The Rural Sexual Health in Youth (RuSHY) Framework

A framework to improve coordination of sexual health in small towns and provide guidance to rural communities wanting to plan, implement and evaluate community-based youth sexual health interventions.

Welcome to the Rural Sexual Health in Youth Framework (RuSHY).

This document contains background on the RuSHY Framework, the RuSHY Framework and a guide on implementation.

It was a recommendation of the research that the RuSHY Framework should be disseminated broadly to allow rural communities the opportunity to utilise the Framework in its current form.

Use of open access and non-scholarly platforms such as web-page, social media and/or practice networks for dissemination should be considered to increase accessibility to the Framework.

Support relating to the project should be directed to Dr Carl Heslop via email carlheslop@iinet.net.au or via SiREN https://siren.org.au/

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WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network

Curtin University

Acknoweldgements:

This study was conducted by the Collaboration for Evidence, Research, and Impact in Public Health. This project was a unique project developed in response to a community expressed need. It is an example of rural insider-research.[1]

This research was not funded and was completed without a stipend or scholarship.

Thank you to my supervisors across the course of this project: Associate Professor Sharyn Burns, Dr Roanna Lobo and Dr Ruth McConigley.

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I would also like to acknowledge the participants that contributed to this research. Country towns are inspirational places full of busy individuals working hard for the betterment of their community. I am forever in awe of rural generosity, volunteerism and hospitality. This project would not have started without the goodwill and support of my community and its commitment to be a better place.

Contents

Nobody's priority and accidental experts

Despite being a priority population in the *Fourth National Sexually Transmissible Infections Strategy 2018–2022*[2], there is a lack of effective focus or funding on how to respond to key issues for rural youth, such as how to:

- bring STI screening rates towards recommended targets;
- provide rural based teachers with appropriate professional development; provide evidence-based RSE with skills and knowledge;
- or to connect rural stakeholders effectively to ensure that the gaps are covered and that rural young people are receiving the basic level of sexual health provision they deserve

The rural workforce involved in sexual health promotion consists of many generalists, often working in isolation with a lack of formalised qualifications or previous experience in specialised areas.

Operating in a landscape where sexual health is often 'nobody's priority' generalists who provide the basic services young people need, become 'accidental experts' and advocates for Relationships and Sexuality Education[3].

Rural stakeholders must be active within their community and ensuring young people are being provided with the minimum level of sexual health services and RSE required. Equitable sexual health service provision is reliant on the actions of the community and its stakeholders.

Sexual health provision within the rural setting needs a champion. This champion may come from outside of traditional settings such as health, education and youth work. In a setting where "accidental experts" are the providers called upon to drive sexual health interventions within the community, having a local champion assists in maintaining momentum and in many respects, keeping everyone on task. This project worked with many "accidental experts", who worked hard to meet the sexual health needs of young people within the community[3].

While communities do their best amongst a lack of prioritisation, training and funding it cannot be forgotten that traditional service providers are required to provide the basic level of sexual health service provision expected for young people within their town. Effort must be made to find solutions to the well-known barriers to access; because while there has been a dearth of evidence on effective processes to address these barriers, the barriers themselves are well documented within the literature[4-9].

Guidance and direction

This RuSHY Framework was developed as a practical document within a PhD research project[10]. The RuSHY Framework was developed following prolonged engagement by the lead researcher with a rural community, PAR and iterative feedback[11]. It represents the culmination of a collaborative development process with stakeholders[3] and young people[12] that examined local realities and constructs to produce solutions and knowledge relevant to the setting that could be further transferred beyond that setting. It aims to improve coordination of sexual health in small towns and provide guidance to rural communities in how to meet the needs of young people (age 16-24) in their towns. With limited literature about relationships and sexuality education (RSE) and health provision in rural Australia[13], this study gives voice to rural workers providing these services – at times through circumstance rather than planning[3].

The RuSHY framework has been evaluated for potential usefulness and the ability to be transferred to other settings by rural-based stakeholders. In its current form, it is recommended for immediate testing and utilisation within rural settings. It is acknowledged that the RuSHY Framework has been developed for a specific community and new communities should acknowledge and evaluate their setting specific considerations in terms of population demographics, service provision and local policy.

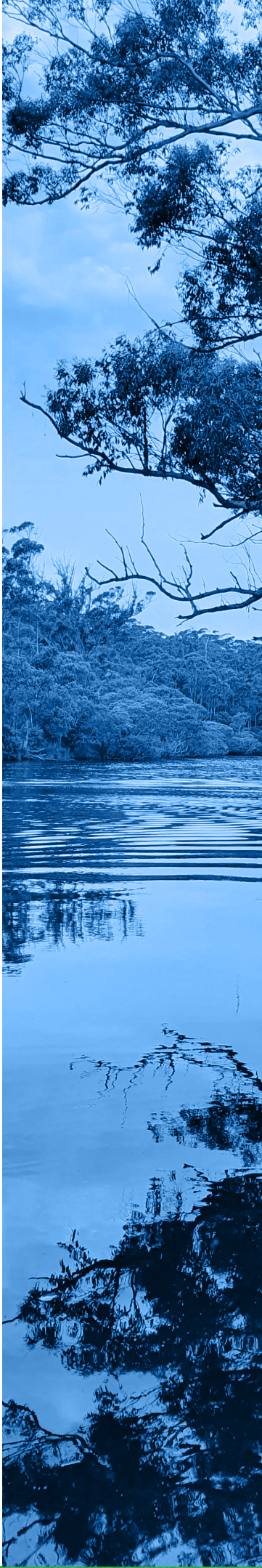
This framework aligns closely with several key action areas within the Fourth National Sexually Transmissible Infections Strategy 2018 – 2022 to address the priority youth population and provides a practical document for the rural workforce.

Sexual health is a major issue for young people aged 16-24 years in Australia[2] and despite testing rates lower than 10%, chlamydia is the most common bacterial sexually transmissible infection (STI) in young Australian adults[14], with a high prevalence seen in young men and women attending rural General Practitioner (GP) clinics[15].

Finding strategies to improve implementation of sexual health interventions and RSE in small communities is important in addressing this issue. The responsibility of providing rural RSE regularly falls upon schools[16-18] however there are often gaps in students' sexual health knowledge and dissatisfaction with the relevance of the provided RSE[19-22].

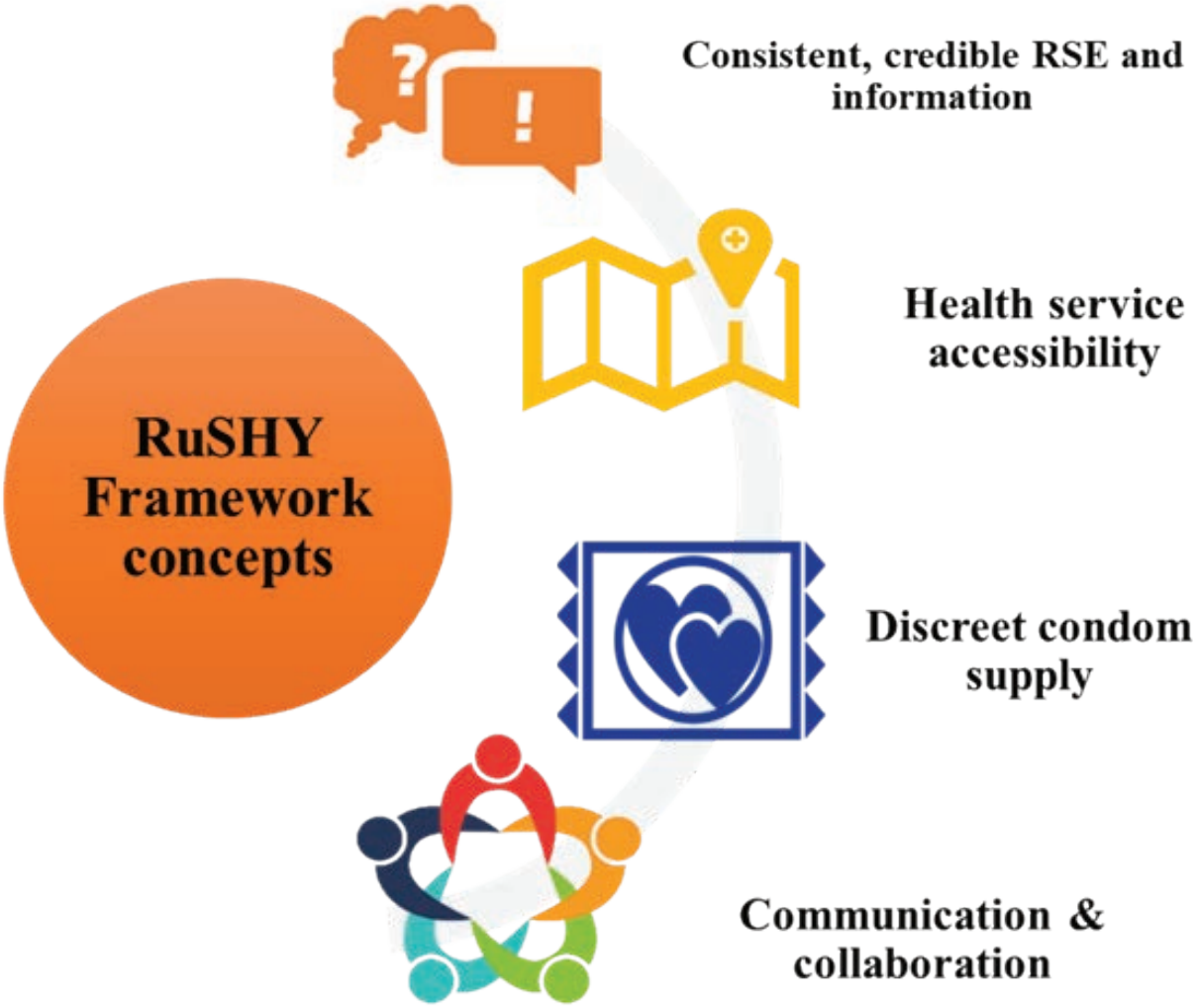
While small towns have limited ability to deliver many services, this framework aims to give workers or volunteers guidance and when addressing sexual health in their own community.

A core outcome of implementing the RuSHY Framework is establishing collaborative relationships between traditional and non-traditional sexual health provider settings to address gaps in service and education provision in the rural area.



Four key concepts

There are four key concepts that appeared from the collected data. These concepts are what was named by participants as important in providing sexual health interventions in the rural setting:



Within the four concepts, there are suggested guidelines included that emerged from collected data and reviews of contemporary rural sexual health research literature. These guidelines are the lived experience of the research participants and are not an exhaustive list of guidelines or suggestions for every community.

The RuSHY Framework provides structural guidance on the facilitation of the coordination and delivery of services and education within an environment of minimal funding and a lack of clear policy direction to the grass-roots workforce.

The RuSHY Framework was developed for sexual health, however, could be adapted for other areas of youth health. Given the synergies with interventions that target mental health, sexual health and alcohol and other drugs; communities could utilise the RuSHY Framework to guide the better planning, implementation and evaluation of community-based interventions that target other health areas.

How to apply the framework

The Framework guides community-based need for improving sexual health in small towns. This may be from community-voiced need; stakeholders wanting to improve practice or changes in local strategy.

The Framework consists of four implementation phases.

1. Community Scan and TOWN analysis
2. PLAN (Plan, Listen, Allocate, Network)
3. ACT (Advocacy, Coordination, Targeted interventions)
4. Review

Beyond an individual focus

The Framework applies Bronfenbrenner's Ecological Framework for Human Development as a theoretical lens[23]. The Framework uses this lens to shine a light on how different the levels of interaction connect to the four concepts.

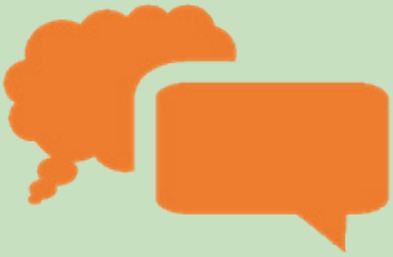
In Bronfenbrenner's framework an individual does not exist in isolation. There are multiple layers and factors that impact on the individual's lived experience.

When applying this idea to this Framework, it is suggested stakeholders and communities target more than the individual and consider the all levels of the socio-ecological model:

- Individual
- Interpersonal
- Organisational
- Community
- Societal

Concept One:

Consistent and credible relationships and sexuality education and information



Key Concept:

The relationships and sexuality education delivered is relevant, acknowledges diversity and moves beyond the biological aspects of sexual health and provides young people with the skills and information that they want and need.

Key guidelines from this research:

1. Consistent messaging throughout the community is important.
2. Relationships and sexuality education (RSE) programs and services should be inclusive of LGBTI youth.
3. Sporting coaches and club members can be educated to act as a first point of contact for youth. RSE should be delivered by a credible presenter in all settings.
4. Schools are important in sexuality and relationships education provision and interventions.
5. Schools should be well connected with health providers and youth services
6. Communities must also to consider how to reach young people not in school.
7. Relationships and sexuality education should be part of a comprehensive school health promotion approach
8. Relationships and sexuality education should be led by the curriculum and not biologically focussed.
9. Young people need education and support around negotiating relationships and consent, resilience, etc
10. If schools feel that outside presenters are more appropriate – they should actively seek or source them from either within their community (such as GPs or school nurses) or beyond (Aids Councils, Youth Doctor programs).
11. Outside presenters can enhance the RSE curriculum but teachers should lead delivery.
12. Teachers should have access to RSE professional development opportunities to build capacity.

Concept Two:

Health service accessibility and competing priorities

Key concept:

Young people want uncomplicated and confidential access to sexual health services and information in their community.

Key guidelines from this research:

1. Where specialist services are uncommon; existing services must deliver services as best they can.
2. Maintaining confidentiality is critical. Young people trust the confidentiality of medical services.
3. There are concerns around anonymity accessing services (waiting rooms or delivering pathology).
4. Services should find opportunities to engage and connect with young people.
5. Regular outreach clinics may not be workable, but one-off clinics, flexible informal services or information sessions in non-clinical settings (sporting clubs, youth clubs) have been successful.
6. Health services need clear policies (bulk-billing and youth access) clearly communicated internally; and advertised to young people via a variety of networks.
7. Health services should explain access issues such as when Medicare cards are or are not needed; what identification is needed; parental consent or presence; booking procedures; and confidentiality.
8. Services should promote themselves through traditional and non-traditional settings.
9. Consider transport to services as a barrier.
10. Services need training and professional development in delivering youth friendly services and can utilise peer-to-peer support to enhance delivery of information. This includes reception, administrative and support staff.

Concept Three:

Discreet condom supply

Key concept:

Young people want to buy condoms cheaply and anonymously from easily accessible places.

Stealing condoms may be preferred to avoid interacting with others when accessing condoms.

Key guidelines from this research:

1. Young women want access to condoms.
2. Young people are willing to buy condoms if they are cheap and anonymously accessible.
3. Improving access to condoms needs community and organisational level advocacy.
4. Communicating the need for condoms to the community is important to reduce backlash or stigma.
5. Traditional services (local government, education, youth and health) should lead advocacy. Credibility is critical and traditional services are respected.
6. Health, youth and education workers should have support in talking about condoms with young people.
7. Young people prefer to access self-serve checkout services when buying condoms.
8. Young people support condom vending machines.
9. Sporting clubs, youth centres and GP consulting rooms are acceptable places to access free condoms – provided there is minimal interaction with peers or adults. External funding to source condoms and lubricant is often available.
10. Condoms in busy areas (waiting rooms) are less acceptable due to a sense of being watched.

Concept Four:

Communication and collaboration

Key concept:

Small towns are interconnected and socially close, yet services can still work in isolation with limited collaboration or communication. Services should initiate contact and spark collaboration in effective and sustainable ways.

Key guidelines from this research:

1. Communities lacking lead or specialist sexual health agencies need to identify who is involved and what is working.
2. Increased collaboration ensures needs are met, there is less isolation and less chance of duplication.
3. Communication between services should rely on organisational rather than personal connections.
4. Services must maintain confidentiality when communicating clinical information.
5. Collaboration increases the reach of messages.
6. Services need orientation and awareness of sexual health services and referral pathways; what SRE students are learning and where young people can access condoms, emergency contraception or pregnancy tests.
7. Services need to know how to refer young people to other services beyond their town – and how to collaborate and communicate confidentially to support these needs (PrEP, termination, specialist services).
8. Active and visible school health nurses can act as an adjunct between health and education. School nurses need to promote services that are available via teachers, stakeholders and other youth settings; and directly.
9. Clear internal communication improves an organisation's ability to communicate with other stakeholders.
10. New connections and collaborations with non-traditional settings such as sporting clubs and youth groups and the wider community are possible. These collaborations rely on positive relationships with club presidents and community members to ensure engagement and support.
11. Collaborations often focus on male-dominated sports. Consider gender equity in seeking new collaborations to ensure equal access to information, education and condoms.
12. Reach young people by advertising services or information in in high-traffic youth friendly shopping or recreation areas.

Applying the framework

This Framework development gives rural sexual health leaders clearer direction in implementing community-wide sexual health interventions.

In developing the Framework and suggesting its implementation, we acknowledge:

- The Framework needs an intial leader, champion or collaboration. This will change community to community and may be driven from education, health, youth services or from sport and community or volunteer groups.
- Not every community or setting has the capacity or ability to deliver all concepts and guidelines. The recommendations are not prescriptive nor exhaustive.
- The Framework is a tool designed to improve what may already be happening and improve coordination. It should not be applied in isolation and should incorporate local actions, guidelines and curriculum.
- There is rarely funding for sexual health services in rural towns. This framework aims to assist stakeholders improve current practice to meet needs rather than a tool for a standalone project reliant on external funding.

Phase one

Community Scan and TOWN analysis

Phase one is reliant on someone or an agency seeing a need to improve sexual health and RSE delivery in the community. It needs consultation with other groups; or seeking contributions of information or time.

The improved coordination and implementation of sexual health interventions in the rural area is dependent on the understanding of the setting and community. This understanding would consider the multi-level interactions that exist and how these impact on how sexual health is provided in the rural area.

Rural stakeholders must confirm the threats, opportunities, weaknesses and needs of young people within their setting and consider the setting specific context that they are operating in. This initial assessment will inform planning and implementation of interventions and reduce the likelihood that interventions will be either ad hoc or not appropriate for the youth they target.

The Community Scan and TOWN analysis allows the examination of the setting in close detail. It is practically focussed and should address the needs of the community. It should consider internal and external threats, opportunities and weaknesses and be collaborative and open to innovation.

1. Community Scan - Understand the context

a. What is already happening in our community?

b. What has our community done in the past relating to sexual health?

c. What budget (if any) is there for sexual health in our community?

d. What history and past events will affect how we encourage stakeholder involvement in a local intervention sexual health strategy?

e. What characteristics and cultural values in our community will affect how we encourage involvement in a local intervention sexual health strategy?

2. Community Scan – Involvement and relationships

a. What/who are the key youth or health related agencies or organisations in our community?

b. Who is already involved in providing sexual health for young people in our community? (Include education; sexual health services; youth services)

c. What is working in our community?

d. Where do young people spend their time in our community? What groups? Schools? Stores? Venues? Places?

e. How do we reach homeless or hard to reach young people? What agencies work with this groups?

f. Where can people access condoms and pregnancy tests? Are they affordable for young people? Are they accessed anonymously?

g. Where can young people access STI tests? Where do they have to deliver pathology?

h. How many GPs are available in the community? How many have sexual health training? How many specialise in youth? What does it cost to see a GP? What is the booking process?

i. Do the schools in the community provide RSE? Who delivers it? Do teachers have access to regular RSE professional development? Is the school connected to the GPs? Is there a school nurse? What is the role of the school nurse? Is there a sick bay?

j. What clubs, groups and organisations connect with young people on a regular basis?

k. What outside experts and regional services are already involved or active in our community?

l. How can we communicate? How can we connect with or communicate with young people?

m. What networking/collaborative mechanisms already exist between stakeholders and organisations?

n. Do we have enough information? Do we need to conduct forums or focus groups with young people, parents or the community to gather more information?

3. TOWN Analysis:

How will local and external Threats, Opportunities, Weaknesses, Needs impact on our ability to address the four key concept areas of the framework?

Threats:

i. What threats could prevent our collaboration/s?

ii. What threats need to be addressed at once?

iii. What threats pose the greatest risk towards the provision of sexual health education and services for young people in this community?

iv. What relationships already exist with local press?

v. How active is our local community on social media?

Opportunities:

i. What opportunities are already available to us?

ii. What opportunities are possible through our collaboration?

iii. How can we involve young people in our planning?

iv. What collaborations are possible in our setting? Could GP's visit the schools to help in delivering RSE? Can health teachers communicate with youth and health services about what is being taught to students? Could sporting clubs have clear information on how to refer young people to health or youth services? Who could supply condoms for free in our area? Would local government support condom vending machines?

v. What community strengths and resources could we mobilise?

vi. What relationships could be developed?

Weaknesses:

i. What weaknesses do we have as a group? As a community?

ii. How can these be addressed?

iii. Do we need outside help? What skills are we lacking? Where can be source them?

iv. Who is 'on board' already? Who is not?

v. How do young people view our services right now?

Needs:

i. What does our community need?

ii. What needs to happen right now?

iii. What other relationships with key stakeholders will be important to acknowledge and develop?

iv. How will we communicate with parents? How will we communicate with young people? How will we manage parental concerns?

Phase two

PLAN (Prepare, Listen, Allocate, Network)

The purpose of stage two is to bring all identified stakeholders from the Community Scan together, consider the TOWN analysis and prepare an intervention program.

This may happen via meetings, emails circulars or forums. All analysis considers the socio-ecological system levels and how these will affect on the delivery of interventions.

1. Prepare – pre-planning and prioritising

a. Review the TOWN analysis and consider the goals of your collaboration.

b. Consider what is feasible. Do not plan to do too much or too big.

c. Investigate Threats and Weaknesses. Identify how collaborative partners will address.

d. Prepare advocacy strategy to target parents and community – ensure key messages are clear and evidence-based. Consider utilising an advocacy toolkit for guidance.

e. Investigate Opportunities and gather resources and stakeholders.

f. Prepare consistent messaging for all stakeholders to use within their interventions.

g. Prioritise the Needs of your community and find strategies for how and when these will be met. Can the stakeholders meet these needs?

h. Name clear goals the collaboration will seek to achieve.

i. Establish a list of interventions that collaborative partners will undertake.

j. Set clear methods for evaluating the activity of the collaboration and clear time lines for evaluation cycles.

2. Listen – reach out to young people and gather feedback

a. Connect with young people in your community and gain feedback on the TOWN analysis and interventions. Seek advice on best strategies connect with young people from local youth focussed community groups.

b. Consider advice from diverse groups of young people from your community – school age, new to workforce, engaged in sport, hard to reach, homeless. Are needs similar? Are you addressing their needs? Are weaknesses showing the same? Are hard-to-reach youth supported?

c. Analyse feedback the youth group. Identify missing interventions. Incorporate feedback into preparation.

d. Communicate within your collaboration to establish what is possible when addressing youth needs.

3. Allocate – provide clarity in roles

a. Allocate a period for the intervention project.

b. Allocate a period for evaluation. Who oversees evaluation? Is evaluation support needed?

c. Who is the lead for the collaboration? Who oversees supporting communication? Who is supplying resources? Who will supply support or expertise? Who does not see a role for themselves?

d. Allocate roles within the collaboration. Which interventions will each partner deliver?

e. Who is the advocacy lead? Who checks and responds to local and social media issues for the collaboration?

4. Network – support your collaborative network

a. Ensure relationships between collaborative partners can be easily supported.

b. Provide opportunities for collaborative partners to easily connect and share.

c. Allow new stakeholders and new partners to easy integrated into the collaboration.

d. Ensure ongoing connection with youth so they can supply additional feedback when required.

e. Ensure all collaborative partners are aware of the goals and evaluation methods.

Phase Three

ACT (Advocacy, Coordination, Targeted interventions)

The purpose of Phase three is to implement and action the planned inventions.

Key components of delivering interventions are advocacy and coordination.

Care should be taken to ensure that coordination is supported, and all information communicated as part of advocacy is consistent and relevant.

Stakeholders will lose support from both young people and the community if they are not seen to be credible.

1. **Advocacy:** ***Sexual health can be a controversial community topic – control the conversation and be prepared with facts, support and a clear message***

b. Have a clear advocacy strategy. Consider using advocacy guides to help your group if you lack experience. Frame your message. Be prepared. Plan for small wins and small gains.

c. Commence advocacy strategy prior to commencement of interventions. Proactively educating the community on the need and the opportunities for sexual health is important.

d. Focus advocacy on the four key framework concepts.

e. Connect with local media to start advocacy. Local media can hold strong power in small communities. While local media may not be the most effective way to reach young people – ensuring you have a good working relationship with before letters to the editor appear may help minimise backlash.

f Ensure advocacy opportunities are responded to swiftly using the clear, prepared messages.

Coordination: ***Ensure communication and focus on Communication and Collaboration framework concept is sustained***

a. Maintain communication between collaborative partners. Communication needs to be simple and effective. Consider and adjust to what is right for your community (meetings, emails, newsletters, workshops, seminars, working groups, etc.)

b. Ensure co-ordinated responses are prioritised by collaborative partners. A lack of collaboration and cooperation can lead to duplication of services.

c. Ensure collaborative partners are aware of what is happening throughout the network.

Targeted interventions: ***Interventions should address the four key framework concepts***

a. Deliver the targeted interventions in our community that address the key framework concepts.

b. Ensure interventions are delivered in the agreed manner. If variation is needed, ensure coordination is supported and evaluation processes are acknowledged.

c. What interventions are successful so far? What is not working? What needs to be changed now to improve the current interventions? What factors have not been addressed?

d. Document what is happening. Document for your evaluation. Is the evaluation method forgotten?

Phase Four

Review

The purpose of Phase Four is to reflect and evaluate on the earlier phases, examine what worked and what didn't and maintain the group. All evaluation should consider the systems at all levels and be continuous in nature.

1. Evaluate Phase Three

a. Was the Advocacy Strategy effective? What was missing? Was criticism addressed appropriately? Were responses from the collaboration prompt and evidence-based?

b. Did partners keep communication and coordination for the entire program?

c. How successful were targeted interventions in meeting the collaborative goals for our community? Which goals were not met? What needs are still unmet?

d. What key framework factors require greater focus?

2. Evaluate our evaluation

a. Was evaluation carried out continuously as we worked?

b. Did we successfully evaluate our interventions?

c. Were our evaluation processes effective?

d. What other layers of evaluation could have been implemented?

e. What support did we need for our evaluation?

3. Review Phase Two

a. What did we miss during the PLAN phase of our project?

b. What is still needed?

c. Was our network effective in delivering our goals?

d. What preparation could be improved upon within the next phase of the project?

e. Did the collaborative partners deliver their roles?

4. Maintain Network

a. Who is still engaged? Who is not? Who needs to move on? Why did people leave or not take part as they indicated they would?

b. Who do we need to bring into our collaboration?

c. How can we improve communication within our network? What worked and what did not?

d. Who needs to take control of this process? What needs to happen next for our community?

5. Recommence Phase One

RuSHY Framework recommendations

The overall aim of this study was to use a participatory action research (PAR) methodology to develop and validate a framework for planning, implementing and evaluating community-based youth sexual health interventions in the rural setting. In achieving this aim, several recommendations for practice and future research have been identified[10].

Framework recommendations:

1. The RuSHY Framework represents a practical document that has been evaluated for potential usefulness and transcontextual validity by rural-based stakeholders. In its current form, it is recommended the RuSHY Framework be immediately implemented within the current setting by stakeholders engaged in sexual health service provision.
2. The implementation of the RuSHY Framework should be observed and evaluated for its effectiveness and potential long-term sustainability.
3. While its trans-contextual validity to other rural areas is yet to be fully confirmed, the Framework is recommended for immediate testing and utilisation within other rural settings, with the acknowledgement that this Framework has been developed for a specific community. Different communities should acknowledge and evaluate setting specific considerations in terms of population demographics, service provision and local policy.
4. This RuSHY Framework was developed for sexual health, however, given the associations and intersections within youth health needs in the rural area, the RuSHY Framework could be adapted by communities for other areas of health. Given the synergies with interventions that target mental health, sexual health and alcohol and other drugs; communities could utilise the RuSHY Framework to guide the better planning, implementation and evaluation of community-based interventions that target other health areas.
5. As identified within the RuSHY Framework, traditional stakeholders such as General practitioners (GPs), health service, youth services, school nurses and teachers must be active and engaged in their support of non-traditional stakeholders to ensure youth sexual health needs are comprehensively addressed within their specific community.

Policy recommendations:

6. The RuSHY Framework provides an advocacy platform with a clear vision for improving rural sexual health outcomes. Rural sexual health provision requires a multi-pronged approach with broadened responsibility and the need for strategic change can only be achieved through ensuring sexual health promotion and RSE provision is supported through adequate resourcing.
7. Ensure a suitable funding envelope alongside policy support for health promotion research that focusses on how to further reduce the burden of STIs, the improved provision of RSE in the rural area and how to increase collaboration in areas that lack specialist services.
8. There is a requirement for clear policy guidance on the provision of RSE education in schools. There is currently a lack of uniformity in what is being taught within Australian schools and the provision of clearer policy support will provide administrators and teachers greater guidance.

Research recommendations:

9. Further research be conducted from a rural insider-research positionality. This positionality has provided rural youth, rural stakeholders and rural researchers with a voice and the ability to shape practice, research and policy for the rural setting, from the rural setting. This ability to plan, conduct, analyse and publish research from not just a rural viewpoint, but a rural positionality reinforces that research does not need to be created and conducted from metropolitan areas, particularly research on and about the rural area.
10. Research to further examine the suitability of Delphi study technique within rural-based research should be employed. The ability to provide anonymous feedback in a timely and responsive manner within this research was of great value to the overall project and it is suggested that Delphi methodology is appropriate for further use in the rural setting.

Practice recommendations

11. Rural stakeholders must confirm the threats, opportunities, weaknesses and needs of young people within their setting and consider the setting specific context that they are operating in.
12. Rural stakeholders must be active within their community and ensure that young people are being provided with and have access to the minimum level of sexual health services and RSE required. Equitable sexual health service provision is reliant on the actions of the community and its stakeholders.
13. While there is a lack of prioritisation within the rural setting, there will be a lack of action towards the Fourth National Sexually Transmissible Infections Strategy 2018 – 2022. Prioritisation is reliant on policy level support and funding. Rural based Local Government Agencies should explore how implementation of the Framework could be supported by Community Development or Health Promotion Officers.
14. There is a need for greater funding in the rural area to support areas that lack specialist rural sexual health services. Achieving the key action areas that address youth from the Fourth National Sexually Transmissible Infections Strategy 2018 – 2022 will not be possible without appropriate funding to activate the strategy.
15. Rural stakeholders cannot continue to "fly under the radar" and deliver sexual health services and RSE in a covert manner. Through avoiding backlash or embarrassment, stakeholders are also avoiding the responsibility of making change at organisational and community levels. There is a need for rural stakeholders to advocate on behalf of young people to ensure that their needs are being met for services and education that are at times embarrassing or stigmatised.
16. Rural stakeholders must be appropriately trained to deliver RSE, sexual health testing and to provide information and youth-friendly interactions. Extending this training beyond core personnel is important in ensuring consistency and credibility.
17. Rural health services need to connect with young people, with other stakeholders and explore collaborations and outreach to improve service accessibility. Health services should examine how to focus on more than the individual and consider community level needs in service provision.
18. Rural communities need to provide condoms in a discreet and youth-friendly manner that minimises contact with adults and peers; allows anonymous access and reduces cost and gender barriers. Free condoms in appropriate locations, self-services areas, and condom vending machines should be explored with local young people to determine the most effective, appropriate and youth-friendly way to ensure access.
19. Non-traditional settings such as sporting clubs, youth groups, arts groups and clubs may be interested in supporting sexual health interventions and should be approached and supported by stakeholders. Communication and collaboration are important factors in the delivery of sexual health interventions in the rural area and a coordinated approach allows credible and consistent messaging on sexual health within the community and new opportunities for collaboration.

Thesis document: Heslop CW. Developing a Framework for Community-Based Sexual Health Interventions for Youth in the Rural Setting; 2019. https://espace.curtin.edu.au/handle/20.500.11937/78311

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