What do strengths-based sexual health approaches for Aboriginal young people look like?: Perspectives from staff who design and deliver them

A report from the project 'Fostering the sexual well-being of Aboriginal young people by building on social, cultural and personal strengths and resources' funded by the Australian Research Council Linkage Program (LP170100190).

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Summary

This report outlines the successful features of strengths-based sexual health programs for Aboriginal young people, as understood by staff who design and deliver these programs in NSW.

What are the key features of strengths-based sexual health service delivery for Aboriginal young people?

A. Extensive effort committed to understanding the local community, their unique experiences, different sexual health needs, and different ways of connecting to culture.
B. Uses cultural ways of working and learning: including 1) working flexibly, 2) following cultural protocols, 3) drawing on relational concepts of health, and 4) using cultural pedagogies (including intergenerational learning)
C. Draws on different expert knowledges (including cultural and sexual health expertise)
D. Makes long term positive impact in young people's lives

What funding, policy and other contexts support the delivery of strengths-based sexual health services?

A. Support to navigate seemingly inflexible school systems
B. Funding arrangements that are flexible, so to offer programming that is community-requested and customizable
C. Environments that acknowledge and address racialized expectations of staff

The research

This report outlines the successful features of strengths-based sexual health programs for Aboriginal young people, as understood by staff who design and deliver these programs in NSW. The research is part of a larger project that sought to move beyond deficit-focussed approaches to Aboriginal young people's sexual health by countering risk and problem-focussed narratives and offer recommendations for policy and practice that focus on Aboriginal young peoples' strengths and resourcefulness.

In this report we document:

- The key features of strengths-based service delivery for Aboriginal young people, as understood by staff who design and deliver them.
- The funding, policy and other contexts that are thought to support these strengths-based service delivery.

Qualitative in-depth interview data were collected from eight participants who were current or former staff of two health intervention programs for Aboriginal young people in NSW. The two interventions included:

- A general health education program delivered in high schools, once a week over two terms. The program was developed in partnership between Aboriginal staff at a local health district and Aboriginal staff at a local community-controlled organisation. The program addressed health holistically, with sessions focussed on nutrition, social and emotional wellbeing and sexual health. It used the 8 ways of learning framework and at the core rested on culture and Country.
- A specialised sexual health education program, delivered in a range of settings (including high schools) at the request of local Aboriginal communities. The program was developed in partnership between a non-government health service and an Aboriginal education and research centre. It used the 8 ways of learning framework and draws on cultural ways of learning between Elders and youth, cultural values of men's and women's business, and is community led.

Six participants were Aboriginal people and two were not Aboriginal; four participants were women and four were men; two participants held senior management positions with the health sector, two were senior health promotion officers, and four were health promotion and education officers, some of whom had nursing backgrounds. Interviews were conducted by JB and KM. They lasted from 20-40 minutes and were audiorecorded and transcribed.

The findings

What are the key features of strengths-based sexual health service delivery for Aboriginal young people?

A. Understanding the local community

All participants talked about the importance of appropriate consultation with each community they work with. Staff recognized that each community has unique experiences, different sexual health needs and different ways of connecting to culture. This was viewed as a way to build trust with communities and to learn how best to adapt sexual health promotion to their needs: “finding out what works in that community [matters most]. And how, you know, how does it work? How does it tick?...So, it’s finding out where we can, what’s unique about that community that we can, we can develop a program around”. (Staff 6)

B. Program is built on cultural ways of working and learning

Most participants spoke at length about the key feature of high quality strengths-based programs being that they are ‘mob-centric’ (Staff 4) or in other words ‘not [just] having the Aboriginal component to the program, but having the Aboriginal component throughout the entire program.’ (Staff 4). Another participant described this as making sure “we are culturally appropriate at every turn” (Staff 2). Using cultural ways of working and learning were seen as the best way to instill connection, belonging and trust for young people. Other important features of ‘mob-centric’’ approaches, as described by participants, were:

- ·Acknowledging that some young people know little about their culture, nor do they know their which Nation/s they belong to. Care was needed not to shame young people that had less knowledge about their culture (Staff1, staff 2, staff 3)
- ·Acknowledging that some Aboriginal staff are also learning cultural ways of working and learning (staff 1)

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- Non-Aboriginal staff knew that cultural ways of working and learning were essential and acknowledged the limits of their work with Aboriginal young people. They sought partnership and co-delivery approaches: “it’s something that should never go away in terms of something that you think about and reflect on. You need to be respectful to what you know and what influence and impact you can have on a community without being from that community. So, there’s certain qualities that I can bring to this role and there’s certain things that I can’t” (Staff 5)

Participants were asked about the specific cultural values, knowledges and pedagogies that they drew on to deliver strengths-based programming. They identified four key features.

Four cultural ways of working and learning:

1. Flexible and adaptable: Flexibility is part of Aboriginal respectful ways of working

Participants talked at length about the need to provide services flexibly and that, in fact, this flexibility is “really part of our culture. It’s like going with the flow and so this is part of our respectful way of working”(staff 1). This meant program delivery needed to be flexible in terms of:

- The content: needs to be “fluid”(staff 4), community and youth-led; adapted for the specific needs of young people in the group (including their age); the specific needs of the local community (“some communities may have recent issues with unintended pregnancies, access to condoms” staff 6); needs of the school (specific issues at the school,).
- The contributors: drawing on different health workers, with different expertise, at different times, taking into consideration who is available and when (Staff 1). Partnership across organisations was common, and wide consultation seen as important (staff 2).
- The timeline for delivery: such as the time available to deliver the content during the school day
- The participants: inclusive and community-led. “We would not limit anyone’s participation based on their level of engagement. In our eyes, it’s, it’s everybody” (Staff 5).

2. Follows cultural protocols: Respectful introduction, men's and women's business

All participants discussed the importance of following protocols of introduction as a way to work respectfully with communities. Protocols of introduction were described as:

- Approaching community leaders first and knowing who are the correct Elders to approach: "getting the right Elders in for the right areas" (Staff 4)
- Showing up to the places where community meets and providing people with an opportunity to get to know staff and the program and yarn: "you have to sit and you have to show your face. You have to sit down and have a yarn, especially when it comes to reproductive and sexual health because, like I say, they're taboo topics" (Staff 7)
- Inviting community to an event to give them an opportunity to get to know the staff and the program: "We usually like to have some pre-sessions … we will invite parents to a free barbeque and all our community elders who have been working with that school and let them know, give them an overview of the program and what we do (Staff 2).

Participants also identified cultural protocols around men's and women's business as important when delivering sexual health programming. This meant needing male and female team members, and separating young people into male and female groups when delivering specific content, although Staff 3 also described how the groups would come back together to learn from each other: "it was delivered then but then we would have the girls kind of explain the overall and then we'd have the boys explain the overall when we're all together" (Staff 3)

3. Based on cultural concept of health as relational

Participants described how strengths-based approaches were built on relational concepts of health. These included:

- Understanding that young people's sexual health was heavily shaped by their relationship with cultural identity, family, community: "we saw, you know, sexual health and our sexual identity as a whole of, whole-of-health approach, like a holistic approach that really was strengthened by our cultural identity and our connection to that." (Staff 2).

- Historical experiences of colonisation and loss: “what we delivered was health-component content with historical content attached to it as well… we would utilise that with historical content, so we would then cater that by explaining to them what was done in traditional times, about how things were done in times before colonisation”. (Staff 3)

4. Uses cultural ways of learning

Participants talked at length about Aboriginal pedagogies and the importance of using these in sexual health activities with Aboriginal young people. Some participants referred explicitly to the Eight Ways of Aboriginal Learning framework (https://www.8ways.online/) because it “catered to all kids where sometimes the education system only caters to some, just due to everyone’s learning abilities. And everyone learns differently” (Staff 3). However most participants described pedagogical approaches that were based around three cultural practices:

Learning based on yarning: Participants described the importance of yarning in Aboriginal culture, and its role in meaning-making, establishing and maintaining relationships, setting responsibilities, and teaching children. Yarning was a key practice through which sexual health was taught in strengths-based programs: “it’s mostly around, to be quite blunt, like yarn.” (Staff 1). As Staff 4 described, yarning was viewed to be more mob-centric: “more about having a yarn with our young people about what the concern is rather than standing at the front of a classroom and sort of just feeding them stuff.” (Staff 4)

Intergenerational learning: Elders are an important part of Aboriginal intergenerational learning systems, but there were other forms of role-modelling used that ensured young people had multiple opportunities to learn and build their own leadership skills. The approaches described by participants revealed a sophisticated system of intergenerational learning that not only passed on knowledge but also engendered leadership skills.

Elders were a central part of strengths-based health interventions because they passed on cultural knowledge but also importantly ‘set the tone from the outset”(Staff 4). This meant that Elders modelled cultural pedagogy, demonstrating how “information is shared between the younger and the older generation, which we traditionally would do, you know…

And passing on knowledge and the voice of experience through our Elders to our young people is paramount in our, you know, not only survival as Aboriginal people but, you know, the way we thrive moving forward. (Staff 4).

Intergenerational learning practices also incorporated leadership opportunities into program design. This could include learning experiences in which young people learned from each other, or were given the opportunity to lead other young people in learning, as described by Staff 3: “we wouldn’t actually lead the conversation. We’d allow the kids to be the ones to do so… so, we would do a lot of empowerment with those young people to just let them kind of take a leadership role within it.” (Staff 3). This was seen as empowering and “letting them choose their own path and sort of giving them as much information so they can make, you know, these sorts of decisions for themselves.” (Staff 4)

***Interactive and ‘hands on’ approaches*:** Several participants noted the problems with simply “talking at” young people, instead identifying that strengths-based programs needed to be engaging, interactive, multi-modal (written, visual and hands-on learning) and promote thinking: “activities that sort of centred around engagement, you know. We’re not talking at our young people: we want them to be engaged and we want them to be involved, and ask questions.” (Staff 4).

C. Draw on range of expert knowledges (cultural and sexual health)

Participants described how strengths-based programs drew on a range of expert knowledges (cultural and sexual health) to curate a learning experience that was based in the most up-to-date and high-quality information.

Participants emphasised the importance of detailed evidence-based content, which could be about bodies and anatomy, puberty, risk-taking, negotiating consent, and values and attitudes. Staff 5 described the importance of ensuring “the integrity of the content is up to date and relevant” and Staff 6 noted that the best programs were “taken from this wealth of resources and stuff that has been developed over many, many years”.

This scientific content was seen to sit alongside the cultural expertise required to deliver sexual health content to Aboriginal young people, and Staff 1 described their efforts to curate a program that included high quality cultural and sexual health knowledge:

Art by Natalie Sneddon

“we would get a nutritionist in, like an exercise physiologist, people with a bit more experience so we could kind of bounce off each other”.

D. Makes long term positive impact in young people’s lives

Participants talked about the importance of producing sustainable long-term impact in young people’s lives: “holistic and sustainable. You know, the two, big keys that this program, sort of, wanted to address” (Staff 4).

It was generally understood that a quality sexual health program would produce positive outcomes for young people, including increasing their capacity to make positive decisions about their sexual well-being and increase their help-seeking capabilities by raising awareness about local services. Building referral pathways and establishing connections between young people and local community and health services was highly valued: “a primary goal is to increase awareness, really, of both services that exist in local communities. So, it’s a point of referral. But I think more so than that it’s a way in which to increase young peoples’ general knowledge of reproductive and sexual health” (Staff 5).

What funding, policy and other contexts are needed to adequately support strengths-based approaches for Aboriginal young people?

A. Support to navigate seemingly inflexible school systems

Flexibility was seen as a key feature of strengths-based sexual health programs, and as a respectful way of working with Aboriginal communities (Staff 1). Yet sexual health programming often took place in school settings and the seeming inflexibility of school policies and practices was identified as a challenge by participants. The specific challenges identified related to:

- Strict timetabling in schools: “we’d work around the schools’ times… we wouldn’t say, “Okay, every session’s gotta be then,” because we know that the school and the kids, their timetables all run and they keep them kind of quite strict.” (Staff 3)
- Discomfort when talking about sexual health with children: “we haven’t done sexual health specifically. Like we’ve done it differently. So, we’ve done like a Party Safe or we haven’t done like sexual health… we’ve tried to go around a bit, you know, because like if you say like STIs, sexual health, they freak out sometimes.” (Staff 1)
- Administrative burden of organising school staff and securing correct consents: “you have an initial meeting with them. Have a follow-up meeting. Send out the flyer. A bit of a rundown on the program topics… then the school wanna send out a letter, like an opt-out letter, because most schools don’t get a letter back from the parents. So, an opt-out letter and then we need a registration of the participants in order for us to register the young people.” (Staff 1)

Participants identified that the most successful experiences were when there was help provided to manage the administrative burden and relationship-building required to run sexual health program in schools. This usually meant that there were support staff or other people to help, such as:

- School based wellbeing staff, including Aboriginal Liaison Officers, who recognised the need for sexual health programs: “Most schools, they’ll have like social-emotional wellbeing co-ordinators or liaison officers.” (Staff 1). “Having someone on the inside that can, you know, can see the importance of it and will drive it from their end.” (Staff 2)

Overall, the school contexts in which strengths-based sexual health programs operate well are those in which there is sufficient belief that sexual health education is important, and adequate staffing to manage the administrative requirements of implementing it.

B. Funding arrangements that are flexible, so to offer programming that is community-requested and customisable

The funding landscape in which strengths-based sexual health programs work was an important context, and shapes the availability and effectiveness of program delivery. Not all participants could comment on the funding landscape, but those that could talked about the need for adequate funding ("to employ Aboriginal health promotion officers across multiple sites" (Staff 6)) but also the need for the funding to be detached from top-down, administratively burdensome indicators of performance. Instead that wanted fundings arrangements that:

- Were self-determined by communities and permitted them to choose when and how often to run sexual health interventions. This was in contrast to arrangements whereby funding was attached to the number of programs run per year, regardless of community need: "[the strengths-based program] is primarily request-based but, you know, we can also be proactive in promoting it … but [because of the funding system] we don't want to just use communities at all to achieve a certain number of KPIs. That's not how we should go about it."(Staff 5)
- Customisable and flexible so to meet the specific needs across a diversity of Aboriginal communities: Staff 6 talked about losing funding to run a strengths-based program and how this "did free us I suppose from the shackles of funding bodies and to really have some fresh eyes look at the program and reworked some of the modules and the structure of it, so it could be flexible and customisable as well." (Staff 6)

Overall, this finding concurs with others in this report about the need for flexible ways of working: strengths-based sexual health programs are best supported when there are flexible and demand-driven funding systems that can respond to the diversity of needs across Aboriginal communities.

C. Environments that acknowledge and address racialised expectations of staff

Both Aboriginal and non-Aboriginal participants talked about needing to navigate racialized expectations of their motives and behaviours. For non-Aboriginal participants this was about addressing suspicion and building trust; but for Aboriginal participants these expectations were based in racist assumptions:

- Non-Aboriginal participants perceived that, sometimes, assumptions were made by some Aboriginal communities about their motives for being in those communities. They reported how communities could be suspicious of their motives and participants knew they needed to work hard to build trust: “we have to sort of tread carefully and not make it an area where people are questioning why we’re there or what our motives are in terms of, you know, what’s behind us being in this community and delivering this information. We need to make a young person feel that we’re there for the right reasons … this is where the, the consultation process is really important”. (Staff 5)
- Aboriginal participants described needing to navigate racist assumptions about Aboriginal people’s work ethic in school and health settings and how, to counter these, they worked to the highest standard: “when Aboriginal people came into the school and then, if they didn’t follow up or didn’t come back, it reinforced this expectation of them. So we really do [need to] turn up on time: you do what you say you’re gonna do [so protect] your personal reputation, your [family] reputation, and Aboriginal [people]. (Staff 2)
- Aboriginal participants described also encountering racist assumptions about Aboriginal people always and necessarily experiencing ill-health and needing professional intervention. Participants felt they had to often explain and advocate for their Aboriginal clients, family and friends: “Like the stigma around counselling services is automatic that, you know, not just amongst young people. I’d say the general population is, “Oh, there’s something wrong,” you know. [Yeah] But no, no, no: [counselling] can just be, you know, a place to sort of talk to someone that’s not involved in your family circle.” (Staff 4)

Overall, strengths-based programs work best when staff, especially Aboriginal staff, can work free of racist expectations about their motives and practices. Navigating these takes away from their time and social/emotional wellbeing.

Governance

An Aboriginal Research Advisory Committee was set up to advise on the study and oversee the cultural safety aspects of the research processes and outputs. This committee included 8-10 members, all of whom were Aboriginal people, including some of the project investigators, university staff, partner organisation staff and peer interviewers. Six members of the research team are Aboriginal people. The project received approval from the ethics committee of the Aboriginal Health and Medical Research Council of NSW (AH&MRC) and was conducted in alignment with the National Statement on Ethical Conduct in Human Research (NHMRC 2018) and the 'five key principles' for research into Indigenous health outlined by the AH&MRC (2020).

More information

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For more information:

https://www.unsw.edu.au/research/csrh/our-projects/what-we-do-well

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Project outputs

Peer-reviewed publications:

Bryant J; Bolt R; Botfield JR; Martin K; Doyle M; Murphy D; Graham S; Newman CE; Bell S; Treloar C; Browne AJ; Aggleton P, (2021). 'Beyond deficit: 'strengths-based approaches' in Indigenous health research', Sociology of Health and Illness, vol. 43, pp. 1405 - 1421, http://dx.doi.org/10.1111/1467-9566.13311

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