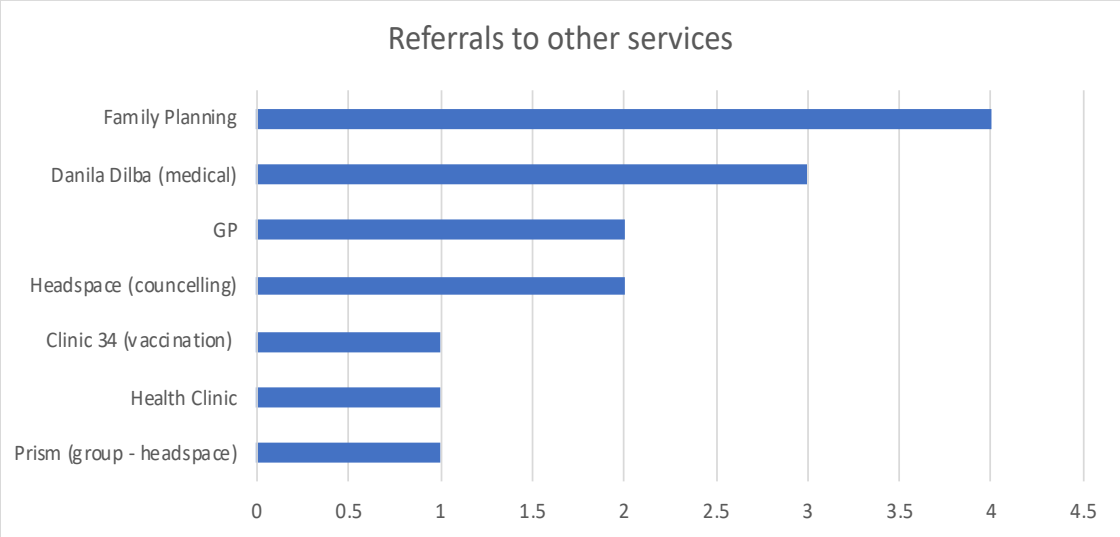


Figure 5: Referrals to other services (Darwin Clinic)

Young people who attend the Clinic may be referred to other services for specific issues that are raised during a Clinic session, such referrals are reflected in Figure 5. Young people who require forms of contraception that involve prescriptions need to be referred to appropriate services (e.g. Family Planning, GP's) that can do this. It is important to note that Figure 5 does not include contacts with other services related to any mandatory reporting issues.

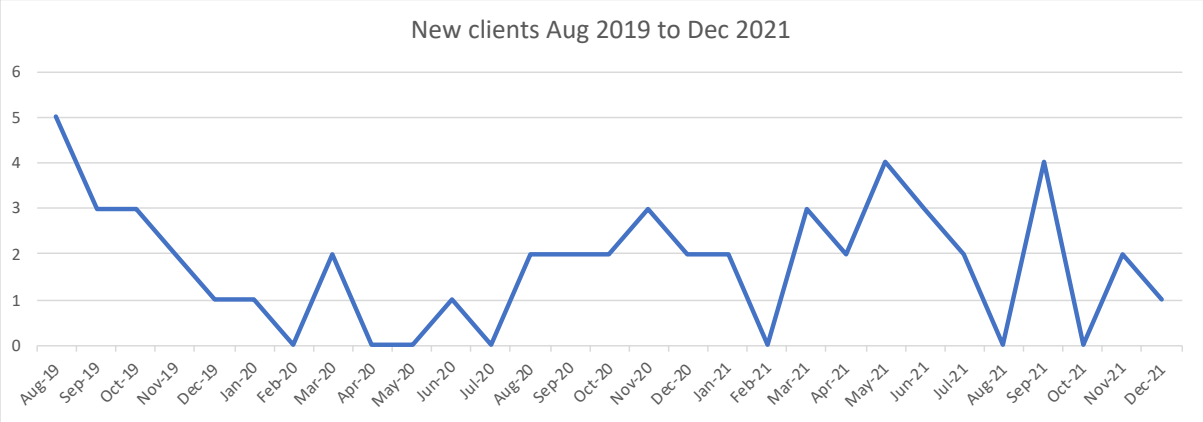


Figure 6: New young people attending over time (Darwin) Aug 2019 to Dec 2021

Figure 6 demonstrates the numbers of new young people seen at the Clinic from August 2019 through to the end of 2021. There is a lot of fluctuation in numbers, with high numbers at the outset when the service was new, and again in May and September 2021.

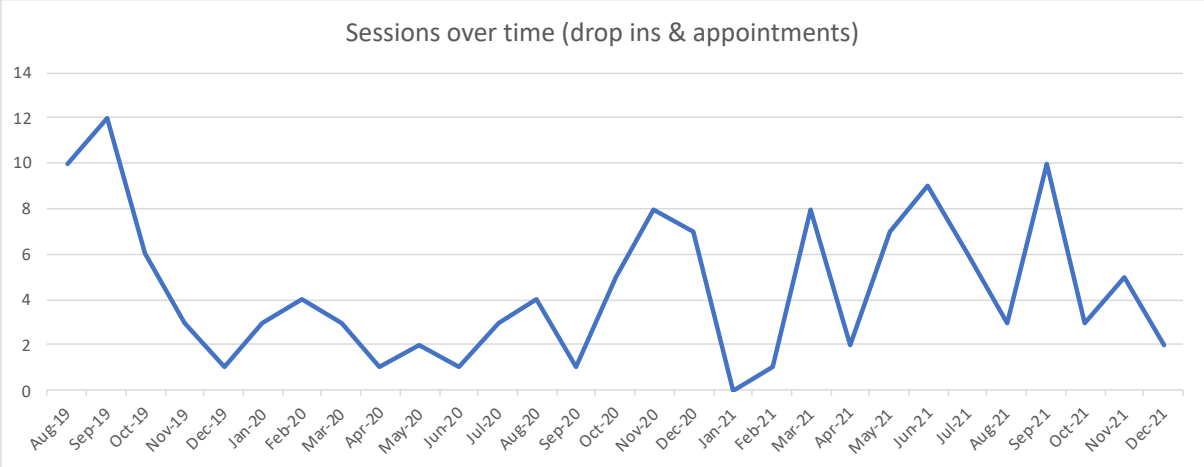


Figure 7: Clinic sessions over time (Darwin) Aug 2019 to December 2021

Figure 7 provides information about young people's attendance over time, from August 2019 to the end of 2021. It is different from Figure 6 as it focuses on the attendance of all young people, not only who are attending for the first time (that is, it includes returning young people). As with new young people, there is a peak at the start, and much fluctuation. From November 2020 thought to October 2021, there are more young people attending with regular peaks of 8 to 9 sessions each month.

Clinic capacity estimates

In terms of the Darwin Clinic's ability to engage with more young people that it does currently, it is useful to think about Clinic capacity. The average length of a face-to-face consultation (based on data from September to December 2021) is 55 minutes (range of 20 to 90 minutes). The actual minutes available to see young people (based on 2.5 hours available per weekly Clinic) is 150 minutes. Therefore, an average of **3 appointments per Clinic is the maximum capacity.**

The Darwin clinic is currently operating within capacity, generally seeing 1 to 2 young people each week. However, attendances fluctuate, and with the high number of DNA's, planning can become difficult. A situation where two young people drop in around the same time means that one of them may need to wait up to hour to be seen. It also means that any follow up appointments cut into the time available for drop-ins. The limited clinic hours currently leave little room to plan for service growth.

It's not purely clinical - do a test, in the door and then out. It's actually about the conversation and the story. Every young person brings a different story.

(Clinic staff member)


SEXUAL
HEALTH CLINIC
For young people in Katherine
aged 12 to 25
At headspace Katherine
Every Tuesday 3pm - 6pm
Drop in or make an apointment via text
or call M: 0467 229 594
Free and confidential
sexual health checks ups, testing + treatment for STIs/BBVs, pregnancy testing + emergency contraception in our safe + private clinic
Education and advice on:
keeping safe, relationships, which contraception is best for you, sexuality + gender identity.
headspace Katherine located at
Randazzo Centre
1/16 Katherine Terrace, Katherine NT
ntahc
NORTHERN TERRITORY GOVERNMENT
headspace
Katherine

Client case file review: Katherine

The first Clinic drop-in session at headspace Katherine was in October 2021. Within weeks of opening, a Covid-19 lockdown was introduced for Katherine, followed by a lockout and other restrictions. This has greatly impacted the Clinic's ability to engage with the community and begin building a client base. The following table (3) provides a summary of Clinic operations during this time.

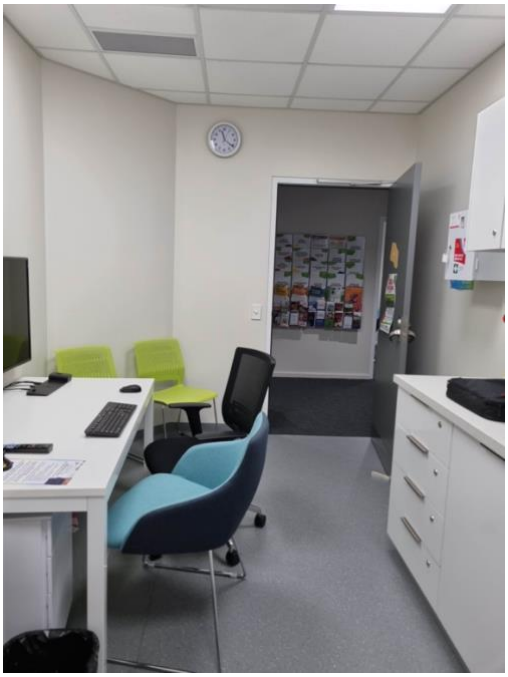
Table 3: Overview of Katherine Clinic Oct-Dec 2021

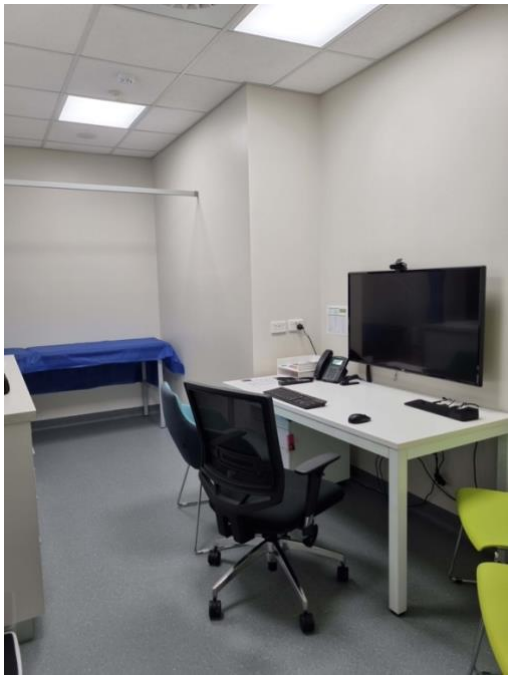
Katherine Clinic overview	
First Clinic	5th October 2021
Young people seen	2
Average age	20 years
Referrals from	Headspace Katherine
Services	sexual health education, information, and support
Number of sessions provided	3

The Covid-19 restrictions provided an opportunity for the Clinic nurse to engage with the community in different ways that have enriched the connections between the Clinic, headspace Katherine, health services, local schools, school-based programs and community organisations. The Clinic Nurse has provided:

- 1 x Education session delivered via that Stars Program at Katherine High 3.11.21
- 4 x Planning and information sessions in December (Stars, Clontarf, Katherine High School staff, headspace Katherine)

As demonstrated in the Katherine interviews (see pages 34 to 40) the school and youth services community has engaged with the Clinic, providing insight and ideas for the Clinics success in Katherine.





Katherine Clinic room (Image taken by Megan Caffrey)

Education Sessions Overview: Darwin & Katherine

After a period of staffing changes, a new Nurse Coordinator was employed in October 2021. Drawing on feedback from partner organisations and the interim evaluation report (August 2021) the Clinic nurse has refreshed connections between the Clinic and local schools. There has been a strong level of community engagement as evidenced by the education sessions facilitated with schools and school-based services. The following table provides a summary of education sessions provided in recent months.

Table 4: Education Sessions run by Clinic nurse (Oct-Dec 2021)

Education Sessions summary (October to Dec 21)	
Number of sessions	10
Schools & session focus	Darwin High School (Love Bites - relationship violence)
	Casuarina Senior College (Love Bites - relationship violence)
	Taminmin High (Love Bites - relationship violence)
	McKillop College (consent, boundaries, sexual violence)
	Essington School (consent, boundaries, sexual violence)
	Parap Primary (puberty and respectful relationships - separate male and female sessions)
	Stars Program (Katherine High School). (Intro to sexual health and sexually transmitted diseases)
Year levels	Year 6 to year 11
Number of students attending	206
Number of school staff attending	17

The following section of the report shifts our focus to the voices of young people themselves. First we examine feedback from young people who have attended the Clinic (clients), and later, information from a survey designed to understand if young people who *had not* attended the Clinic had heard about it, and where they currently get information and support about sexual health.

The views of young people

Young people's views are crucial to understanding the value of the SHC, it's reach into the community, and areas for improvement. Twenty-three young people's voices were heard via the evaluation processes. Initial feedback was gained in March 2021, through a discussion with the headspace Darwin Youth Advisory Group. Seven people attended this discussion and they also provided advice on ways to engage other young people in the evaluation. Two web-based surveys were developed, one for young people who have attended the Clinic (clients) and another for any young person (12 – 26 years) living in the Darwin or Katherine regions ('non-clients'). The 'non-client' survey was distributed via headspace social media and had 11 responses. A survey link, with an option for an interview, was provided to young people who had attended the Clinic. This was distributed between August to December 2021. Five young people engaged with the evaluation in this way (four surveys and one phone interview). The participants were aged between 16 and 18 years. All were female.

Feedback from young people who have accessed the Clinic

All young people who had attended the Clinic and participated in the evaluation were from the Darwin and Palmerston areas. The Katherine Clinic had not been operating for a long enough to engage participants, as such, the information below concerns the Darwin clinic only.

What works well? Young people's views about Clinic strengths.

Feedback from all five young people who had attended the Clinic was very positive. The following quote provides one young person's summary of what worked well for them.

> *Just keep doing what you do. It's great and I felt so, so respected and comfortable. It wasn't a judgemental environment at all and I felt safe saying what I was involved in to an adult, whereas in other circumstances it would have felt weird.*

Table 5 provides a breakdown of the various aspects of the Clinic service that young people appreciated. The number is brackets represent the number of clients who shared that view.

Table 5: Young people's views on Clinic strengths

Clinic Strengths	Client quotes related to strength
Young people felt listened too (5)	*The communication was really good. They were really reassuring.*
Young people got the support and information they needed (5)	*Staff went above and beyond to make me feel comfortable and do the testing I wanted.* *Everyone was great, I would go there again.*
The staff respect young people (5)	*Super respectful, kind and non-judgemental* *The headspace people are super friendly, everywhere, like at stalls and at school. That makes you want to come.*
Young people felt safe at the Clinic (5)	*Having two people in the room felt great – like there could be two lots of input, and they were accountable to each other and me. Like having back up.*

Transport to and from the Clinic was not seen as a barrier for any of the participants. One participant who came from the rural area noted that they had access to a car, but if they hadn't then access would be more difficult.

What could be improved? Young people's ideas about strengthening the Clinic

The following ideas for improvement were suggested by young people who had attended the Clinic, and their own words are used to demonstrate ideas. The number in brackets is the number of participants who suggested same idea.

Table 6: Young people's ideas for improving the Clinic

Ideas for Improvement	**Young people's quotes related to Idea**
More promotion of Clinic & normalising of sexual health in the community is needed (3)	*Word of mouth is really important. It's important that this is normalised, that there is less stigma about sex and getting tested and getting the information.* *Promoting the clinic as a place you can talk about all things related to sex is needed. You don't have to have a test. You don't need to be ashamed.*
Ensure Clinic information is easy to find (2)	*It was hard to find out about it online. You need a better website.* *It was hard to find out information about when the clinic was open and if I should book in or just turn up. Coming from out of town it's a big drive so I wanted to know I would be able to see someone.*
Open a Clinic in Palmerston (1)	*Having it in Palmerston would make it easier to go.*
Have the option to see a male practitioner (1)	*My boyfriend was not very comfortable at all. Nobody's fault, he just didn't like being there. So for young males a male worker would be good so they feel more comfortable.*
Be open for more than one day per week. (1)	*Be open on multiple days.*

Information from young people who have not accessed the Clinic

A short web-based survey was designed to understand awareness of the Clinic and learn more about where young people are accessing information and support about their sexual health currently. The survey was distributed via headspace social media links and promoted through partner organisations via posters with QR code links to the survey. The survey was open during December 2021. The number of respondents was low, with eleven people aged between 14 and 23 years (average age of 16) completing it. Of the respondents, there were six females and five males. All participants spoke English at home. Seven participants lived in the Darwin area, three in the Palmerston area and 1 in Katherine.

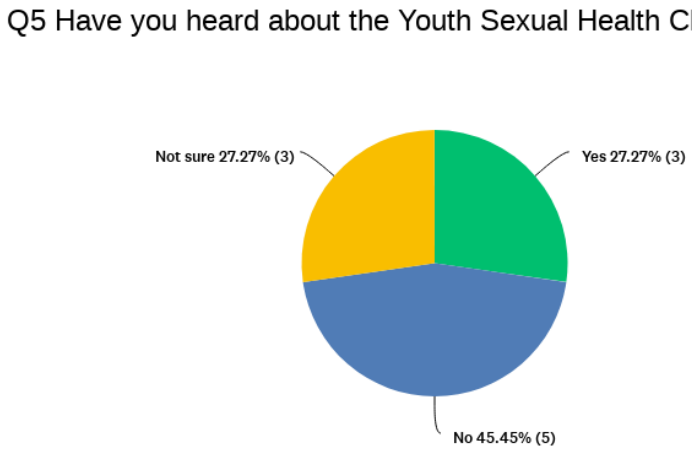


Figure 8: Awareness of the Clinic

Figure 8 demonstrates that three of the 11 young people were aware of the Clinic. Of these three, two had heard about from someone they knew, while one had seen a poster about it.

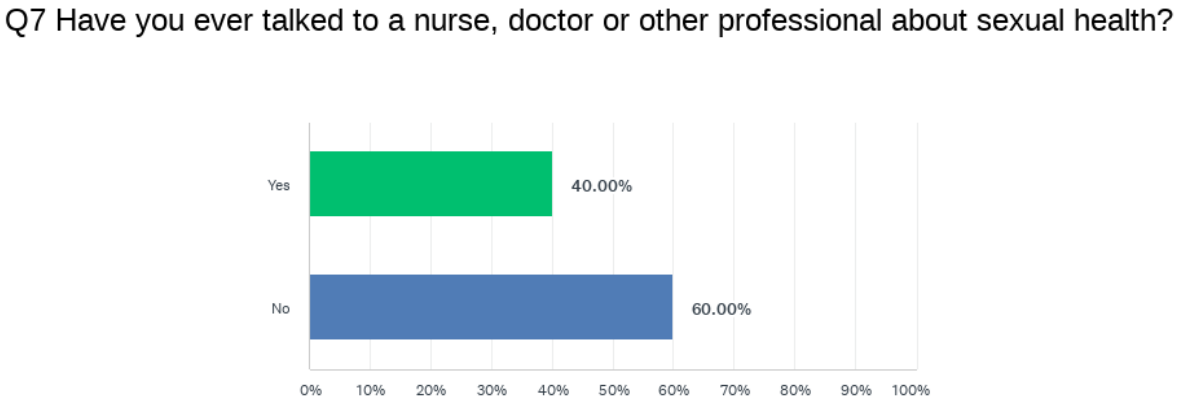


Figure 9: Previous professional help

Less than half of the survey respondents has spoken with a health professional about their sexual health in the past. This reinforces the need for access to a youth specific Clinic.

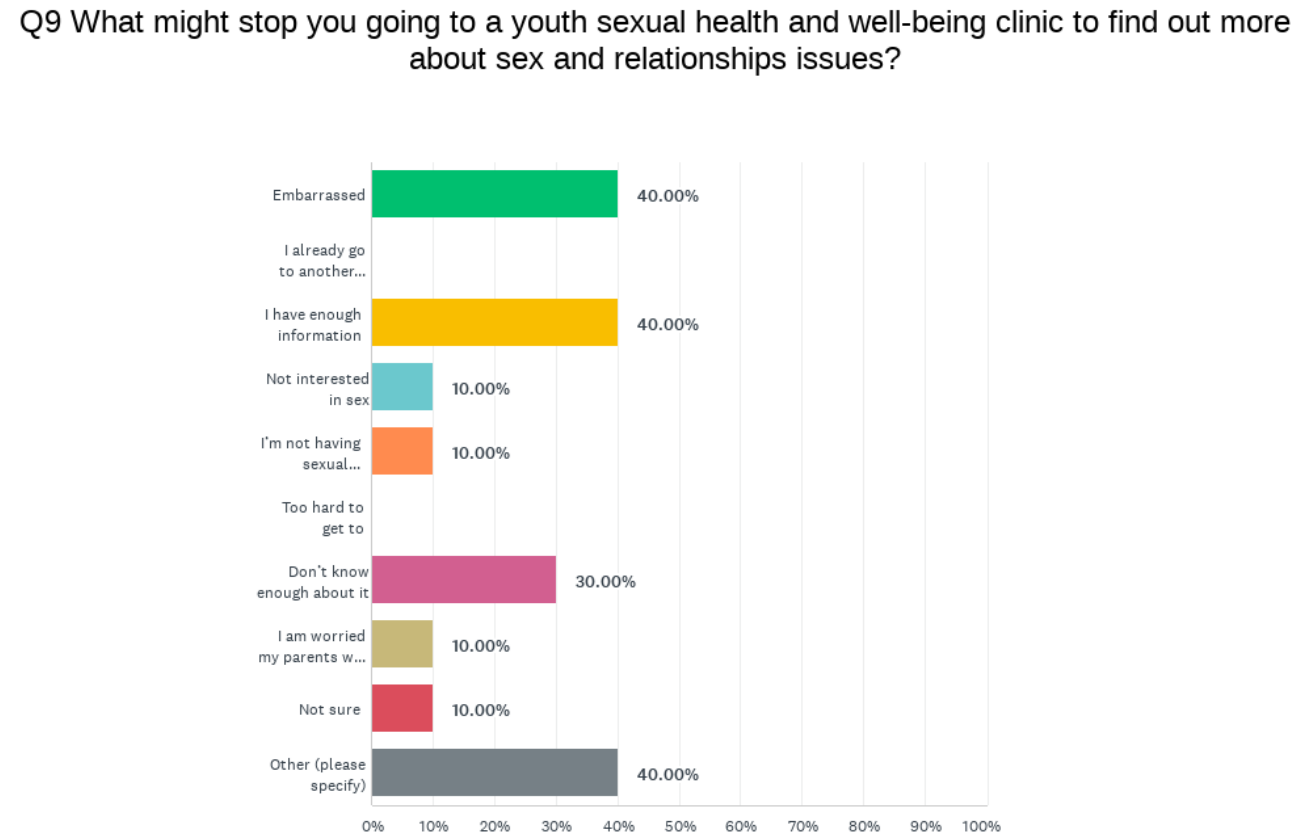


Figure 10: Potential barriers to accessing the SHC

Interestingly, the potential barriers to accessing the Clinic were very mixed. Embarrassment, having enough information, and not knowing enough about the Clinic were the most common responses, along with those in in the 'other' category (who each stated that there was nothing stopping them from attending).

Discussion group feedback

In March 2021, a discussion with young people from the Darwin headspace Youth Ambassadors Group was held with the evaluator and NTAHC staff to explore awareness of the Clinic and appropriate methods to engage with young people about it. The ideas shared are presented below. The information was used to re-design the Clinic posters (see page 10, and 19) and refresh promotional posts of social media.

More promotion is needed

- General lack of awareness about the SHC. The young people that new it existed were still unclear about what it is, who it is for, and how to access it.

Promotion ideas:

- Instagram
  - Instagram is the main social media platform that the group engaged with.
  - Participants suggested NTAHC could use Instagram to reach out to young people about the SHC. Use tags to link to other services/groups (e.g. headspace, Youthworks) that young people are already accessing so they see NTAHC posts.
  - Participants also advised that they use Instagram to check out a service and see if it looks welcoming/will meet their needs, before going to it.
- Posters
  - Participants said they read the posters on the back of toilet doors. QR codes on posters were suggested, to direct young people to SHC websites for more information and to find out how to refer. Toilets in nightclubs, at bus stops, libraries, cinema's, major parks and shopping centres are good places.
  - A better poster is needed though – graphics should be local. Less clutter on page.
  - A specific logo for the SHC and maybe a slogan could be good.
- Pamphlets/Resources
  - Suggestions for pamphlets included 'how to look after your sexual health' with content targeted specifically to lesbian, bisexual, gay, queer, questioning, trans and intersex young people. Having resources relevant to you makes you trust the service.
  - Highlight confidentiality - YP need to know the service is private and confidential.

Highlight LGBTIQA+ friendliness and cultural safety

- Young people need to know that a service is truly LGBTIQA+ friendly, and culturally safe. One participant discussed having negative experiences with a range of health services.
  - Services can demonstrate they are LGBTIQA+ friendly by overtly saying so on their promotional material/webpages/social media.
  - More than a 'rainbow flag' is needed. Participants want services to demonstrate their commitment to safe care for all young people by having materials on hand (e.g. pamphlets/posters) in the reception area that are relevant and targeted to LGBTIQA+ and Indigenous young people.

This completes the youth feedback section of the report. The following sections provide an exploration of the views of partner organisations, associated youth services, schools and community leaders. Feedback on the Darwin Clinic is considered first. Following this, ideas for the Clinic in Katherine are presented.

Feedback from partner & associated organisations (Darwin)

Participants

- Five SHC staff (nurses and counsellors, current and past) from NTAHC and SARC
- Six representatives from partner and associated organisations.

Organisation & analysis of interview data

The feedback was gathered during individual and small group interviews. All interviews were completed by the evaluator. A qualitative thematic analysis was used to draw out the themes in the interview data. A summary of the analysis is presented in Table 7 to orient the reader to the results, then further detail follows. The strengths of the service and then the challenges are discussed using quotes (in italics) from participants to demonstrate ideas

Table 7: Strengths and challenges of the SHC (Darwin)

Strengths & Challenges of the Youth Sexual Health Clinic		
	Theme	**Sub-themes**
Strengths	SHC meets a need	High rates of STI's and need for sexual health & relationship information and education
		A unique, youth-specific service
	SHC is governed and operated by strong organisational partnership	Good working relationship between NTAHC, SARC and headspace means a good service for young people
		Partners bring important skill sets, experience, connections and resources
	The SHC is accessible to young people	Location is good (near bus stop, shopping centre, headspace is known to young people)
		Transport options available (taxi vouchers)
		Drop in option after school option works well
		Warm referral options (ease of links between partner organisations)
	The SHC engages well with young people	A safe space (private and confidential)
		A unique nurse and counsellor model
		Holistic, client-led, flexible care
		Respectful, skilled, and relatable staff
Challenges	Organisational challenges	More youth input is needed into service planning and promotion
		Strategic planning needs refreshing and refining
		Demands on partners (staffing)
	Promotion of the Clinic	A consistent promotion and engagement strategy was lacking in the past
	Access barriers	Stigma & shame about sexual health
		Stigma about attending a clinic
		Assumptions about the partner organisations
		Language barriers
		Limited clinic opening times
		Sexual health may not be a priority for young people
	Service delivery challenges	Not being able to prescribe birth control
		Working with perpetrators
		Assessment paperwork
		Two-staff model may not always work
		Clinical room lacks warmth and youth friendliness

Exploring the strengths of the Sexual Health Clinic (Darwin)

The service meets a need

All interviewees highlighted the need for the clinic, and the lack of youth-specific sexual health services in the Darwin area. Some interviewees discussed specific reports and health statistics that demonstrate high rates of sexually transmitted infections for young people in the NT, highlighting the need for information and education in sexual health, relationships and consent. The following quote highlights this point.

The stats demonstrate a need, and the Clinic meets a need. It's great. It's really important.

While interviewees acknowledged that there are other services (for example, GP's, Clinic 34, Family Planning) that can provide sexual health information and testing, these services were not specifically youth-focused and youth access could be limited because of their location (too public), their cost, their associations with family, their perceived lack of privacy or concerns about judgement. The following quotes make these points.

The clinic is needed. It's free, it can be anonymous. Young people need their own space and their own service.

There are a range of other services that target specific groups– but none of these are specifically youth focused.

The organisational partnership is strong

The positive and productive nature of the partnership between SARC, NTAHC, headspace Darwin and headspace Katherine, was noted by interviewees. This collaboration has strengthened the Clinic and the relationships between these organisations, as we see in the following comment:

Each of the services involved really gets how important it is, it's a strong relationship.

Each partner organisation brings relevant and appropriate staff, skills, experience, and other resources to the Clinic (such as the Clinic space itself). This has resulted in generally well-integrated service provision for clients, as we see in this quote.

The inter-agency connectivity is really important for any young person that walks in.

The Clinic location is good

Having the Clinic physically located at headspace Darwin (at Casuarina) was considered a strength by most interviewees. headspace is located near a major shopping mall and bus depot, both central locations that young people access. Because headspace provides a range of youth wellbeing services, young people are generally familiar with it and have trust in the organisation as youth friendly, safe space. The following quotes highlight the important of this, in terms of access and reducing stigma.

The headspace environment is youth friendly. The clinic staff are friendly. This contributes to access

The location means there's less stigma about 'sexual health' – they could be going to headspace for all kinds of reasons.

There are transport options

In terms of getting to and from the Clinic, the Casuarina location helps with accessibility, as young people can get the bus there after school. In addition to this the Clinic offers free transport in the form of taxi vouchers should a young person need them. The following comment demonstrates the importance of having different options for transport available.

Free taxi vouchers are there if needed, that can be important if you're a teenager with no car and not wanting to use bus. Sometimes parents will pick them up to take them home, but the taxi offer is there.

Drop-in option and after-hours timeframes are good

Being able to walk in and see a nurse and/or counsellor on a Thursday afternoon is an asset for young people. As some interviewees commented, calling up, or trying to arrange an appointment, can be a little daunting for some young people. Being able to just get the bus after school and walk in is a real advantage in terms of accessibility, the following comments provide further understanding.

Teenagers can be quite sporadic, so having access to a drop-in is good.

It can take courage to ask for what you need, to work up to making an appointment. So making that easy is really important.

Some interviewees noted that the 3.30 to 6.00pm timeframe for the Clinic was good as it is after school hours, but before it gets dark.

Love the drop in straight after school. Strait of the school bus.

'Warm referral'

Interviewees who worked at the partner organisations pointed out the value of the 'warm referral' aspect of the Clinic. They discussed how good it is to be able to speak with a young person about the Clinic and say, "*it's right here*" or "*I know the nurse, I can call and let her know you are coming in*". Comments from interviewees who had referred young people make this clear:

It's a one-stop shop for young people who already access headspace, and who might disclose a need for sexual health education/information. Counsellors within headspace can refer them easily – it's in-house.

I refer to the clinic when a case is complex and separating out the sexual health element for work with another person is useful. Sometimes the existing client relationship doesn't fit with talking about their sexual health or with doing test/swabs etc. So, it's great to have another service on site that can do that.

If someone discloses a history of sexual assault, they can be referred to SARC…. If they need that specialised counselling, they've already met the nurse. It's a warm referral.

A safe space: private and confidential

From the moment young people enter the headspace building, there is discretion and privacy offered by all staff. This is critically important when working in a sensitive practice context.

The receptionist is discreet; you just take a number. headspace is a 'generic' service that offers a range of programs so you could be going there for anything.

Privacy is really well protected at headspace. They could be seeing a counsellor, or just dropping in to use the wi-fi.

Being able to remain anonymous from first contact to completion of service was viewed as an important option for young people's engagement. While very few took up the offer of complete anonymity, just having it there is reassuring and empowering as the next comment suggests.

You can be anonymous; you don't have to give a name. This can help when young people are concerned about privacy issues in relation to peers or family. It also empowers young people in that they are in control of the information they choose to provide.

Some interviewees pointed out that headspace is not generally associated with "*anything medical*". The spaces (reception, offices, drop in areas) are not considered clinical, and feel generally welcoming, colourful and youth friendly. This can help to foster a sense of holistic care, as the following quote makes clear.

It's not associated with anything medical - just a room in headspace which the kids all knew. Even backpackers have come. They didn't want a clinical situation – more about the relationship and connection.

A unique model (counsellor and nurse)

The interviewees agreed that the Clinic offers a unique service for young people because there is immediate access to two practitioners with different skills. Having both a counsellor and a nurse present in each Clinic session provides a wide range of options for assistance that is "*right there in the room*". This is important because the topic is sensitive, there is time for deeper engagement, and for safety reasons, as we see in the following comments:

Sexual health is such a sensitive topic for young people' – they don't have to share information multiple times – and can get a holistic service. It's a wrap-around service.

It's not purely clinical - do a test, in the door and then out. It's actually about the conversation and the story. Every young person brings a different story.

From a safety point of view, with intimate examinations, it's good to have two professionals.

While the 'standard' combination is to have both practitioners present, the young person gets to say who they want to have in the room. There is no judgement and no issue with selecting one or both practitioners. Some interviewees pointed out a further benefit of the model is the 'three-person dynamic'.

The three-person dynamic can be less intense than two people in a room. You can get a more relaxed conversation and can lead to great discussions from different viewpoints.

Holistic, flexible, client-led care

Closely linked to the previous theme, the Clinic model provides the framework for holistic, client-led service that has the flexibility required to meet the needs of the young people that drop in.

Engagement is led by the young person, and they can get support in all areas of their life.

The time-factor was noted by many of the interviewees, with staff able to take the time needed. There was great flexibility in timeframes, spanning a quick 20-minute drop-in to a longer series of discussions that provides important sexual health and wellbeing discussion and education. The following comments provide further detail.

You might see someone once for 15-minute test, others come every week for an hour. It's great to watch young people's sexual health and wellbeing knowledge grow, learning her rights to her body. It's so important.

Staff offer lots of services, physical info on STI's and contraception, all the other sex education information, just answering questions young people might have. It is quite flexible in what they provide depending on what the young person wants and needs.

Approachable and relatable staff

All interviewees highlight the importance of the having great staff employed in the Clinic. This is particularly so in the case of young people who have been in contact with the child protection or justice systems. Staff that relate well to young people, demonstrate respect, actively reduce stigma and create safety, are key to a service engaging with young people.

Trust and rapport are great, it's a safe space, relationships can be built between staff and client.

Sometimes the justice system has been the young person's only experience of counselling or sexual health care. It's important to build trust and safety.

Interviewees also noted that the staffing team has stabilised over recent months after a period of change, and this stability is good for Clinic in general.

Sexual Health Clinic Challenges (Darwin)

The interviewees identified a range of challenges spanning from youth input in planning and promotion, through to the stigma still associated with sex and sexual health in our society. These issues, along with the associated difficulties such as service promotion, are addressed here.

Youth input

Interviewees acknowledged that engaging with young people on the topic of sexual health is challenging due to a complex intertwining of personal, developmental and societal factors. Yet most agreed that more local youth input into the Clinic, specifically its youth engagement strategy, is needed. Some noted that more youth ownership of the Clinic could help to build awareness and enhance its reputation among young people.

Strategic planning & monitoring

While the Clinic developed from a need for such a service, interviewees pointed out how the strategic plan would benefit from revisit and refinement of its overarching vision, goals and related objectives and actions. Some felt that a clearer plan was needed, which included methods for monitoring the Clinic objectives and regular sharing of this information. The following quotes show how the Clinic has evolved and the importance of being able to understand and monitor activity.

Knowing what the vision is for the clinic; the long-term goals, the results we are seeking, is very important for understanding it's success over time.

Initially it was targeted towards young people at risk of domestic and family violence (particularly in the Barkly region) but it is now open to all young people.

Stress on partner organisations

Organising, staffing and overseeing a Clinic takes time, resources and long-term commitment from all partners. At times, this can prove difficult as each organisation goes through the inevitable ebbs and flows of resources and turnover. The Clinic creates an additional workload for partners, particularly those who provide in-kind support. This could potentially impact long-term sustainability of the service.

SARC provide a staff member from their team free of charge, that is a risk for its sustainability - SARC staff workload is an issue.

Promotion Challenges

Most interviewees agreed that more promotion is needed but noted that the sensitivity of the topic could make it difficult to this well. Others pointed out that because of staffing changes over the life of the Clinic, there have been periods of time where promotion and engagement with the community was lacking.

When there is a permanent nurse coordinator in place things run really well as they are actively engaging with the community to raise awareness of the clinic. Young people's engagement with the Clinic can fall off when no-one is taking the lead and promoting it.

Because high staff turnover is common across most sectors, knowledge about the Clinic, including referral pathways, can be lost or forgotten by services working with young people. This highlights the need for ongoing engagement with relevant services, as the next comment makes clear.

The police have no idea about the Clinic. Staff need to go to the Police when a new intake of general duties police come on board. Same with police auxiliary, you have to continue to bring them information, flyers, because no one wants to talk about sex.

Interviewees advised that a multi-faceted, ongoing, consistent approach to promotion and community engagement is needed. This could involve development of a Clinic 'brand', a stronger social media presence, engaging an ambassador with influence, regular engagement with schools and school counsellors as well as all other youth related community services and networks. Work on many aspects of promotion has increased over recent months, creating a good foundation. Suggestions for ongoing promotion are included in the recommendations.

Access barriers for young people

Stigma and 'shame' about sexual health

The social stigma attached to sex, sexuality and sexual health care can create barriers to Clinic access. Interviewees noted this was amplified with younger people as they begin to explore their sexuality, sexual life, relationships and identity.

Stigma and shame are the number one barriers.

Some interviewees pointed out that no matter how good the Clinic is, or how well it is promoted, sex remains a stigmatised topic across society (and more intensely in some communities). This will create barriers to accessing a sexual health clinic. The following comment adds more depth to this idea.

Bigger picture issues about sex education in our society go beyond this project, but are important for context about stigma. Staff across the youth sector, community and young people all need to be more comfortable with discussing sexual health and feel confident to refer to the SHC.

Stigma/uncertainty associated with attending a Clinic

Attending a Clinic of any kind can be difficult for a young person, particularly if they are attending alone and for the first time as an independent person. People may not know what to expect, what will be asked of them, and unsure of the social 'norms' around interacting in a clinic environment. They may also be unsure about the levels of privacy and information sharing, or fear judgement from staff. All of this can create a sense of uncertainty or even fear of attending that becomes a barrier to access.

Alongside this is the issue of thinking a clinic is only for people who have 'something wrong' with them. That is, you would only go there if you were sick, troubled, or in some way 'abnormal'. One interviewee questioned if the word 'clinic' should be avoided as it may contribute to the idea that there is a problem. The issues with promoting the clinic also come into play here, as the next comment highlights.

If it gets known that there is a sexual health clinic at headspace on that day, it could be too shame to go there.

Assumptions about the organisations involved.

Some interviewees pointed out that the names of the organisations involved in the Clinic may be off-putting to young people who can hold assumptions about the services (if organisations names are on signage or promotional material). One interviewee provided an example of a high school student telling them;

You have to have AIDS to go to NT AIDS and Hepatitis Council things.

Another interviewee pointed out:

The appointment phone number for the Clinic goes through to a sexual assault service and that could be problematic. If a young person wasn't sexually assaulted, they could think this is the wrong service for them. This could be a barrier.

Language barriers to access

The Clinic does not currently have information or promotional material in languages other than English. For some migrant and Indigenous populations this could be an issue. This is particularly problematic if there are cultural issues surrounding the topic of sexual health and hesitance about seeking out help or information.

Limited operating hours

The Clinic is open for 2.5 hours, one afternoon each week. This can be a barrier for a young person who is not able to attend on that day.

Sexual health may not be a priority for young people

Two interviewees pointed out that young people can have a lot going on in their lives. Commitments such as study, work, caring roles, family, and friendship obligations, take time and energy. Focusing on sexual health may simply not be a priority for young people until a serious issue or problem arises.

Service delivery challenges

Not being able to prescribe birth control

Contraception is a common concern at the Clinic, and it is important for young people to be able to access appropriate forms of contraception while they are there. Because there is no medical

practitioner within the Clinic, staff must refer clients to someone else who can do this.

Having to take or refer clients to other services who can prescribe or dispense prescriptions can be difficult. It becomes an extra inconvenience, an extra worker a young person has to deal with when they might already be feeling embarrassed. Ideally the Clinic would be a one stop shop.

Interviewees reported that ideally all forms of contraception could be provided at the Clinic, or an easy access in-house option could be arranged. One interviewee suggested that having an overseeing general practitioner could allow the Clinic nurse to provide prescription contraception, however a "*really strong system would need to place to allow that to happen*".

Working with a perpetrator

One interviewee discussed a situation where a young person, who was known to them as a perpetrator of sexual violence, accessed the Clinic. This was difficult for the worker and their colleague who had previously worked with the victim. The interviewee requested the development of protocols for working with perpetrators at the Clinic.

Assessment paperwork

The initial meeting with a young person generally involves the use of a structured assessment tool. One interviewee felt that perhaps there were too many questions in the assessment tool, that don't promote empowering engagement or allow for rapport building to occur very easily. The process can take a significant amount of time. This is problematic when a young person comes in wanting a quick test with no strings attached. It also runs counter to the narrative of anonymity that is offered. Another interviewee also pointed out the some of the questions could be difficult for younger clients to answer, as the following comment demonstrates.

A 12-year-old won't understand half the questions on the forms, especially around things such as miscarriage.

Two-staff model might not be good for all young people

While most interviewees found value in the nurse and counsellor model, one person highlighted some of the potential problems with this model. They felt that having two adults in the room could be quite confronting for a young person, suggesting *"it might spook them".* Having two adults and one young person in the room, "*could be tricky for the young person to feel empowered, until they got to know them*". It was suggested that an alternative way forward may be to "*build trust with one adult first, then link to counsellor if needed".* The following comment adds further detail to this idea.

The subtle non-verbal communication dynamic between two people is important. Increasing that to three, means the young person is outnumbered and could get defensive.

It was also suggested that young people may already have access to a counsellor, particularly if they have contact with the child protection or justice systems. They may feel "*over counselled*" and simply want a test or some information. The same interviewee suggested the assessment processes should alert a nurse to the need for a counsellor. If the counsellor is on site, they can be brought in after this need is confirmed by the young person.

The room could be less clinical

The physical appearance of the room used for the Clinic was reported to be a little '*too clinical*" by some interviewees, who explained that the room is usually a GP's consulting room when not being used by Clinic. The following quote highlights this.

The room is a bit pokey for three or more people. It feels a little bit too clinical, more freedom to decorate it and make it a comfier space would be good.

Feedback from Partner & Associated Organisations (Katherine)

The Clinic opened in Katherine in October 2021 and within weeks it was impacted by Covid-19 lockdown and lockout restrictions. Because of this, the aim of the interviews was on looking forward to 2022, with a focus on exploring both the current strengths and potential challenges of the Clinic.

Participants

18 representatives from partner and associated organisations (including headspace Katherine, local schools and youth support services) participated in a phone or online interview (group and individual). These took place in December 2021.

Organisation & Analysis of Interview Data

Notes were taken during the interviews, and these were re-read and checked for accuracy. A simple qualitative analysis was used to draw out the themes. A summary of the analysis of Clinic strengths and challenges is presented in Table 8, then further detail follows. Quotes from interviewees are used throughout to provide examples of points (these are in italics). Table 9 provides an overview of suggestions for moving forward with the Clinic in Katherine.

Table 8: Strengths and Challenges for the Clinic (Katherine)

Strengths & challenges for the Youth Sexual Health Clinic (Katherine)		
	Theme	**Sub-themes**
Strengths	There is a clear need for the SHC in Katherine	A youth-specific service is needed
		High rates of STI's and pregnancy: accurate and positive sexual health & relationship information and education needed
		LBGTQI young people need support & information
	The SHC is heading in the right direction	Location is good
		A safe space (private and confidential)
		A choice focused (2 practitioner) model
		Approachable, culturally informed, relatable staff.
Challenges	Organisational challenges	Sustainability of drive-in, drive-out model for Katherine.
		Staff turnover and change at headspace Katherine.
	Promotion of the Clinic	A new service and a sensitive topic
		A consistent, multi focused promotion strategy is needed.
		Target parents and community leaders
	Access barriers	Stigma & shame about sexual health
		What is 'sexual health'? It needs explaining to young people
		Stigma about attending a clinic
		Misconceptions about the organisations involved
		Language barriers
	Service delivery challenges	More outreach will be needed until the Clinic is well established
		Covid-19 Impacts: Clinic cancelled for six weeks

The Strengths of the Sexual Health Clinic (Katherine)

There is a clear need for the Clinic

There has been a lack of youth-specific options for young people.

All interviewees highlighted the need for the clinic in Katherine. They noted a lack of youth-specific sexual health services and the importance of having options for care and support. This need was also expressed by headspace Katherine Youth Advisory Group.

There is a need for more talk about sexual health. It can be hard for families to talk about it with their children, sex is seen as negative by some families. Young people need a safe space to help break down these barriers

While interviewees acknowledged that there are other services (for example, GP's, Clinic 34, Wurli Wurlinjang Health Service) that can provide sexual health information and testing they were not always youth-focused and youth access could be limited because of their associations with family, community members, lack of privacy or concerns about judgement.

Schools and school-based services could also experience difficulties in delivering sexual health curriculum for a range of reasons including a lack of teacher training or teacher discomfort, student attendance issues, lack of clarity about policies concerning distribution of condoms and other materials and having both male and female students in the class.

The issue of pornography creating unrealistic and sometimes harmful expectations about sex was also raised. One interviewee pointed out that "*porn is everywhere, and kids have easy access to it constantly if they want it".* Two interviewees agreed that pornography can negatively shape young people's assumptions about what sex 'must' involve. This can include violence and demeaning representations (of women particularly). Interviewees stressed this creates a need for young people to have access to information about safety, consent and respect.

High rates of STI's and need for accurate and positive sexual health & relationship information and education

Most interviewees discussed high rates of STI's and unplanned pregnancies among young people in the Katherine region. Many believed a youth-focused sexual health Clinic would help young people understand these issues better, so they can make informed choices about their sexual health and wellbeing.

The prevalence of incomplete or incorrect sexual health information available to young people was also noted by interviewees. For example, one person noted that while there may be general understanding of a topic or issue, the specifics can be vague. The following quote makes this clear.

There can be a lot of giggles, and some misinformation. Or it can be a case of 'mum wants me to get an Implanon, but I don't know what it is really, or what it will do to me'. They need to know the detail, what it will do to their body. There is not always a lot of support from families.

LGBTIQA+ young people need support and information

Two interviewees pointed out that there was a need for LGBTIQA+ young people to have a safe space, accurate information and support about their sexual health. There were very few people or services young LGBTIQA+ people will confide in or seek information from in Katherine, often because they felt unsafe to do so. It is hoped the Clinic would be proactive in promoting itself to this audience.

The SHC is heading in the right direction

The location is good

Because headspace provides a range of youth wellbeing services, most interviewees believed that young people are familiar with it and have trust in the organisation as a youth friendly, safe space. Being located in the main street also means it is accessible for anyone who can get into town.

A safe space: private and confidential

Young people enter the headspace offices through the public library entrance on the main street in Katherine. This means young people could be entering that door for a range of reasons. There is discretion and privacy offered from all staff which is key to safe practice in a sensitive context. Some interviewees pointed out the headspace rooms are also not generally considered a clinical space, and there is a 'youth friendly' welcoming feeling.

A choice-focused Clinic model (two staff)

All interviewees agreed that it is important for young people to have the option of seeing either a male or female practitioner, and an Indigenous or non-Indigenous practitioner. At the time of writing, the Clinic offered young people the option of seeing a female non-Indigenous sexual health nurse, and/or a male Indigenous health worker. The young person gets to say who they want to have in the room. There is no judgement and no issue with selecting either or both practitioners. The following quote shows how important access to two, different staff is.

Having a male and a female staff option in the Clinic is critical.

Interviewees noted that there will be particular issues or topic areas that a young Indigenous person may only wish to discuss with a person of a specific gender, and Clinic staff need to respect and work with that.

Approachable, culturally informed and relatable staff

All interviewees noted the importance of the having relatable, knowledgeable and respectful staff employed in the Clinic. Staff that relate well to young people, demonstrate cultural respect, actively reduce stigma and create safety, are key to engaging well with young people. Interviewees also highlighted some particular cultural issues in Katherine that are important for the Clinic staff to have an understanding of. For example:

It would be inappropriate for a female to talk about condoms with a young male, but issues about consent and STI's would be okay to discuss.

Other issues raised included boys pressuring girls into sexual activity before they are ready, the need for education and modelling of healthy relationships between partners and within families, and age-specific services.

The current sexual health nurse, Megan Caffrey, was frequently noted as an example of a good practitioner. At the time of writing, only two young people had engaged with the Clinic (due to very limited operating times), however Megan had started running some school-based sessions. One interviewee provided the following feedback about a session for four young women.

The feedback on Meg's session was really good. This role relies on personality and ability to relate to young people. The information needs to be good, but the delivery is critical, and Meg has skill in running sensitive sessions like this. She can relate to the students really well.

Sexual Health Clinic Challenges (Katherine)

As a new initiative in Katherine, the interviewees identified challenges, both current and foreseeable, for the Clinic. These are explored below.

Organisational Challenges

Sustainability of 'drive-in, drive-out' model for Katherine

Some interviewees, particularly those with experience in Katherine (or in positions that involved regular long-distance driving), questioned the ongoing viability of the sexual health nurse having to drive to and from Katherine every week. Some believed this might be okay over the short term, but for a consistent service, there needs to be a Katherine-based sexual health nurse. The need for this became particularly clear during the Covid-19 lockdowns and lockouts in Katherine, as we see in the next quote.

Telehealth is an option, and we offered this, but it is not a preferred option for young people we are working with.

Because relationships are critical in a sexual health Clinic, an ongoing and stable presence is required. Relationships can be difficult to establish from a distance, and a service can be negatively impacted if the staff member is not able to get to Katherine every week, for any reason.

Staff turnover at headspace Katherine

Two interviewees noted that staff turnover at headspace Katherine has resulted in a reluctance (by the young people they worked with) to engage with headspace services. By extension, this could impact the Clinic.

Promotion Challenges

New service and sensitive topic.

Most interviewees agreed that more promotion is needed but pointed out that the newness of the service means it is an 'unknown' for young people. Positive word of mouth may need to spread for it to become an accepted part of the youth support 'landscape' in Katherine. The sensitivity of the topic could make it difficult to promote the Clinic as well. As one participant noted, sexual health and wellbeing may not be high on a young person's list of priorities, until it is. It may take a crisis of some kind for a young person to need to attend.

The area is so stigmatised, so much shame attached to it. I don't know how you get around that. I don't know if promoting the Clinic can change that. But kids need to know it's there, and when they need it, which will be when they are in a crisis, then they will know where to go.

A consistent, ongoing promotion and engagement strategy is needed.

Because there will always be new cohorts of young people, there needs to be consistent promotion of the Clinic over time. Interviewees highlighted young people's immersion in on-line worlds, and suggested that a multi-faceted, online, ongoing, consistent approach to promotion and community engagement is needed. This would involve a strong social media presence (Instagram and Tik Tok). Some suggested engaging a local Clinic ambassador with community influence as part of an online information campaign.

Another frequently mentioned point in the interviews was that high staff turnover is common across the youth sector. Knowledge about the Clinic, including referral pathways, can be lost or forgotten when new staff replace current ones. There is a need for ongoing liaison and information sharing with the education, justice and youth sectors to ensure the Clinic service becomes well known and remains so.

Targeting parents and community leaders

The importance of ensuring that promotion also targets parents of young people, and community leaders, was noted by many participants. While it can be difficult to engage with families on the topic of sexual health, hosting some general community information sessions at headspace offices, to introduce and explain the service to parents was suggested as a good way to create more understanding and promote the Clinic. One interviewee explained how information sessions might slowly break down stigma in the following quote.

Consistent discussion with accurate, clear information is needed. There will be shame the first time people hear it, but the more people hear it the less shame there will be.

Access barriers for young people

Stigma and 'shame' about sexual health

The social stigma attached to sex, sexuality and sexual health can create a barrier to Clinic access. Interviewees noted this was amplified with younger people as they begin to explore their sexuality, sexual life, relationships and identity. Some interviewees pointed out that no matter how good the Clinic is, or how well it is promoted, sex remains a stigmatised topic. This will create barriers to accessing a sexual health clinic.

What is sexual health?

Interviewees pointed out that many young people will not be clear on what is meant by 'sexual health' so as a starting point, they suggested ideas such as workshops held in conjunction with appropriate school and youth services staff to raise these issues with young people in Katherine.

The language around sexual health needs to be broken down. All the terminology and language in relation to STI's and testing needs to be explained. What a test involves exactly, that needs explaining. You are more likely to attend if you know what is going to happen and who you will see.

What is a swab? What is a urine test? Basic information about this stuff is needed.

Stigma/uncertainty associated with attending a Clinic

Attending a Clinic of any kind can be difficult for a young person. Young people may not know what to expect. They may be unsure about privacy and information sharing or fear a lack of understanding from staff. All of this can create a sense of uncertainty about attending.

Assumptions about the organisations involved.

Two interviewees pointed out that the headspace location may be off-putting to young people who might hold assumptions about mental health services. One interviewee provided an example of young people they work with feeling embarrassed about anything to do with mental health, therefore being unlikely to drop into a service such as headspace.

Language barriers

The Clinic does not currently have information or promotional material in languages other than English. For some Indigenous and non-English speaking populations this will be an issue. This is particularly problematic if there are cultural issues surrounding the topic of sexual health and hesitance about seeking out help or information.

Service delivery challenges

Outreach needed first

Linked to the ideas of promoting the clinic and demystifying sexual health previously noted, almost all participants felt that as a critical first step, a program of outreach into schools, youth services and the community more broadly was needed. Some outreach activities have already commenced, and these were highly valued by interviewees.

I think outreach is the key in Katherine.

Another key element of outreach is providing opportunities for young people to meet the sexual health nurse. This can help them feel more comfortable and normalise the idea of a Clinic. It may also help to build relationships and provide a familiar face so young people can more confidently link with the Clinic.

Impacts of Covid 19 Lockdowns.

The Clinic began operating for one afternoon per week in Katherine on 5th October 2021. By November the Covid 19 pandemic had impacted Katherine with a range of lockdown and later lockout restrictions. The Clinic was cancelled until 14 December 2021. Fewer than half the planned Clinics were able to run.

Suggestions for the Katherine Clinic

The 18 interviewees provided a range of ideas for the clinic as it grows in 2022. These suggestions have been summarised in the table below.

Table 9: Katherine suggestions for the Clinic

Suggestion area	Detail
Service Planning & Design	Invite youth ambassadors from headspace to be involved in Clinic planning and promotion in stronger way as the Katherine Clinic evolves.
Promotion & Community Engagement	Develop a suite of promotion resources including: • Brochures/posters in diverse languages common to the region. (e.g. Creole, Filipino, Hindi) • Include clear visuals so everyone can understand information • Develop different materials for different age groups (12- and 25-year old's need information presented very differently) • Break down 'sexual health' what it is and what it means as some young people may not know. • Accessible website with lots of easy-to-understand visuals. • Clinic video that introduces staff, shows the space. This may reduce some of the 'mystery' about what happens at the Clinic
	Engage a local Clinic ambassador or 'champion' that young people look up to. Share stories of how the Clinic can help young people.
	Embed regular school (and related program) outreach activities such as: • Maintain relationships with school counsellors and relevant staff • Maintain connections with education support programs (STARS, Clontarf, re-engagement programs) • Value adding – building SHC information to existing training that happens in schools and with school-based programs • Offer training sessions to students and their parents. For example, what is sexual health and why it's important, de-stigmatising sexual health, clinic information and how to refer. • Provide up to date pamphlets and posters in languages spoken in the school community • Invite school groups into the Clinic space to demystify and create a sense of safety and inclusion. • Develop different information/education sessions relevant to different age groups.
	Have a consistent presence at Katherine Youth network meetings to remind people (particularly new people) about the Clinic.
	Offer professional development activities (about sexual health, stigma, the Clinic) to all youth focused services, police, and the hospital.
	Engage with the Defence community at Tindal. Meet with Defence social work and community support staff as a starting point.
	Have a presence at local events such as Youth Week and Pride celebrations
Referring	Consolidate systems to ensure all potential referring services have the information they need about the clinic including - referral pathways, how

	the clinic operates/types of service, free (+ free taxi vouchers), opening hours, and age range.
	Include options on referral forms for who you want to see (male/female, Indigenous/non-Indigenous). Include photos of staff if possible.
	Inform parents about SHC so they can refer. They also need to know SHC exists so they can encourage their young people to attend. Context matters and it's changing all the time – parents may not be up to date with current sexual health, gender and identity and sexuality info.
Service Delivery	Consider options for a mobile clinic that could operate out of spaces where young people are already (schools, holiday activities, shopping centre, pool and skate park, schools)
	Scaffold engagement to build confidence and knowledge. This might start with outreach activities (as above), then engagement with web-based sexual health information and resources, with options for increasing engagement anonymously and incrementally. For example, an online chat option for specific questions, or a text messaging option. If further engagement was needed, then phone contact or face-to-face options can be offered dependent on the young persons need. As noted previously, an online referral form might include photos of staff and a short 'blurb' about them and their background. Young people could select who they wish to see.

Conclusion

This evaluation set out to document Clinic service, to understand the strengths and challenges involved, and explore the achievement of Clinic aims. The evaluation also sought to explore how best to move into the future. Before providing recommendations, the results from all data sources are brought together to clarify the core learnings. To begin, the strengths and challenges of are summarised.

Clinic strengths

- The Clinic responds to an acknowledged need for a youth-specific sexual health and wellbeing service.
- It is holistic: The two-practitioner model works well for young people and staff (safety, different skill sets, wrap-around service).
- Young people feel listened too, respected, and safe.
- Young people get the support and information they needed.
- The Clinic is generally accessible to young people who need it.
- It is governed and operated by strong organisational partnership.
- The development and delivery of education sessions in partnership with schools and school-based programs provides important information, linkages, and promotes the Clinic to students.

Clinic challenges

- Stigma and 'shame' about sex and sexual health: It remains a difficult topic for young people and the community generally.
- Sexual health can be a low priority for young people.
- Awareness of the Clinic in the community is limited.
- Some access barriers remain: limited Clinic hours, no male practitioner (Darwin), limited availability of resources in diverse languages, community assumptions/misconceptions about the organisations involved.
- Limited ability to provide some types of contraception (referrals needed for prescriptions).
- Limited ongoing youth input into Clinic planning and promotion.
- Partner organisations can experience staffing pressures/insecurities (reliant on continued in-kind supports of all partners, drive-in, drive-out model may not be sustainable for Katherine Clinic).

The Clinic is meeting its original objectives

The four aims for the Clinic were:

1. Increased sexual health screening and education for a cohort of vulnerable young people as identified by SARC, NTAHC, headspace, Territory Families and the Department of Health.
2. Formalised referral pathways between agencies for young people accessing sexual health and wellbeing clinic
3. Improved access to protective behaviours and healthy relationships education that builds on the capacity and strengths young people identify within themselves and their communities.
4. Development of a formal report detailing the project and including quality improvement measures, evidence of project responsiveness and potential for replication and expansion.

Each of these aims have been met.

1. **The Clinic has developed as a holistic, safe, respectful and youth friendly service.** Feedback from clients, partner organisations, referring services, community and schools all attests to this aim having been met. The Clinic opens each week for 2.5 hours (Darwin), and in that relatively small space of time, provides a consistent, safe and holistic service.

Staff went above and beyond to make me feel comfortable and do the testing I wanted….The communication was really good. They were really reassuring.
(Young Person)

The Clinic has increased sexual health screening and education for a cohort of vulnerable young people. This has been achieved because the Clinic now *exists* specifically for young people and has been accessed by 55 young people. Education sessions have been attended by over 200 school students and 17 school staff. The case file analysis also provides evidence of referral sources (Figure 4), confirming Clinic access by young people from SARC, NTAHC, headspace, Territory Families, and the Department of Health.

The stats demonstrate a need, and the Clinic meets a need. It's great. It's really important.
(Darwin Medical Practitioner).

2. **Referral pathways have been developed and strengthened to enhance young people's access to the Clinic.** The interim evaluation report (August 2021) highlighted that the existing connections between partner organisations meant referral systems were strong in that context. However, the need for easy referral to the Clinic for those outside the partner organisations was clear. Since the employment of the new Sexual Health Nurse in September 2021, a clear referral pathway has been formalised (for self-referral or by another service), with updated referral information and forms available online (for example see https://www.ntahc.org.au/clinics and https://headspace.org.au/headspace-centres/katherine/sexual-health-and-wellbeing-clinic/)

The inter-agency connectivity is really important for any young person that walks in.
(Darwin Youth Service)

3. **The Clinic has improved access to protective behaviours and healthy relationships education that builds on the capacity and strengths young people identify within themselves and their communities.** Tables 2 and 4 combined provide evidence of over 260 young people engaging either in Clinic sessions or education workshop sessions. Much of this work (as Figure 3 and Table 4 highlight) has been focused on sexual health and wellbeing education, including healthy relationships and protective behaviours.

It wasn't a judgemental environment at all, and I felt safe saying what I was involved in to an adult, where in other circumstances it would have felt weird
(Young Person)

4. **The completion of this evaluation report meets the final Clinic aim, which focused on the development of a report detailing the project and including recommendations, evidence of project responsiveness and potential for replication and expansion.** Recommendations are provided in the following section.

Embodying the principles of Territory Families *Safe, Respected and Free from Violence* Prevention Grants

Feedback from young people, organisations and community presented throughout this evaluation has demonstrated that the Clinic works consistently to embody the principles of the Territory Families *Safe, Respected and Free from Violence* prevention grant program. The grant program supports local projects, activities and actions that seek to challenge and change social and cultural attitudes, values and structures that underpin domestic, family, and sexual violence in the Northern Territory. The Clinic has contributed to the development of a community of domestic, family, and sexual violence prevention practice by embracing the following three principles specifically.

1. Educate the community about domestic, family, and sexual violence and develop the capacity of the community to respond to these types of violence.

The Clinic engages with a range of stakeholders via partner meetings, youth sector meetings, community and school-based student education sessions. The Clinic is also moving into the space of providing professional development opportunities to health, community, and education sector workers. Through these mechanisms, SARC, NTAHC and headspace continue the process of educating the community about domestic, family, and sexual violence, and its impacts.

Domestic, family and sexual violence are topic areas that must be handled safely, sensitively and in response to local issues, strengths and needs. The feedback from this evaluation indicates that the Clinic is contributing to education in these critical areas, and participants have provided ideas for further community education opportunities.

In addition to the day-to-day education the Clinic provides to individuals, groups and community, the development and sharing of this evaluation report will also contribute to broader community understanding. The report will contribute to a growing body of literature on the issues, successes and challenges related to providing meaningful education about domestic, family, and sexual violence to young people.

2. Foster positive personal identities and challenge rigid gender roles, gender inequality, sexism, and discrimination

The Clinic model has a focus on holistic, client-led, empowering practice. It is clear in its intent to foster positive personal identities and challenge disempowering gender roles, inequality, sexism and discrimination. Feedback from evaluation participants indicates young people feel empowered, safe and accepted within the Clinic. Within the Clinic environment, each young person is given the opportunity to explore impacts of inequality, gender roles and their experiences of sexism and discrimination. The protective behaviours and sexual health education resources utilised by the Clinic staff, as part of each young person's consultation, have been developed with an empowerment focus. A range of resources are available for use during Clinic and group-based sessions. For example - '*Yarning On'* (Shine SA), a resource for talking with Aboriginal young people about sexual and reproductive health, consent and relationships; The Central Australian Aboriginal Congress' '*Community Health Education Program* for delivering holistic sexual health education to young Indigenous women living in and around Central Australia; and, *Love Bites* a NAPCAN healthy relationships program. New resources are reviewed regularly to ensure Clinic staff meet current best practice standards and have the resources required to address local issues

The evaluation results have also provided a range of ideas for further strengthening of practice in this respect, including the development of pamphlets/brochures and web-based resources specifically addressing a range of gender identities and roles.

3. Encourage protective behaviours and support children and young people to exercise consent and engage in healthy and respectful relationships.

The evaluation has demonstrated that sexual health education is a major aspect of the service provided to young people at the Clinic. It is also a focus of group-based educations sessions for young people in schools and community groups. All young people accessing the Clinic are offered protective behaviours education based on the evidence-based interventions used within the three partner organisations (SARC, NTAHC & headspace). A harm reduction approach is utilised with young people participating in high-risk behaviours. The different ways young people can seek and give consent, and how that may manifest in everyday life is a theme throughout all education sessions (individual and group). Clinic staff work to ensure concepts surrounding consent and healthy relationships are relevant to the individual or group, and their circumstances.

The strengths and limitations of the evaluation

The mixed methods, developmental approach to this evaluation has provided an understanding of the Clinic from a range of viewpoints and data sources. Bringing this knowledge and experience together is a strength of the evaluation, as the findings from each source resonates the others. While engagement with staff from partner organisations and associated youth services, schools and community has been strong, further participation of young people would have added to the evaluation. As the evaluation has highlighted, it can be difficult for young people to engage in dialogue about sexual health, and help seeking, and this may have impacted willingness to participate. Reassuringly, much of what has been learned aligns strongly with what the existing research literature tells us, and this adds confidence to the evaluation results.

Recommendations

The Sexual Health and Wellbeing Clinic has met its original stated aims. The Clinic responds to a widely acknowledged need in the community and provides a safe, holistic, and respectful service. **It is recommended that this work continue to grow into the future.** To this end, it recommended that

1. Long term, increased funding is secured to build on the foundations set in the **Darwin** Clinic. This would involve the following aspects.
    a. The Clinic offering two sessions per week (one for booked appointments, one for drop-ins).
    b. An increase in staff so there is always access to one male and one female practitioner.
    c. Continue to strengthen relationships with schools and youth services through the provision of education and awareness sessions.
    d. Investigate options for a mobile Clinic that could provide regular visits to schools and youth services, and youth spaces in the Darwin and Palmerston areas.

2. Long term and increased funding is secured in order to consolidate the newly established Clinic in **Katherine**. This would involve.
    a. Employment of a part-time Katherine based sexual health nurse to ensure stability and consistency of Clinic service and continue the building and maintenance of networks to support referrals and awareness in Katherine (e.g. youth service providers and peak bodies).
    b. Investigate options for a mobile Clinic that could provide regular visits to schools and youth services and locations where young people congregate in and around Katherine.

3. Explore options for the name of the Clinic. Removing the word 'clinic' and including the word 'youth' or 'young people' in the name may be beneficial.

4. Development, promotion and distribution of a set of easy-to-read information pamphlets (in partnership with young people) for young people, families and carers focused on topics such as: What is sexual health and why is it important? LGBTIQA+ specific education and support information, overcoming shame and seeing advice, explaining different STI/BBV tests and what they involve, and information for parents or carers wanting to support their young people.
    a. Pamphlets should be available in printed, electronic and web-friendly versions and can be used in group education sessions, Clinic sessions and distributed to community groups, GP's and other health services.
    b. These resources need to be translated into local languages and include graphics that enhance understanding for all community members.
    c. Development of these resources should be done in partnership with local community leaders.

5. Development, promotion, and distribution of age appropriate 'hospital packs' that can be provided to young people accessing a hospital or health centre by social workers, nurses and other appropriate staff members. The packs could include Clinic information and pamphlets, and other appropriate freebies and resources.

6. Development of regular in-service education sessions for hospital staff in Darwin, Palmerston and Katherine. The sessions could be focused on how to engage safely with all kinds of young people about their sexual health, what the Clinic offers and how to refer.

7. Engage a Clinic ambassador who is selected in consultation with young people. The person (perhaps a local identity or leader) would help to promote the importance of sexual health and wellbeing and raise awareness of the Clinic.

8. Investigate options for 'in house' prescribing of contraception and other appropriate medications so that clients do not have to be referred to other services for this.

9. Develop a refreshed set of Clinic objectives that are nested within the broad aims of the Clinic and determine a set of indicators and measures to track the progress of each of these objectives. This would include the following.
    a. Develop a Clinic program monitoring system, that allows partners to track the indicators and can be integrated into the Clinic workload.
    b. Consider how many young people the Clinic aims to see each week and month.
    c. Consider how many education sessions the Clinic aims to run each quarter.
    d. Report quarterly to all partners on the progress of objectives. This will provide a strong understanding of how the Clinic is tracking, and where the focus of promotion might need to shift.

10. Establish a regular reporting, feedback and planning sessions between the Clinic coordinator and the headspace Youth Ambassador Groups in Darwin and Katherine.

11. Establish a regular Clinic evaluation cycle for ongoing learning, development, and service improvement. As part of this, explore options for sharing of evaluation learning with professional and broader communities as a way to continue the open discussion of sexual health education and support for young people.

Appendices

1. Letter confirming Human Research Ethics Clearance (Menzies School of Health Research)
2. Evaluation Protocol
3. Literature Review
4. References

1. Letter confirming Human Research Ethics Clearance (Menzies School of Health Research)

menzies
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30 June 2021

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Dr Gretchen Ennis
Research & Evaluation Consultant
Useful Projects
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Via Email

Dear Dr Ennis,

HREC Reference Number: 2021-4035
Project Title: *Evaluation of Sexual Health & Wellbeing Clinic (NT Aids & Hepatitis Council)*

Thank you for letter dated 11th June 2021 and taking the time to respond to the issues of concern identified by the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC) at its meeting held on the 26/05/2021.

This project was considered by the HREC and the Aboriginal Ethics Sub-Committee (AESC) and assessed against guidelines for human research including the NHMRC *National Statement on Ethical Conduct in Human Research 2007*.

I am pleased to advise that **full ethical approval** of this research project has been granted following assessment by representatives of both the AESC and the HREC. Please note that approval applies only to research conducted after the date of this letter and continued approval is dependent on annual reporting.

Approval Date: *30/06/2021*

Approval is granted for the above research project until the next report due date.

Annual progress report due: *30/06/2022*

Approved timeframe (subject to compliance and annual reporting): *30/06/2021 to 30/06/2022*

The nominated sites/s participating in this project that have been approved by this HREC is/are:

- Sexual Health and Wellbeing Clinic
- Headspace offices (Casuarina and Katherine, NT)
- NT Aids and Hepatitis Council (Woods Street, Darwin City).

Please note:

* Researchers must comply with site specific governance regulations, data custodian and other stakeholder requirements.

The documents listed below are approved:

Document	Version	Date
Evaluation Protocol	2	08.06.2021
Interview Guide	2	08.06.2021
Survey Questions	2	08.06.2021
Information Sheet for Organisations	1	29.04.2021
Consent Form for organisations	1	29.04.2021

(16 and over) - Interviews	2	08.06.2021
Information Sheet for Young People (aged 12-15) – Interviews	2	08.06.2021
Interview Consent Form: Young People	2	08.06.2021
Information Sheet for Young People – Surveys	1	09.04.2021
Client Case Record Data Collection Form	1	30.04.2021

The documents listed below are noted:

Document	Version	Date
Letter of support from lead/contracting organisation – NTAHC		29.04.2021
CV for Principal Investigator		05.05.2021
NT Working with Children Card	Exp 20/08/2022	05.05.2021

APPROVAL IS SUBJECT TO the following conditions being met:

1. The Coordinating Principal Investigator will **immediately report anything that might warrant review** of ethical approval of the project.

2. The Coordinating Principal Investigator will notify the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC) of any event that requires a **modification or amendment to the protocol or other project documents** and submit any required amendments in accordance with the instructions provided by the HREC. These instructions can be found on the Menzies' website.

3. The Coordinating Principal Investigator will submit any necessary reports related to the **safety of research participants (e.g. protocol deviations, protocol violations)** in accordance with the HREC's policy and procedures. These guidelines can be found on the Menzies' website.

4. The Coordinating Principal Investigator will **report** to the HREC **annually** and notify the HREC when the project is completed at all sites using the specified forms. Forms and instructions may be found on the Menzies' website.

5. The Coordinating Principal Investigator will notify the HREC if the project is **discontinued at a participating site before the expected completion date** and provide the reason/s for discontinuance.

6. The Coordinating Principal Investigator will notify the HREC of any plan to **extend the duration of the project past the approval period listed above** and will submit any associated required documentation. The preferred time and method of requesting an extension of ethical approval is during the **annual progress report**. However, an extension may be requested at any time.

7. The Coordinating Principal Investigator will notify the HREC of his or her **inability to continue as Coordinating Principal Investigator**, including the name of and contact information for a replacement.

8. The safe and ethical conduct of this project is entirely the responsibility of the investigators and their institution(s).

9. Researchers should immediately report anything which might affect continuing ethical acceptance of the project, including:

    - Adverse effects of the project on participants and the steps taken to deal with these;

- Other unforeseen events;
- New information that may invalidate the ethical integrity of the study; and
- Proposed changes in the project.

10. Approval for a further twelve months, within the original proposed timeframe, will be granted upon receipt of an annual progress report if the HREC is satisfied that the conduct of the project has been consistent with the approved protocol. Report templates are available on the Menzies ethics webpage.

11. Confidentiality of research participants should be maintained at all times as required by law.

12. The Patient Information Sheet and the Consent Form shall be printed on the relevant site letterhead with full contact details.

13. The Patient Information Sheet must provide a brief outline of the research activity including: risks and benefits, withdrawal options, contact details of the researchers and must also state that the Human Research Ethics Administrators can be contacted (telephone and email) for information concerning policies, rights of participants, concerns or complaints regarding the ethical conduct of the study.

14. You must forward a copy of this letter to all Investigators and to your institution (if applicable).

This letter constitutes ethical approval only. This project, including amendments to the research protocol or conduct of the research which may affect the site acceptability of the project, cannot proceed at any site until separate site specific assessment or research governance authorisation has been obtained from the CEO or Delegate of the institution under whose auspices the research will be conducted at that site, if not already obtained. Please forward this approval letter to the relevant research governance office.

Should you wish to discuss the above research project further, please contact the Ethics Administrators via email: ethics@menzies.edu.au or telephone: (08) 8946 8687 or (08) 8946 8686.

The Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research wishes you every continued success in your research.

Yours sincerely,

Dr. Bianca Middleton
Chair, Fast Track Sub-Committee
Human Research Ethics Committee
of the Northern Territory Department of Health
and Menzies School of Health Research
http://www.menzies.edu.au/ethics

This HREC is registered with the Australian National Health and Medical Research Council (NHMRC) and operates in accordance with the NHMRC *National Statement on Ethical Conduct in Human Research (2007)*. NHMRC Reg no. EC00153

2. Evaluation Protocol.

Evaluation Protocol

Evaluation of the Sexual Health & Wellbeing Clinic (SHC Evaluation)

Chief Investigator: Gretchen Ennis, Useful Projects**.**
Date and Version No. 8.6.21. Version 2.
Commissioned by: Northern Territory AIDS & Hepatitis Council (NTAHC)

Project Description

The project is focused on the evaluation of The Sexual Health & Wellbeing Clinic (SHC). The SHC is a one day a week Clinic facilitated by the Northern Territory Aids & Hepatitis Council (NTAHC) in partnership with the Sexual Assault Referral Centre (SARC), headspace Darwin and headspace Katherine. It is a sexual health clinic specifically for young people (12-25) and takes a whole of community approach to promoting respectful relationships, good sexual health, wellbeing, and the development of a strong empowered identity within the young person's unique circumstances.

The evaluation will use a mixed-methods approach that includes surveys, semi-structured individual interviews with all stakeholder groups (young people, staff, partner services and referring organisations). A thematic analysis will be used to analyse the interview data. Surveys will be analysed using descriptive statistical methods. Documents generated by SHC (funding, reporting and acquittal documentation) along with anonymised client records will also be used to review program timelines, describe services provided, and capture trends in service needs.

Aims and Significance

The evaluation aim is to explore the extent to which the SHC service objectives have been met, and what the barriers and enablers to service provision have been. There will also be an exploration of 'where to from here?' as the service aims to expand to the Katherine region.

The SHC objective are

- Increased sexual health screening and education for a cohort of vulnerable young people as identified by SARC, NTAHC, headspace, Territory Families and the Department of Health.
- Formalised referral pathways between agencies for young people accessing sexual health and wellbeing clinic
- Improved access to protective behaviours and healthy relationships education that builds on the capacity and strengths young people identify within themselves and their communities.
- Development of a formal report detailing the project and including quality improvement measures, evidence of project responsiveness and potential for replication and expansion.

This evaluation is significant in that it will assist the SHC to document and explore an innovative service model (nurse and counsellor working together with each young person) along with the strengths and challenges of the SHC so far, and to learn from this as they plan further activities into the future.

Evaluation Methods

Study design & methodology.

As the SHC is in the implementation phase, having been running for a year, process and outcome evaluation are the most suitable types of evaluation. While there will be descriptive quantitative data gathered via surveys for clients and young people generally, the evaluation involves a mainly qualitative approach, using individual and group interviews.

Document review will be used to summarize and describe materials generated by the SHC (meeting minutes, funding documents, activity promotional materials etc). A review of client case notes files will also be used to explore the numbers of clients, their demographics, specific services that are provided, rates of return clients, 'no-shows' and to understand referral sources and linkages made.

These methods have been selected in consultation with all SHC partners, and the methods were discussed and modified in consultation with the headspace Darwin Youth Ambassadors Group during March 2021.

Data collection methods, instruments, and procedures

This is a mixed-methods evaluation involving interviews, surveys, case files, and document review.

Interviews

Semi-structured Interviews will be held with the four stakeholder groups listed below. Individual interviews are expected to be between 30 and 60 minutes long.

SHC clients (young people who attended the SHC)

At the end of each SHC consultation, the Nurse will let young people know that the SCH is being evaluated and provide them with evaluation information sheets about both the survey and interview options for young people. If they would like to take part in the evaluation interview, they can either give their contact details to the nurse for the evaluator to follow up, or they can choose to email/phone the evaluator themselves.

If they wish to do an anonymous survey, a QR code and website link are printed on the Information sheet so they access the survey at a time that suits them.

Young people can select to have a guardian, friend or other person of their choice at the interview.

Youth participant interviews will be held in private meeting spaces, either at NTAHC offices in Darwin, headspace Darwin and Katherine. These services already provide non-intrusive, confidential services to young people and maintain high levels of privacy. Participants will already be familiar with the services and locations. They do not need to provide their name to the evaluator (as young people do not need to provide identification to the SHC if they do not wish).

Staff at SHC and partner organisations.

An evaluation information sheet for staff of SHC partners will be emailed to all relevant staff at each of the three partner organisations, with an invitation to participate in an interview. The email will come from the SHC lead person in each of the organisations. Potential

participants can contact Gretchen directly to organise an interview if they wish to participate.

Staff at organisations that refer young people to the SHC

An evaluation information sheet for SHC referring services will be emailed to all relevant staff at each of the three partner organisations, with an invitation to participate in an interview. The email will come from the SHC lead person in each of the organisations. Potential participants can contact Gretchen directly to organise an interview if they wish to participate.

Instruments used in all interviews will include a digital voice recorder and the question schedule. The question schedule for staff and for young people is included at the end of this document.

Written consent for all interviews with staff from SHC partner and referring services will be required. A copy of the interview consent form is attached to the ethics application at Attachment 5.

As the SHC is open to all young people from 12 to 25 years of age, some potential interview participants may be younger that 18 years. Consent from a legal guardian or parent will not be sought for this group. Young people can access the service without providing any identifying information if they wish. Guardian/parent consent is not possible under such circumstances. The evaluator will ask if the young person would like to complete a written consent form.

Surveys

SHC clients (young people who attended the SHC)

At the end of each SHC consultation, the Nurse will let young people know that the SHC is being evaluated and provide them with an evaluation information sheet for young people. This includes information on participation options, including interview (as above). If they wish to do an anonymous survey, they will be provided with a card that has a QR code and website link to access the survey at a time that suits them. This survey seeks to understand clients views about their SHC experience. It is anonymous, and brief. A copy of the SHC client survey questions is attached.

Young people who have not accessed SHC

To gain an understand of potential barriers to accessing the SHC, a web-based survey link will be distributed via the email lists and notice boards at headspace Darwin, headspace Katherine, NTAHC and distributed to the Palmerston and Regions Youth Services Network and the Darwin Youth Services Network members. This survey seeks to understand awareness of the SHC and barriers to accessing it. It is anonymous, and brief. A copy of the 'all young persons' survey questions is included at the end of this protocol.

No formal written consent will be sought for surveys, as they are brief and anonymous and young people can choose not to participate without any negative consequences.

Existing document Review

Documents generated by the SHC (meeting agenda's and minutes, funding applications and acquittals), event information, and products generated via their specific activities will be gathered and reviewed in order to develop rich program descriptions and timelines. No participant names will be included in these documents, or in the analysis of them. Each set

of documents/products will be copied (with any identifying information blacked out by the SHC Nurse) and provided to the evaluator.

Client Case File Review

Anonymised client files will be provided to the evaluator to review in terms of the following:

- Demographics
- Presenting issues
- Services provided
- Number of follow up visits
- Referral made to other services

Client files are paper based and will be reviewed over two sessions in a private office at the SHC clinic space. They will be anonymised by NTAHC prior to being provided to the evaluator. This involves appropriate NTAHC SHC Nurse copying each file and blacking out identifying information before it is provided to the evaluator. The evaluator will return these documents to the NTAHC SHC Nurse at the end of each session.

Planned analysis methods

Interviews

A qualitative, inductive thematic analysis (Stake, 2010) will be used to analyse the interview data. Data will be analysed to form major themes or 'ideas' within the participants responses to the interview questions. These themes will be brought to life using de-identified quotes that illustrate particular ideas or provide evidence of assertions made.

Surveys

A descriptive quantitative analysis will be used to analyse the survey date. This will involve frequency distributions, measure of central tendency, and cross tabulation of variables that reveal information relevant to the aims of the evaluation.

Document Review

A descriptive review of documents (Bowen, 2009) will take place to explore the work completed by the SHC and to summarize this.

Sequencing of all research activities

Data collection, of all data, will begin once HREC approval is gained. Once approved:

- Document review will begin as soon as participating organisations provide documents to the evaluator.
- Case records review will begin once the records have been anonymised by NTAHC SHC Nurse.
- Interviews will be held during July and August over a six-week period.
- Surveys will be distributed during July and August
- Analysis will occur as the data comes in
- Preliminary evaluation results will be presented to the SHC partner organisations in a workshop in October 2021
- The final evaluation report will be delivered 17 December 2021.

Identification of potential limitations of the study

The study could be limited by a lack of engagement of the various groups, most specifically young people who have accessed the SHC. This will be mitigated by using a range of data collection methods, as some may appeal to potential participants more than others, and through the use of case records to understand service use.

No evaluation can capture all aspects of a program, but the evaluator and SHC partners have worked together to develop a design we believe is 'fit for purpose' and will provide useful information with minimal potential risk to participants groups.

Protocol Attachments

Interview Guides

[Version 2. 8.6.21]

SHC Clients

1.Could you please tell me your: Age, gender, main language spoken at home
2. Do you remember how you first heard about the SHC?
(cover: where they referred, who by?, have they seen any media or promotional materials about the SHC?)
3. What was the main reason you came to the SHC?
4. Did you get the help/information/resources you needed?
5. Have you accessed other sexual health screening services before?
6.What are your thoughts about the staff at the clinic?
(cover: empathy, language use, safety, respect shown, helpfulness)
7.Do you think the SHC could be improved in any way to be more youth friendly? (if so, how)
8. Was it easy for you to get to the SHC?
9.Would you tell others to come to the SHC? (why/why not?)
10.What do you think the organisers of the SHC need to know that they might not already?
11. What do you think are the best ways to encourage other young people to come to the SHC?

SHC partner services interviews

1. Could you tell me about your role/your services role in the SHC?
2. What are your views on the SHC in general? (strengths/weaknesses)
3. What do you think the benefits of the SHC for young people are?
4. What do you think the challenges of the SHC for young people are?
5. If you could start all over again with the SHC, would you change anything? What would improve it?
6. What do you think the barriers to young people attending the SHC might be?
7. What do you think helps them to attend?
8. What support and/or information would help you to make referrals to other services if needed? (prompts - training, professional development, networking event - informal afternoon teas, etc.)
9. Who do you think might not be accessing the SHC that could benefit from it? How might that group be engaged?
10. Are the demographics of clients changing in any way – are there any trends or issues you are noticing?
11. Are there any 'stand out stories' from the SHC you would like to share?
12. What would it take to strengthen the SHC – what would you need to improve your work with the SHC?

Referring organisations interviews

1. What is your relationship to the SHC?
2. Have your clients/service group, been referred to SHC l? If so, how did that process go?
3. What do you think are the benefits of the SHC might be? (to young people , to the community, to orgs involved)
4. Have you observed any changes in the young people you work with that may be related to the SHC?
5. How might the SHC be added to or improved?
6. What other activities might you like to see the SHC being involved with?
7. Do you think there are groups who could benefit from the SHC, but are not accessing it?
8. How might engagement with young people be improved?

Web-Based Survey Questions

Version 2. 8.6.21

SHC Client Participant Survey

1. Age
2. Gender
3. Main language spoken at home
4. How did you hear about the SHC?
    - I was referred by someone
    - I walked past and saw it
    - I heard about if from someone I know
    - I saw a poster about it
    - Instagram
    - Facebook
    - Can't remember
    - Other
5. Main reason you came to the SHC?(open answer)
6. Think about your experience at the SHC, and answer these questions (5 point Likert scale response options + comment box for each)
    - I feel listened to at the SHC
    - I got the help I needed at the SHC
    - I found the information I needed SHC
    - I tell other people to come to the SHC
    - I feel safe at the SHC
    - I feel respected by the staff
    - It was easy for me to get to the SHC

7. How could the SHC be improved? (open response)
8. If you would like to enter the draw for a $100 shopping voucher, please click this link to enter your contact details (these will not be linked to your survey answers)

Survey questions for young people not attending SHC

1. Age
2. Gender
3. Have you heard of the Sexual Health & Wellbeing Clinic? - Yes/no
4. If yes, how?
    - I walked past and saw it
    - I heard about if from someone I know
    - I saw a poster about it
    - Instagram
    - Facebook
    - Can't remember
    - Other
5. Have you ever talked to a nurse, doctor or other professional about sexual health? - Yes/no

6. Where do you get your information about sex and sexual health? (open comment)
7. What would stop you going to a youth focused sexual health and wellbeing clinic to find out more about sex and relationships issues?
    - Embarrassed
    - I go to another service
    - I have enough information
    - Not interested in sex
    - I'm not having sexual relationships yet
    - Too hard to get to
    - Don't know enough about it
    - I am worried my parents will find out
    - Other reason?

8. Any other comments?
9. If you would like to enter the draw for a $100 shopping voucher, please click this link to enter your contact details (these will not be linked to your survey answers).

3. Sexual Health & Relationship Information, Education, Support and Care for Young People in Australia: A literature review

1. Review Background & Method

Background
This review forms part of the evaluation of the Sexual Health and Wellbeing Clinic Evaluation (SHC Evaluation) commissioned by the Northern Territory AIDS & Hepatitis Council (NTAHC). It has been written to help with contextualizing the work being done with the SHC and to help inform service development into the future. It was undertaken in April and May of 2021.

Aim of Review
To gain an understanding about what is known, in the Australian context, about young people's access to and experience of relationship and sexual health information, education, support and care.

Method
A narrative review method was used to conduct the review. Narrative reviews are useful for obtaining a broad perspective on a topic. This type of review can provide a comprehensive, critical, and objective analysis of the current knowledge on a topic (Baumeister & Leary, 1997; Onwuegbuzie & Frels, 2016). A narrative review is an important part of a research or evaluation process and helps to establish focus and contextualize the work. It does not seek to locate, assess, and interpret every piece of literature on a topic (as in a systematic review). It is useful because we can identify patterns in research, theory and critique in order to gain a broad understanding of current trends and issues in the area.

Process for gathering the literature used in this review
An online journal data-base search was completed in (during April 2021). The following search terms were used in various combinations: 'youth', 'teen' 'adolescent' 'young people', 'sexual health clinic', 'counsel*', 'nurse*', 'wellbeing', 'sexual health', 'prevent*' 'resource*', 'risk factors', 'protective factors', 'barrier*', 'enable*', 'child protection', 'Northern Territory', 'Australia;' The search only included articles written in English, published from 2010 onwards, and that appeared in peer-reviewed journals. The titles and abstracts were read to determine relevance to the literature review topic. The reference lists of relevant articles were also scanned to locate any further potential resources.

Relevant Australian and Northern Territory Government documents (for example – plans, strategies, and reports) were also reviewed. A general web-search was completed using the same search terms to locate any other web resources, such as evaluation and research reports commissioned by organisations involved in, or linked to, youth sexual health services.

2. Organisation of the Review

The review has been organised around the following headings

- Definitions
- The Sexual Health of Young People in Australia
- How and Where do Young People Get Their Information about Sexual Health & Relationships?
- Access to sexual health and relationships care and education: issues, barriers, enablers
- Sexual Health and Young People 'At-Risk'
- Interesting Models for Education, Care and Support for Young People
- Research Considerations

3. Definitions

Young People

Defining 'young people' can be contentious, and age ranges differ depending on the purpose of the definition. It is acknowledged that within and overlapping the category of 'young people' is another category of 'young adults' which is generally consider 18-30 (Hendry et al., 2018). For this review, 'young people' includes those aged between 12 and 26 years of age. This is the age range the SHC targets.

Sexual Health

'The World Health Organization defines sexual health as a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence' (CDC. 2019).

4. The Sexual Health of Young People in Australia

The Secondary Students and Adolescent Sexual Health Survey

This is a national survey that explores the sexual health and well-being of Australian adolescents. It is undertaken approximately every five years and asks anonymous questions about young people's knowledge, behaviour and educational experiences related to sexual health and well-being. The Commonwealth Department of Health funds the survey which has been running since 1992. For further information see the website at .http://teenhealth.org.au/about-survey.php. The 2018 survey is the most recent.

Key findings from the 2018 survey report show there is room to improve young peoples' sexual health knowledge (Fisher et al 2019). They also demonstrate that 'students are largely engaging in responsible behaviours, though there is room to increase risk- reduction practices; and that students are accessing a diverse array of educational sources' to learn about blood borne viruses (BVV's) and STI's. The report also finds that 'more could be done to improve programs both in and out of schools' (Fisher et al., 2019 p. 2). Fisher et al point out that a key priority area for action is to' raise awareness and knowledge of HIV, STIs and BBVs. Knowledge of transmission and symptoms is an important precursor to perceptions of risk and
subsequent behaviours to mitigate that risk.' They point out that:

Across all knowledge questions, students answered an average of 56% correctly, while reporting relatively low rates of perceived risk, testing and vaccination. While most students scored well in knowledge of HIV transmission and STI symptoms, there continues to be opportunities to improve overall sexual health knowledge among students in Australia. (Fisher et al 2019, p.3)

In terms of young people's sexual behaviours Fisher et al. (2019, p. 3) summarised that:

Most students have engaged in some form of sexual activity, from deep kissing (74.4%) to sexual intercourse (46.6%). Across all behaviours, Year 12 students engaged in more forms of sexual activity than Year 11 students; similarly, Year 11 students engaged in more forms of sexual activity than Year 10 students.

Young People Need More Knowledge

Education about healthy relationships and sexuality is needed and does not increase sexual risk taking. Helmer et al (2015) found that young people in SA, NT and WA realised that they needed more knowledge so they could have healthy relationships. Their research challenges popular beliefs that 'providing young people with open, honest information around sex will encourage them to have sex or increase sexual risk taking. Making sexuality education more of a priority and listening to the needs of young people could be a positive step towards improving sexual health and well-being'. (Helmer et al., 2015, p. 158)

LBGTIQA+ Young People: The Writing Themselves in survey

A longitudinal Australian survey focused on LGBTIQA+ young people, and conducted approximately every six years, began in 1998 (Hill et al., 2021). Titled Writing Themselves In, it is the first national survey of same sex attracted young people in Australia. This project has highlighted the 'marginalisation of same-sex attracted young people and identified very high levels of stigma and discrimination. The most recent Writing Themselves In (4) received 6,418 responses (43 of these, or less than 1% were from the NT). The survey the largest ever of LGBTIQA+ young people in Australia (Hill et al., 2021).

In summary the survey included:

- a diverse sample of LGBTIQA+ people, including 4.0% of participants who identified as Aboriginal and/or Torres Strait Islander, 11.0% who were born overseas, and 39.0% who identified as having disability or a long-term health condition.
- Half (50.6%) of participants were cisgender women, 22.3% cisgender men, 19.5% non-binary, 6.5% trans men, and 1.2% trans women.
- Almost half (45.0%) of participants identified as multi-gender attracted. In total, 33.8% participants identified as bisexual, 16.6% as gay, 12.0% as lesbian, 11.2% as pansexual, 8.4% as queer, 4.6% as asexual, and 13.4% as something else.
- The vast majority (95.3%; n = 6,114) of participants reported attending an educational institution in the past 12 months, with 60.0% attending secondary school, and 24.1% university, and 5.9% TAFE.

Information from this survey is used throughout this review, but some important figures for a general 'setting the scene' of the wellbeing of young LGBTIQA+ survey participants includes:

- 60.2% had felt unsafe or uncomfortable in the past 12 months at secondary school due to their sexuality or gender identity. This compares to approximately29.2% of participants at university and 33.8% of participants at TAFE.
- 38.4% of Secondary school, 34.4% of TAFE, and 17.2% of university students missed days at their educational setting in the past 12 months because they felt unsafe or uncomfortable.
- 40.3% felt unsafe or uncomfortable at full-time work in the past 12 months due to their sexuality or gender identity. This was also true for 35.6% of participants who worked part-time and 31% who worked casually
- 40.8% of participants reported in the past 12 months experiencing verbal harassment based on their sexuality or gender identity.
- 22.8% reported experiencing sexual harassment or assault based on their sexuality or gender identity in the past 12 months.
- 9.7% reported in the past 12 months experiencing physical harassment or assault based on their sexuality or gender identity.
- 23.6% of participants had experienced homelessness in their lifetime, and 11.5% had this experience in the past 12 months.
- 26.0% of those who had experienced homelessness felt that this experience was related to being LGBTIQA+.

The survey asked explored the question, '***What makes you feel good about yourself***?' 'A number of themes emerged that speak to the creativity and confidence of LGBTIQA+ young people, as well as some of the challenges they are still seeking to overcome. These were:

- The value of social connectivity to friends and family
- Romantic connection and partnerships
- Satisfaction derived from creativity and achieving
- The importance of affirmation from within (how I feel about myself)
- Being affirmed by others (how I am seen and treated by my social world)
- Having an influence on others and effecting positive change within their community

(Hill et al., 2021, pp. 15-17)

Rural & Remote Young People

Young people in Australia have higher rates of sexually transmissible infections (STI's) than the general population (Edwards, Britton, Jenkins, Rickwood, & Gillham, 2014). Therefore knowledge and education about STI's is critical. Young people's knowledge of STI's is low in rural and remote areas. People who get STI's are 'not like me'. A research paper from 2014 examined young people's 'perceived vulnerability to sexually transmitted infections (STIs) and their efforts to create a sense of personal safety within an environment in which risks may be high and where STIs are highly stigmatised'. Research involved Indigenous and non-Indigenous 16- to 25-year-olds from across Australia, including communities in the NT. They found stigmatisation of young people with STIs and explored a range of 'protective mechanisms peer groups employ to create perceptions of personal safety' (Senior, Helmer, Chenhall, & Burbank, 2014, p. 453).

The Writing Themselves In Survey (Hill et al., 2021) highlights the seriousness of the challenges young LGBTQI people in rural and remote locations experience. The most recent survey (2021, p. 19) found that:

- More participants in rural/remote areas reported experiencing high/very high psychological distress (87.5%) than those in regional cities or towns (83.3%), outer suburban areas (79.8%), or inner suburban areas (73.2%).
- More participants in rural/remote areas reported in the past 12 months experiencing verbal harassment based on their sexuality or gender identity (45.4%) than those in regional cities or towns (41.0%), outer suburban areas (40.4%), or inner suburban areas (37.0%).
- Almost two-thirds (65.1%) of participants in rural/remote areas reported experiencing suicidal ideation in the past 12 months, followed by three-fifths (60.5%) in regional cities or towns, 57.1% in outer suburban areas, and 49.2% in inner suburban areas.
- Participants in rural/remote areas reported the highest levels of suicide attempts in the past 12 months (14.0%), almost twice that of those in inner suburban areas (7.1%).

Aboriginal and Torres Strait Islander Young People

A 2017 review of 19 qualitative research papers on young Indigenous Australians' sexual health demonstrates the 'profoundly social nature of young people's sexual lives'. 'Findings reveal efforts made by some young Indigenous Australians to control their sexual lives, mitigate risk and maintain their sexual health'. The review showed sexual health risk and vulnerability factors included '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' (Bell, Aggleton, Ward, & Maher, 2017, p. 1208)

'Aboriginal and Torres Strait Islander people in remote and very remote communities in Australia experience high rates of sexually transmissible infections (STIs), 4- to 29-fold the rates reported for non-Aboriginal people living in remote areas.' With young people (16-29) being particularly vulnerable (Lobo, D Costa, Forbes, & Ward, 2020).

An earlier piece of research also focused on young Aboriginal and Torres Strait Islander people comes from 2014: The Sexual Health and Relationships Survey (The Goanna Survey) was the first national survey of young Aboriginal and Torres Strait Islander people in relation to sexually transmissible infections (STIs) and blood-borne viruses (BBVs) undertaken in Australia (Ward et al., 2014) . 'The survey involved collection of data across four areas; (i) demographics; (ii) questions assessing knowledge of STIs and BBVs; (iii) questions relating to risk behaviours and (iv) questions related to use of and access to health services. Just under 3,000 Aboriginal and Torres Strait Islander people aged 16 – 29 were surveyed in every Australian jurisdiction'. Some of the key findings include:

- Gender - 59% of participants were females, 39% male, and <1% transgender.

- Age - 43%, 31% and 25% of participants were aged 16 – 19, 20 – 24 and 25 – 29 years respectively at the time of survey.
- Sexual identity - Most of the participants identified as heterosexual (~90%); 6% of males and 3% of the females reported their sexual identity as gay or lesbian respectively.
- Overall knowledge of STIs and BBV transmission and treatment were good. Correct answers provided to STIs and BBVs knowledge questions were lower among males compared to females - median score of 9 and 10 respectively out of a possible 12. 26% of participants aged 16 – 19 years responded correctly to at least 11 of 12 knowledge items, whereas 46% of 25 – 29-year olds answered the same answers correctly.
- Sexual Activity - Most participants reported being sexually active (>80%). The youngest age groups were less likely to be sexually active 26% compared to participants aged 25 – 29 years (5%).

Heterosexual Young Males (17-19)

An overview of young heterosexual young males sexual behaviours was conducted in 2017. Researchers pointed to the limited data on the patterns of early sexual behaviours among teenage heterosexual boys. The authors aimed to study 'the nature and onset of early sexual experiences' of this group using a survey design with 191 heterosexual men aged 17–19 years (Chow et al., 2017). Results showed:

- Median age at first oral sex was 16.4 years and 16.9 years for first vaginal sex.
- Most men had engaged in oral sex (89.5%) and vaginal sex (91.6%) in the previous 12 months with 32.6% reporting condom use at last vaginal sex.
- Of the total lifetime female partners for vaginal sex reported by men as a group (n=1187): 54.3% (n=645) were the same age as the man, 28.3% (n=336) were a year or more younger and 17.4% (n=206) were a year or more older.
- Prior anal sex with females was reported by 22% with 47% reporting condom use at last anal sex.
- Median age at first anal sex was 18.2 years.
- Anal sex with a female was associated with having five or more lifetime female sexual partners for oral and vaginal sex.

Young People's sexual health and mental health: The links are complex but integrated services are a good idea

The links between mental health and sexual health are complex and various studies have found some quite different results. For example, in 2014, Edwards et al argued that research demonstrated a clear link between emotional distress, depression, substance abuse and sexual risk-taking behaviours in young people' (Edwards et al., 2014, p. 354). A later study noted that while 'Poor mental health has previously been associated with risky sexual health behaviours among young people internationally and in clinical samples…..little is known about this relationship in non-clinical settings'.

The authors of this study conducted survey of 1345 Australians aged 15–29. They considered sexual health behaviours including contraception use, STI testing, sexting and age at first sexual intercourse in relation to mental health. The authors found that recent poor mental health was reported by 29.7 % of participants. Their results suggest that 'mental health is largely driven by variables other than sexual health behaviours, although youth mental health services should consider inclusion of sexual health promotion within the scope of their services.' (Carrotte, Vella, Hellard, & Lim, 2016, p. 1082).

The *Writing Themselves In* survey highlights the very high rates of mental ill-health within their sample of LGBTQA+ young people. The authors note that the best available comparison they can 'make to the general population is drawn from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. While the report of that survey does not break down responses in the 14- to 21-year-old range, it does do so for those aged 16 to 17, hence the comparison we make here' (Hill et al., 2021, p. 19). They find:

- High or very high levels of psychological distress among 16- to 17-year-old participants of *Writing Themselves In* 4 (83.3%) were more than three times that of the 27.3% reported among the general population aged 16 to 17 years.

- Almost three-fifths (59.1%) of participants aged 16 to 17 years had experienced suicidal ideation in the past 12 months, more than five times the proportion observed in the general population aged 16 to 17 (11.2%).

The idea of integrating sexual health and mental health services was also highlighted in an earlier study. Fernadez et al (2009) found that depression was linked with a history of self-harm, earlier alcohol use and having tried cannabis. They also found high levels of depressive symptoms among attendees to a sexual health clinic for young people. Because of this they concluded that a sexual health clinic was therefore 'an appropriate setting for screening and providing guidance for depression and other health risk behaviours' (Fernandez et al., 2009, p. 799).

In summary, while the links and associations between mental and sexual health in young people are complex and difficult to tease apart, the idea of having integrated sexual and mental health services appears to be very sound.

5. How and where do young people get their information about sexual health and relationships?

Schools

The 6th National Survey of Secondary Students and Sexual Health 2018 provides information on the formal and informal sources of relationship and sexual health information for Australian secondary school students. They state:

Most students reported that they received relationships and sexuality education (RSE; 83.6%) at school. Most RSE was delivered by their regular teacher (82.1%) as part of their Health and Physical Education (HPE) subject (70.6%) in Years 7-8 (75.9%) and/or Years 9-10 (80.8%). One in three (37.8%) students found their RSE very or extremely relevant. (Fisher et al., 2019, p. 6).

When asked about what they wanted from RSE, students said
they want RSE that is engaging and affirming, delivered more often, and covering a wide range of age-appropriate content provided by well-trained teachers or other professionals who are comfortable with the topic (Fisher et al., 2019, p.6).

Friends

A paper by Byron (2017) examined how young people's friendships influence safer sexual practices. The authors interviewed Sydney-based young people (18-25 years) and reviewed Australian-based sexual health websites aimed at young people. The interviews showed that *friendships can support young people's sexual experiences, concerns and safeties beyond the practice of 'safe sex' (condom use). This is evident in friends' practices of sex and relationship advice, open dialogue, trust and sharing experiential knowledge, as well as friend-based sex.*

However, sexual health websites do not engage with the ideas of friendship, or its value to a sexual health agenda. The authors conclude that *greater attention to friendship among sexual health promoters and researchers would improve professional engagements with young people's contemporary sexual cultures, and better inform their attempts to engage young people through social media* (Byron, 2017, p. 486).

The majority of students in the *6th National Survey of Secondary Students and Sexual Health 2018* reported that they felt most confident talking about sexual health with female friends (71%), did so frequently in last year (53.9% reported several times to almost weekly) and trusted them to provide accurate information (52.7% indicated high levels of trust). Students also talked with their mothers and male friends, though less so than female friends. (Fisher et al., 2019 p.4).

The *Writing Themselves In* Survey (Hill et al., 2021, p. 15) provides information about the people young LGBTQI people share information about their sexuality or gender identity with and

who supports them. 95.5% of participants had disclosed their sexuality or gender identity to friends, followed by family (71.9%) or some classmates (70.5%). Less than half of participants had come out to co-workers (43.2%) or teachers (36.0%), and 28.8% to sports teammates.

It was friends who were most likely to be supportive when told about the person's sexuality or gender identity (88.3%), followed by teachers (65.2%), teammates (63.6%) and co-workers (60.8%); while family (57.3%) and classmates (42.1%) were reported as the least supportive. (However, the number of participants who are out to teachers, teammates and co-workers is very low.)

60.6% of participants attending university who had disclosed their sexuality or gender identity reported feeling supported by their classmates, compared to one-third at secondary school and 43.2% at TAFE (Hill et al., 2021, p. 15).

Social Media/Internet

Social media and networking sites are now commonly used platform for sexual health communication with young people. Use of social media for sexual health community presents a range of opportunities and challenges for both health professionals and young people. These include s learning through interactivity and addressing concerns about privacy (Evers, Albury, Byron, & Crawford, 2013).

In 2016 Gabarron & Wynn argued that online social media represent 'powerful channels for health promotion, including sexual health' (Gabarron & Wynn, 2016, p. 32193). In a review of literature about use of social media for sexual health promotion however, they found that

> *Although billions of people worldwide actively use social media, we identified only 51 publications on the use of social media for promoting sexual health. About a quarter of the publications have identified promising results, and the evidence for positive effects of social media interventions for promoting sexual health is increasing.*

The *6th National Survey of Secondary Students and Sexual Health 2018* points out that

Most students (78.7%) had accessed the internet to find answers to sexual health questions, although they did so infrequently (86.5% indicated once a month or less) and cautiously (55.5% indicated only moderate levels of trust in online sources)' (Fisher et al., 2019, p.4).

Other Sources (Family, GP's, Community Health)

According to The 6th National Survey of Secondary Students and Sexual Health 2018, the most trusted source of sexual health information were GPs (88.6%), followed by mother (59.8%) and community health services (54.7%) (Fisher et al., 2019 p. 4).

For young LGBTQI Australians, 22.9% of the Writing Ourselves In participants accessed LGBTIQA+- specific sexual health information, and 19.6%accessed LGBTIQA+-specific mental health information online in the past 12 months (Hill et al., 2021, p. 17)

6. Access to sexual health and relationships care and education: issues, barriers, enablers

Experiences of LBGTIQA+ Young People

A study examining how young bisexual women in Tasmania experience sexual health care in general practice settings provides some important information for providers nationally. Fifteen bisexual women (18 to 26 years) took part in interviews, about the experience of seeking sexual health care in rural Tasmania. Four main themes were found in the interview analysis:

(a) issues of health care accessibility in rural Tasmania
(b) the importance of visual signs of inclusivity in rural clinics
(c) practitioner attitudes
(d) use of inclusive, gender-neutral language.

The authors concluded that rural bisexual women prefer practitioners who make meaningful efforts to be inclusive and take a non-judgmental approach to sexual health care (Grant & Nash, 2019).

The *Writing Themselves In* Survey points out that 62.9% of survey participants had accessed an in-person professional counselling or support service, and 21.2% accessed a professional text or webchat support service, with 13.2% using a professional telephone support service in their lifetime. LGBTIQA+-specific services were thought to provide better service than standard services.

Two-thirds of participants said they would prefer to access a professional support service in person if they were to need one in future, followed by 19.1% who preferred text or webchat, and 2.1% telephone (Hill et al., 2021, p. 17)

How well do young people understand their developing sexuality?

This is a question Helmer et al (2015) asked in their research paper about the project titled Our Lives: Culture, Context and Risk. The project 'investigated sexual behaviour and decision-making in the context of the everyday life experience and aspirations of Indigenous and non-Indigenous young people (16-25 years)' in the NT, WA and SA. The authors also considered what young people 'thought was necessary to improve the quality of sexuality education'.

Participants suggest that current forms of sexuality education are too clinical, didactic, and unengaging, and are missing in relevant content. Young people requested more information on relationships, first sexual experiences and negotiating condom use.

The ability to provide relevant and engaging sexual health promotion and relationships and sexuality education is influenced by social and cultural factors. Heslop et al (2019) discussed the findings from interviews with 15 young people about their experiences of sexual health promotion and relationships and sexuality education in a rural Australian town. They found four key themes in the interviews:

1. relevant and credible sexual health education
2. make it easy
3. GP accessibility
4. discreet condom supply.

The importance of staff attitudes and their ability to be welcoming and non-judgmental is critical for young people feeling able to access sexual health services. In 2015 researchers in Qld undertook a mixed-methods study across four towns in rural and regional Queensland. A total of 32 service providers were interviewed and 391 young people participated in a Young People's Survey. They found that

> *service providers frequently identified structural barriers, confidentiality and lack of awareness of SRH services as barriers for young people seeking SRH care. Young people also reported that structural factors such as transport, cost and service operating hours were important however, they placed greater value on personal attributes of service providers, particularly welcoming and non-judgemental attitudes* (Johnston et al., 2015, p. 257).

Services and Culturally Diverse Young People in Australia

Health professional views about issues and best practice in engaging with young people from minority ethnic, migrant and refugee backgrounds on the topic of sexual health were the focus of a paper by Botfield et al (2017). Five key themes were found:

(1) appreciating the complexities of cultural diversity

(2) recognising structural barriers and disincentives to engagement

(3) normalising sexual health

(4) balancing 'youth-friendly' and 'culturally-competent' priorities, and

(5) going beyond simple translation.

In a further study about the role 'generations' play in engaging young people from migrant and refugee backgrounds with sexual health care, Botfield et al (2018) interviewed 27 young people aged 16 to 24 years. They found 'A theme of 'generational difference' recurred throughout the interviews' and this was used as a way to explain a perceived disjunction between service providers (older generation) and young people (younger generation).

The participants 'saw themselves as generationally distinct, and commonly positioned 'older people' as judgemental and less accepting in relation to sexual health'. The authors conclude that 'to enable information and services to better reach young people across the many cultural and linguistic groups living in contemporary Australia, attention must be paid to ensuring they feel included as a member of a 'young generation', and ensuring services are inclusive and welcoming' (Botfield et al., 2018, p. 398).

LBGTIQA+ young people from a multicultural background are considered in the *Writing Themselves In* report. Hill et al (2021, p. 19-20) find that:

- Over half (51.8%) of participants from a multicultural background reported they had felt unsafe or uncomfortable at their educational setting in the past 12 months due to their sexuality or gender identity.
- Fewer participants from a multicultural background (53.1%) reported feeling supported by family about their sexual identity, gender identity and/or gender expression than those from an Anglo-Celtic background (62.4%).
- Participants from a multicultural background reported in the past 12 months experiencing higher levels of verbal (41.6%), physical (10.5%) and sexual (23.2%) harassment or assault based on their sexuality or gender identity, compared to those from an Anglo-Celtic background (verbal 38.7%; physical 7.7%; sexual 21.6%).
- A greater proportion of multicultural participants (10.4%) reported experiencing a suicide attempt in the past 12 months, compared to Anglo-Celtic participants (8.4%).

Services and Aboriginal & Torres Strait Islander Young People in Australia

'In remote and very remote Australia, young people engage youth workers in sexual health discussions, often out of necessity due to low access to health services.' In a study by Ming, Kelty & Martin (2021, p. 221), ten youth workers and managers in the Pilbara, WA, were interviewed about their experiences and the impact of sexual health training on their work. They found more local training with additional online supports were needed.

> *The results of this study suggest current training is not meeting the needs of youth workers and youth service managers in the Pilbara, and they feel under equipped to address sexual health topics with young people. (Ming, Kelty, & Martin, 2021, p. 221).*

7. Sexual Health and Young People 'at-risk'

The importance of Youth Workers – Linking young people to services.

Youth workers can be an important link between young people and sexual health information and services. An article by Ming et al al (2021) notes that youth workers may be the only professionals available to young people in remote and very remote locations. Janssen and Davis (Janssen & Davis, 2009) point out this is especially so for vulnerable and at-risk young people. Janssen and Davis identify *the important role of youth workers in engaging clients proactively around a broad range of sexual health issues, and then discuss real and perceived barriers that youth workers face in meeting the sexual health needs of young people. The article presents a discussion engagement framework - the PLISSIT model - and practical examples to assist workers to improve their skills and confidence in this area (Janssen & Davis, 2009, p. 19).*

Aboriginal and Torres Strait Islander Young People at Increased Risk – The need to understand social determinants.

Research indicates that Aboriginal and Torres Strait Islander young people may be at increased risk of some sexually transmitted infections. However, there is little information about why these young people are at more risk of adverse sexual health than their non-Indigenous counterparts and a need to understand the social determinants of sexual health risk in this context.

MacPhail and McKay (2018) undertook a systematic review to assess the evidence of social determinants impacting on Aboriginal and Torres Strait Islander adolescents' sexual health in Australia using 14 studies from 2003 to 2015. 'Findings suggest that social determinants such as access to healthcare, poverty, substance use, educational disadvantage, sociocultural context, gender inequalities, status and identity, and social disadvantage impacted on Indigenous adolescents' sexual behaviours and sexual health risk.

Evidence from the literature included in the review suggests that peer education may be an acceptable and appropriate approach for addressing such issues. There remains a need for programmes and services to be community-developed and community-led, thus ensuring cultural appropriateness and relevance'. The authors also argue there is a significant need to' unpack how sexual norms are experienced by Indigenous adolescents, particularly outside of remote Australia – and how these experiences act as either risk or protective factors to good sexual health and positive social and emotional well-being' (MacPhail & McKay, 2018, p. 131).

Young People with Refugee Backgrounds – Looking at Sexual Health Literacy

'Young people with refugee backgrounds face many challenges when making their lives in a resettlement country and their sexual and reproductive health needs are often overlooked.' Research focused on 142 recently arrived young refugees (16 -25 years) settling in Melbourne explored how resettled youth access, interpret, and implement sexual health information, with a particular focus on how social contexts shape attitudes and understandings. The authors found that while young people had 'some knowledge of HIV and AIDS, knowledge of other STIs was limited. Importantly, narratives about risk and protection were informed by concerns for maintenance of social wellbeing' (McMichael & Gifford, 2010, p. 263).

8. Interesting Relationship & Sexual Health Service, Education and Care Models for Young People in Australia in Australia

E-sexual health – could be promising because of anonymity

'E-health refers to internet-based health care and information delivery and seeks to improve health service locally, regionally and worldwide.' E-sexual health provides opportunities for online sexual health services 'irrespective of gender, age, sexual orientation and location'. 'Sexual health is one of the common health topics which both younger and older people explore on the internet and they increasingly prefer sexual health education to be interactive, non-discriminate and anonymous'. (Minichiello, Rahman, Dune, Scott, & Dowsett, 2013, p. 790)

Service Examples

Sydney Sexual Health Centre/headspace

In Sydney, the Sydney Sexual Health Centre, in partnership with headspace, run a free sexual health clinic for young people at Headspace Bondi Junction called the Satellite clinic. No appointments are needed. It is for young people aged 25 years and under who are an Australian permanent resident or citizen. At the Satellite youth clinic services include:

- STI/HIV and pregnancy testing, as well as treatment, advice and support
- Safer sex information and free condoms
- The "morning after pill" and talk about better contraception methods e.g. "The pill"
- Hepatitis vaccinations and discuss cervical cancer vaccinations
- Advice about relationship and sexuality issues
- Help in finding other services that can support you.

They have a 'useful links' page with access to online and other resources - https://www.sshc.org.au/Links#c

Young, Deadly and Free Peer Education Program

The Young Deadly Free (YDF) sexual health youth peer education program was implemented in 15 remote or very remote communities in four Australian jurisdictions in an effort to address endemic STI rates in these communities. A study which sought to evaluate the effect of YDF included 128 young people who took part in youth peer educator training to deliver education sessions on sexual health topics to other young people in their communities. 426 young people who attended peer education sessions delivered by the trained youth peer educators also participated in the study. 'Gains were reported in STI knowledge, intentions to test (and number of STI tests). Feelings of shame associated with STI testing remained high. The authors conclude that 'normalising STI testing among Aboriginal young people would help reduce feelings of shame' (Lobo et al., 2020).

9. Other Important Ideas About Young People and Research on Relationships and Sexual Health.

Young people are interested in being part of research on these topics

A study of young people experiencing homelessness explored their 'attitudes, beliefs, and needs regarding reproductive and sexual health'. As well as their thoughts on being involved in research about these topics. The authors found that young people 'were enthusiastic about openly discussing such issues, which they deemed as highly relevant to their daily lives'. Young people also 'identified that how they were engaged in such research, and having opportunities for longer-term contributions to such efforts, were both important and exciting to them' (Begun et al., 2020, p. 271).

Young People and sexual health research in the NT – use of 'body mapping'

Body mapping has been used with youth to discuss general health issues, however young people are often reluctant to engage with issues related to sexual health, due to feelings of shame and fear of stigma. The use of body mapping as a tool for exploring sexual health and sexual decision making among young people aged 16–

25 was explored in a 2013 paper by Chennal et al. 'Sexual health case scenarios were developed and used in conjunction with body-mapping exercises. The use of scenarios was an effective way to explore sensitive information, while protecting young people from revealing any specific identifiable information about themselves' (Chenhall, Davison, Fitz, Pearse, & Senior, 2013, p. 123). This could be an effective tool for future research and engagement with young people around sexual health.

Engaging Young Aboriginal People in sexual health research in Australia.

Bell et al (2021) point out that 'In a context of ongoing colonization and dispossession in Australia, many Aboriginal people live with experiences of health research that is done "on" rather than "with" or "by" them''. Their article acknowledges this and the agency of young people, by developing and using a peer research methodology involving Aboriginal young people as researchers, advisors, and participants in a sexual health study in a remote setting in the NT. The authors found that 'enabling Aboriginal young people to play a central role in research with other young people about their own sexual health' was important. They also discuss future priorities 'including developing more enduring forms of coinvestigation with Aboriginal young people beyond data collection during single studies, and support for young researchers to gain formal qualifications to enhance future employability'(Bell et al., 2021, p. 16).

10. Conclusion

This review has provided an overview of recent Australian research concerning young people's access to and experience of relationship and sexual health information, education, support and care. We have learned that while most high school aged students have engaged in some form of sexual activity there is much room to improve young people's knowledge about sexual health. There is widespread marginalisation of same sex attracted young people and very high levels of stigma and discrimination for young LGBTIQA+ people, particularly in rural and remote areas. Rural and remote young people have higher rates of STI's than the general population (and their knowledge of STI's is lower than their metropolitan counterparts). Aboriginal and Torres Strait Islander people in remote and very remote communities experience even higher rates of STI's.

Young people currently get information about sexual health from a range of sources including schools (as part of relationship/sex education classes), friends, social media, Web Sites (a particularly good source for LGBTIQA+ specific information), general practitioners and other health professionals, and parents. The successful provision of relevant and engaging sexual health promotion, relationship and sexuality education and support is influenced by a range of political, social, and cultural factors. Yet there are a range of actions that can be taken to improve access. This includes: ensuring there are visual signs of inclusivity in clinics (pamphlets, posters, other materials that include representation of all young people), practitioner attitudes (preference for practitioners who make meaningful efforts to be inclusive and take a non-judgmental approach to sexual health care), discretion, culturally safe practice, recognising structural barriers and disincentives to engagement across diverse cultural groups and normalising sexual health.

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