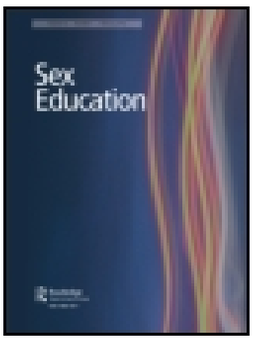

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'Half the time it's just guessing': youth worker and youth service manager experiences of sexual health training in the Pilbara, remote Western Australia

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ABSTRACT

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. Youth workers' and youth service managers' perspectives on these interactions and the sexual health training they receive are poorly understood. In this study, youth workers and youth service managers working in the Pilbara, a remote region in Western Australia, participated in semi-structured online video interviews. Participants (n = 10) were asked about their experiences and the impact of sexual health training on their work. Data were thematically analysed. Four themes were developed: Pilbara youth workers and youth service managers need sexual health training; locally delivered sexual health training is preferable; online sexual health training may augment knowledge; and strategies to optimise sexual health training are 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. Suggestions are made to improve youth workers' and youth service managers' access to effective sexual health training.

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Introduction

Young people are a priority population outlined in Australia's Fourth National Sexually Transmissible Infections Strategy as they are the age group at greatest risk of contracting sexually transmitted infections (STIs) (DOH 2018). Current understanding of young people's experiences suggest they desire relationships and sexuality education (RSE) on a broader array of topics (e.g. pleasure) and in greater depth than that offered in most Australian school curricula (Barbagallo and Boon 2012; Ezer et al. 2019; Helmer et al. 2015; Johnson et al. 2016).

Access to sexual health counselling, medical, allied health and social support can be restricted or unavailable in remote and very remote regions such as the Pilbara (in the north-west of Western Australia), due to its sparse population and large distance from the nearest capital city (Wakerman et al. 2017). Even when sexual health services are available, young people's access to these services may be compromised (Johnston et al. 2015).

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Perceived and real anonymity, an important factor for young people accessing sexual health services, is unlikely to be preserved in small towns where 'everyone knows everyone' due to community interconnectedness (Heslop, Burns, and Lobo 2019, 648). Rural or remote locations may not have a full complement of the necessary medical and allied health workforce to address youth health needs, including sexual health (Carbone, Rickwood, and Tanti 2011; Hodges, O'Brien, and McGorry 2007). Therefore, components of RSE and engagement in sexual health topics are often delivered to young people by those without sexual health training, such as youth workers.

In Australia, youth workers and youth service managers typically engage young people (aged 12–25 years) in 'out of school time' in residential and street settings through informal and structured face-to-face, group and online interactions; as well as providing support and advocating for individual client's needs (Archer 2012). The youth sector includes organisations and individuals who work with young people to ensure their rights are protected and promoted and their needs are met (Archer 2012).

Limited research has explored youth workers' or youth service managers' experiences of sexual health training and its impact on their work with young people regarding sexual health (Colarossi et al. 2014; Gupta et al. 2015). The research that does exist is quite old. Dempsey and Harrison (1998) identified that youth workers felt barriers to addressing young people's sexual health needs were a lack of sexual health knowledge and a fear of breaching role boundaries. However, many key issues embedded in sexual health discussions are identical to the issues youth workers regularly help young people with such as peer pressure, communication skills and relationship issues (Janssen and Davis 2009). Youth workers have long expressed a need for greater training and resources to address sexual health topics with their clients (McCarthy et al. 2015), with training in remote communities incorporating additional barriers.

Pilbara youth services provide support for young people facing a multitude of issues, including alcohol and other drug use, low school participation rates, mental illness and suicide (Garwood, Sercombe, and Boldy 2017). In 2016, a Western Australian Country Health Service (WACHS) regional report noted the age-standardised rate of all STIs was 1.9 times higher in the Pilbara than in the rest of the state (WACHS 2018). These high rates of STI notifications were concerning because they provide an indicator of young people's sexual health (Kang, Skinner, and Usherwood 2010).

In the Pilbara, the predominant professional development model for youth workers and youth service managers requires them to travel large distances between towns or to the state capital, Perth (1,251 km south), to receive non-locally delivered sexual health training. This incurs significant expense and time away from delivering core youth services (Brown and Green 2009; Wilkins et al. 2015). One approach to mitigating this has been the local delivery of training. For example, Sexual Health Quarters (SHQ), a non-governmental organisation which provides sexual health services and education in WA, has developed at least three sexual health training courses which have been delivered in Perth, in the Pilbara, or a mix of both settings, for over a decade (Thompson, Greville, and Param 2008). Other approaches include sexual health training workshops delivered locally in the Pilbara by organisations such as the WA AIDS Council, the Youth Affairs Council of WA (YACWA) and the Aboriginal Health Council WA. These shorter courses often focus on fewer topics, for example gender diversity or STI screening.

There is currently no Australian literature focused on youth workers' or youth service managers' experiences of sexual health training and little published evidence to guide policymakers, the youth sector and training providers on how to best support these workers. Against this background, this study aimed to explore the benefits, disadvantages, enablers and barriers of locally and non-locally delivered sexual health training for youth workers and youth service managers in the Pilbara.

Methods

The study employed a qualitative design conducted using a constructivist philosophical framework (Savin-Baden and Major 2013). Constructivism underpinned this study as the participants' expression of their ideas, knowledge and experiences in the open-ended, semi-structured interviews informed the emerging dialogue. Ethics approval for the study was provided by the University of Western Australia Human Research Ethics Committee (reference: RA/4/20/5416).

Setting

The Pilbara region covers a vast area of 498,000 square kilometres and is Western Australia's second most northern region (WACHS 2018). Most of the Pilbara is classified as very remote (99.9%) and the remaining 0.1%, is classified as remote according to the Accessibility/Remoteness Index of Australia which systematically classifies Australia into five categories ranging from Major Cities to Very Remote (ABS 2018). The estimated population of the Pilbara is 61,435, of which approximately 9,007 people are aged between 10 and 24 years (ABS 2019). Aboriginal people accounted for 16% of the region's population compared to the WA average of 3.6% in 2015 (WACHS 2018). While the Pilbara has a lower proportion of young people aged 10–19 years compared to the State demographics, the age structure for Aboriginal people in the region is younger compared to non-Aboriginal residents (WACHS 2018).

Participants

A purposive sampling strategy was utilised where by participants were approached for the study through social media advertisement, cold-calling youth services, existing contact with the first author and headspace Pilbara (a non-governmental organisation providing primary mental health services for young people). The first author had four years' experience working with the youth sector delivering sexual health training and had previously travelled to the Pilbara to deliver workshops with YACWA's Youth Educating Peers (YEP) Project.

Participants were recruited from a diverse range of youth work settings including residential services, non-government and local shire youth centres and education settings. Criteria considered were current experience working as a youth worker or youth service manager in the Pilbara, gender and remoteness. Interviewing youth workers and youth service managers from a range of settings and varied experience enabled the study to reflect the diverse and sometimes idiosyncratic practice of youth work (Bessant, Sercombe, and Watts 1998).

Of the 11 people who completed the pre-interview questionnaire (described below), 10 participated in an interview. The non-attender was contacted via email and stated they were unavailable for an interview timeslot. A total of five adult youth workers and five youth service managers currently working in Pilbara youth services across five towns participated (one male and nine female). This ensured responses reflected recent experiences and knowledge and included perspectives from both leadership and practitioners. Of the ten participants, eight were based in remote areas and two were based in very remote areas. This is reflective of the estimated proportion of youth workers by gender in the region (ABS 2019). Participants' experience working as a youth worker or youth service manager in the Pilbara ranged from 6–12 weeks (n = 2), 1–3 years (n = 5), to greater than 3 years (n = 3).

Participants' identities were protected by using pseudonyms and ensuring contextual clues such as their workplace, type of education setting, town or age are not included. This is particularly important for this study because some towns in the Pilbara have small populations and few youth sector staff.

Data collection

Participants completed a short online pre-interview questionnaire to collect demographic and background information such as their experience in the region, professional role and sexual health training experience.

Participants then completed a semi-structured face to face online video interview lasting 23–93 minutes (mean 49.7 minutes) using *Zoom* videoconferencing software with the first author. Online synchronous (real-time) video interviews have been suggested as a viable option for qualitative research, with the advantage of reducing cost and reconciling geographical distance (Lo Iacono, Symonds, and Brown 2016). Four of the interviews were conducted with audio only due to poor Internet connection or difficulties using the video conferencing software.

All interviews were conducted between July and August 2019. Participants were asked questions regarding their experiences discussing sexual health with young people, prior sexual health training, if and how their organisation provided training opportunities, and their thoughts about how to provide accessible and effective training.

Data analysis

Data were transcribed verbatim from video recordings and were uploaded into NVivo version 12 (QSR International Pty Ltd. 2018) to facilitate analysis by the first author. The data were open coded using inductive category development and constant comparison coding until data saturation was achieved, and no further themes emerged. This process involved the first author reviewing each new transcript line by line to identify meaningful codes which could be grouped together. As new data emerged, existing codes were continuously revised to ensure an accurate representation of the dataset. Thematic analysis was selected to generate a rich description of the entire dataset, potentially including unanticipated insights (Braun and Clarke 2006). The third author reviewed the coding and analysis of all transcripts and differences were resolved by consensus with input from the second author.

Rigour

Methodological rigour was enhanced by collecting data from both youth workers and youth service managers to increase the diversity of perspectives on the topic of locally delivered sexual health training. This allowed for a triangulation of data sources to develop a robust understanding of the topic and provided greater opportunity to uncover deeper meaning (Carter et al. 2014). To enhance confirmability and reduce bias, the research team reviewed analysis and emerging themes and provided input before consensus on the final themes was achieved (Savin-Baden and Major 2013).

Findings

Resonating across all participants was the importance of sexual health training to equip youth workers and youth service managers with confidence and knowledge to educate young people about sexual health. While there were some perceived benefits to non-local training, locally delivered sexual health training was preferred. Another theme: the role of online sexual health training in augmenting knowledge, also emerged from discussion around the format of training and accessibility of training for remote youth workers and youth service managers. The final theme, how best to optimise sexual health training, identified five ways of optimising the benefit of sexual health training in the Pilbara.

Youth workers and youth service managers needed sexual health training

Youth workers engaged young people in conversations about sexual health, but lacked formal sexual health education themselves, and perceived the need for training. Research participants discussed a range of sexual health topics with the young people they worked with. They recalled examples of helping individuals with their issues, particularly assiting young people understand and access medical services.

> We've become quite a source of support, whether it's taking young people to medical appointments or talking to them about their options. I went to a doctor's appointment where a young girl got an Implanon (contraceptive implant) the other day because she didn't have any other support from family. We work closely with the nurse at Population Health to identify people who are sexually active in the community and who their contacts are to prevent chlamydia outbreaks. We'll try and manage them once they've occurred. We have to have a few of those conversations. (Mel, remote youth worker)

Implicit in their examples was the required sexual health knowledge youth workers needed to provide informed and accurate advice. Additionally, youth workers felt young people were increasingly raising gender and sexuality as topics they wanted assistance with.

> A lot of talk around contraception because we're finding general practitioners are very quick to hand it out but not explaining how to use it or use it properly. We're almost a secondary service in that way. And lots of things around gender and sexuality. (Jennie, remote youth worker)

Some youth workers and youth service managers connected the provision of free condoms at their service to opportunities to discuss sexual health. Since these discussions

occurred in the context of condom use, education on sexual health topics unrelated to STIs and contraception may have been more difficult to connect to these opportunities.

> We've got condoms and lubrication that's been donated by Population Health and other people. There's a group of the boys that know I have the condoms there now, so they'll actually come and hit me up when they want them. And those are opportunities I take to try talk to the guys. So really it's just always around practising safe sex and treating people with respect and consent. (Peter, remote youth worker)

Youth workers and youth service managers noted working with young people required confidence in addressing topics such as consent, respectful relationships, pornography, and cultural issues.

> They would say, 'so and so didn't want to suck my dick so I punched her in the arm' and then we'll have a discussion about why he thought that was appropriate and he'll say 'it's because she's my woman so she has to do these things.' And then when you talk further about what do you think you have to do in a relationship, and you unpack that the young people usually go 'that's just what we know from porn or we didn't know there is a choice.' Especially girls 'we didn't know there was a choice when you have sex or not have sex or do certain things.' (Samantha, remote youth worker)

Most participants reported they relied on their personal knowledge of sexual health gleaned from their school education and personal experiences when discussing sexual health with young people. Many expressed dissatisfaction with the extent of their knowledge and identified specific training as the solution for their lack of knowledge or confidence.

> The only sort of training and the only exposure to [sexual health] was when I was in school health lessons and as we all know they're brief and dance around a lot of the topics. (Mel, remote youth worker)

> Without training I just rely on the knowledge I already have, and half the time it's just guessing, and because the issues up here are so diverse, there's such a big range, there's no way I know how to deal with each individual issue without that training. So, the training easily directly impacts the outcomes we get with our young people in a positive way. (Jennie, remote youth worker)

Participants also noted health workers were an important source of knowledge. They described working relationships which leveraged the skills of local health workers and youth workers for young people's benefit.

> We do have those conversations with the clinical nurse from Population Health and the nurse and the doctors at the hospital so that we get a better understanding [of sexual health]. We can speak to the kids in their way, which the nurses and the doctors can't necessarily do, but we need to know what the nurses and doctors are trying to say before we can pass it on. (Mel, remote youth worker)

> Someone from the Allied Health or the Health Department might pop into the school and just kind of do a general 'This is something that's popping up in community … here's some details.' (Jane, remote youth service manager)

However, these informal relationships were only described by participants working in smaller towns and it is unclear if larger towns had similar partnerships.

Youth workers and youth service managers generally expressed a desire for more sexual health training. They highlighted the difficulties of prioritising sexual health over other relevant issues.

> There is often a fair bit going on. But, not around sexual health training at all. And for where we are that should be one of the biggest priorities. Trauma informed practice, all that stuff, that's absolutely fantastic and suicide prevention absolutely worthy cause and worth doing the training for and upskilling for that, but the sexual health stuff gets missed from all these other things that get focused on. (Peter, remote youth worker)

> There's the choice of what do you bring up. Do you bring up sexual health? An organisation has to choose if that's important enough when domestic violence is here. (Samantha, remote youth worker)

All participants expressed a desire for sexual health training, but only some could identify a specific course they wanted to attend. Others felt previous sexual health training had motivated them to develop further skill and knowledge in the area.

> I don't know a lot about [other sexual health training]. But I just jump at anything to do with sexual health because the YEP [Youth Educating Peers] tour. Because I learned so much from that, there's gotta be so much more I can grow in this area. Usually you go to a training and you take one or two things away, but I've taken six or seven things that I use now all the time and so it's just exciting to learn more in that area. (Jennie, remote youth worker)

Several participants desired training and support to prepare them to engage Aboriginal young people in sexual health discussions, which they felt was an important group they needed specific training for.

Locally delivered training was preferable

Financial cost

Participants emphasised that locally delivered training was more affordable in comparison to sending staff to non-local training.

> Having it here in the Pilbara is a big plus because we don't have to go anywhere. You'll get people that would just never go to Perth because some organisations aren't as well off financially as us and so there's just no chance they're going anywhere. (Jennie, remote youth worker)

When flights, accommodation, relief staff wages and other expenses were considered, training in Perth was too expensive for multiple members to attend.

> It'd be easier for us to spend 500 AUD for two or three people if they're training us up here. They have a couple days off and they do the training and it's done. As opposed to a couple of thousand [dollars] for getting it down [in Perth]. (Peter, remote youth worker)

Time away from services

Local training minimised disruption to busy schedules. As Alice, a very remote youth service manager, described, 'after the four-hour training session we can go back to our job in the afternoon.' Conversely, a barrier to attending non-local training was the time staff

were out of the service. This could be problematic for smaller services where staff were not easily replaced.

> We don't have enough workers out here on the ground or in all the organisation. So, it's hard to get away without feeling so inundated when you get back. (Samantha, remote youth worker)

> In terms of staff travelling elsewhere for training, that can be quite a barrier because there's no intra-regional flights or anything like that, so you have to drive. It takes quite a long time. (Anne, very remote youth service manager)

Local training benefited from familiarity with setting and staff

Participants found training delivered locally was more relevant to community needs. Mel, a youth worker, suggested locally delivered training had greater community consultation compared to non-local training.

> Generally, when it's delivered in the Pilbara there's some sort of influence from the Pilbara community in the training that's delivered. So, it's more specific to the region you're in. (Mel, remote youth worker)

Jennie, also a remote youth worker, felt the local training environment was more familiar and comfortable which meant it specifically addressed her community's needs.

> Just having it here is so much more comfortable because you're learning with people that you know. We're such a small sector here that we all know each other, and you work with everyone every day. So the training is a lot more tailored to what we're experiencing because we can ask questions that we're all going through. (Jennie, remote worker)

However, it was suggested that embarrassment and discomfort around other locals can detract from having open discussions.

> We've got such a small town. Everybody knows each other and sometimes people are probably a bit ashamed to tell their story and they say nothing. (Helen, remote youth service manager)

Local networking

Participants highlighted the opportunity for collaboration that training brought to towns. Having shared models and terminology assisted teamwork and prompted inter-service planning and action addressing sexual health issues.

> We have training locally and it's great because it means that you're linking with people that you know and that can actually promote conversations in regard to 'we've just done this training, where to from here, how can we work together?' (Alice, very remote youth service manager)

One youth service manager noted a benefit of non-local training was networking opportunities outside of the Pilbara. That way 'bringing ideas and resources back' to the Pilbara was possible.

> Going to Perth is a little bit different because you're linking with other service providers that you've probably never met before, so it provides a really good opportunity to create new connections. (Alice, very remote youth service manager)

However, Jennie felt her region's issues were poorly understood in metropolitan training, where other participants were unfamiliar with working in a remote context, and therefore she was less likely to participate in discussions.

> If I'm sitting in Perth with a heap of Metro people, I'm probably just going to stay quiet because no one will understand what I'm talking about. (Jennie, remote youth worker)

Low availability of local sexual health training opportunities

Some youth workers and youth service managers worked in organisations with limited training budgets which prevented them from arranging local or non-local training.

> We're just lucky that we have the budget to be able to do that. But if we didn't, we would solely rely on what's available here in [the town] or in the Pilbara and there's not a lot of stuff. (Jennie, remote youth worker)

Local training was too entry level

The repetitiveness of entry level training, attributed to high staff turnover rates, frustrated experienced staff concerned about receiving a limited selection of training compared to metropolitan counterparts.

> It's the same things that come to town every time like suicide prevention, protective behaviours. It's the same all the time and it's good because we have high turnover and so you've got new staff to send but when you're actually the one staff that's been here a long time, there's nothing really new. (Jennie, remote youth worker)

Online sexual health training may augment knowledge

Although participants could not identify examples of online sexual health training they had engaged with, some believed it could be potentially useful.

> I can think an online version of some of the training that I have done in the past would be useful. So the [. . .] did a training on just general LGBTIQA+ [lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual, plus], what all the words mean and being inclusive, and I think even that some of that kind of stuff would be useful to have online. (Anne, very remote youth service manager)

Some participants who supported online training added that a hybrid approach which combines online training with face to face components would be beneficial.

> Online training is not a bad thing. But it would be really good to have sessions where you did get to meet with other people, but you can take some of the stuff away and finish and do things online. (Alice, very remote youth service manager)

However, previous experiences of online training were unsatisfactory for some participants as it was too simplistic.

> It's not detailed. It's sort of common knowledge training. It's not college, it's not university material. It's just basic. (Helen, remote youth service manager)

Other participants had difficulty concentrating on the material due to lack of engagement.

> You just don't give it your full attention if you're sitting at a computer just listening to training … It's probably not as good as being in classroom training. I find a lot of the staff will just click-click-click just to get to the answers at the end. (Helen, remote youth service manager)

Optimising sexual health training

The idea that training should be 'place-based', occur locally, be interactive and engaging, and have input of local services during planning were recurring themes. The importance of a 'local champion' to provide an avenue for external facilitators to learn about the community's needs, maximise attendance and gain trust was emphasised. Participants also noted regional peak bodies were useful resources which supported youth services to arrange and attend training.

Enlist local champions for community consultation

Most participants felt community consultation was key to maximising success when training was delivered locally by external facilitators. Many believed that consultation with local services should occur early and was important for tailoring content to community needs, arranging an appropriate time and location, and being a trusted voice to promote the training to other services.

> I spoke to [the training facilitators] on the phone before they came up. So, they had some idea of what we're facing … you need to have some understanding of where you're going because training can't just be delivered the same everywhere. (Lisa, remote youth service manager)

Make it interactive and engaging

Participants desired interactive and engaging training as they believed their profession responded positively to activity and discussion-based workshops.

> Having it here works, and just the practical delivery of getting staff to do the things young people would be doing and do the activities, that really sticks instead of just sending out information and PowerPoints that no one ever reads. (Jennie, remote youth worker)

Provide follow-up support and resources from training providers

It was felt to be beneficial when facilitators provided support and resources to local organisations after the training itself. Participants were able to share knowledge with colleagues who did not attend the training and were able to integrate learning into their organisation's practice and programming.

> There were a couple people on my team that actually missed out and we have a new person. I found the email that was sent with all the resource links in it … now I can pass it on to the team member that's organising the programme that will have that topic. (Lisa, remote youth service manager)

Utilise peak bodies

The importance of peak bodies was emphasised by most participants. Peak bodies are non-governmental organisations representing the interests of the sector and are usually

focused on advocacy, research, capacity building and community education rather than service delivery (Johnson, Rothstein, and Gajdosik 2004). These peak bodies are active in organising and promoting training calendars, conducting consultations with the youth sector, and providing support to services organising training.

> Even if it was in [this town], because different organisations organise different trainings, like the youth service in [the next town] will organise a fantastic training for their staff and they'll invite [another youth service] because they're next door. We'd also love to go that training, but we'll hear about it the day before or afterwards … I think there's some missed opportunities with people not talking or operating in silos. (Lisa, remote youth service manager)

Discussion

In their responses, youth workers and youth service managers detailed how sexual health training could be made more accessible and effective. They wanted interactive and engaging locally delivered training by expert facilitators delivered to everyone working with young people in their towns. Participants also desired community consultation which shaped the planning and content of the training. They also wanted to know about upcoming local training with enough forewarning to complete their organisational processes to attend, which was assisted by maintaining communication with peak bodies.

The strong relationships between youth workers and young people identified in this study present an opportunity for informal and formal sexual health education out of school time (Colarossi et al. 2014; Gupta et al. 2015). Many participants revealed their primary source of sexual health knowledge derived from their own school education and personal experience, which is not an evidence-based strategy for educators (Burns and Hendriks 2018). If youth workers are not provided with current best practice sexual health knowledge and skills, despite their best intent, then there may be a danger of perpetuating harmful myths and missing opportunities for meaningful positive interventions in youth sector settings. Indeed, participants recognised the need for additional training to feel confident in addressing the multitude of sexual health concerns young people were sharing with them.

Youth workers desired sexual health training which was specific to the needs of their communities and the Aboriginal young peoplethey worked with. Focusing on culturally appropriate and relevant sexual health training has been shown to build community capacity to respond to sexual health issues, enhance non-health worker's skills and develop partnerships (Thompson, Greville, and Param 2008). This study's findings are consistent with other research showing rural and remote service providers benefit from networking opportunities (Wilkins et al. 2015). These opportunities to come together for training, socialising or collaboration may reduce the professional isolation many rural and remote youth workers describe (Geldens and Bourke 2006). Furthermore, another benefit of local training revealed by participants was the opportunity created in remote towns for collaboration between services. Community consultation by training providers may supplement local collaborative efforts and optimise the efficacy of training. This consultation may also enable communities to support long term efforts addressing sexual health issues by tailoring existing content for their needs. Consultation may enable capacity building in small communities as training efforts can be integrated into longer term projects (DOH 2018).

Locally delivered training was preferred by both youth workers and youth service managers in remote and very remote Pilbara. These results are supported by findings in the limited international literature where a narrative inquiry of Nebraskan youth workers' professional development needs explored the financial and time benefits of locally delivered training (Larson 2018). One Nebraskan participant said she felt she could not spend too much time away from her programme in case problems arose in her absence (Larson 2018, 94). These sentiments are similar to those expressed by rural Victorian youth workers, particularly the difficulties of accessing training due to travel costs (Geldens and Bourke 2006).

Participants reported they were frustrated that training never progressed beyond a basic level in the Pilbara and attributed this to high staff turnover in the region. This is consistent with findings of an evaluation of six sexual health projects for Aboriginal and Torres Strait Islander young people in a range of Australian settings, including rural and remote, which identified difficulties recruiting and retaining staff (AIHW 2013). Providing further opportunities targeted at those who had completed introductory sexual health training was a suggestion made by participants in this study which may increase skill levels and retention. The literature investigating investment into professional development for social service workers suggests training can improve recruitment and retention in addition to improving service delivery (Curry, McCarragher, and Dellmann-Jenkins 2005).

Participants highlighted that online training should not attempt to replicate face to face training as they felt it was a poor substitute. Instead online training should focus on conveying key sexual health information such as current terminology regarding gender and sexuality, STI advice and reproductive anatomy. The integration of face to face elements would allow some of the reported benefits of local training such as networking, interactivity and place-based training to be gained. An evaluation of online sexual health training for nurses found some benefits included increased flexibility and access to content but noted the importance of interactive and engaging online training for participant retention (Brook et al. 2015).

Future research in this area could explore the impact of sexual health training on the policies, procedures, attitudes and programming of youth services and the influence of these organisational changes on young people's experiences. Given the difficulties LGBTIQA+ young people encounter in some rural and remote Australian towns (Heslop, Burns, and Lobo 2020; Jones 2015), sexual health training and corresponding organisational change may be one avenue to address the needs of young people in these settings. This study did not discuss training evaluation, which is crucial for sustained efforts in capacity building. Future studies should therefore aim to assess the impact and outcome of specific training programmes (O'Malley, Perdue, and Petracca 2013).

Limitations

Settings which share characteristics with the Pilbara, such as remoteness and high youth sexual health needs, should interpret these results with reference to their own local strengths and issues. The small scope and limited resources of this study meant the valuable perspectives of young people, training providers and health workers could not be included. Future research involving these groups, ideally in the same project, should elucidate the issue of sexual health training in the Pilbara and explore the relationships

between various stakeholders in the youth sector. While participants in larger population centres had enough Internet bandwidth to facilitate uninterrupted interviewing, smaller more remote towns had difficulty sustaining a quality connection for the duration of the interview which may indicate a limitation of employing online video interviewing in remote settings.

Conclusion

In remote and very remote regional settings, it is vital that young people's sexual health is supported by suitably trained youth workers and youth service managers. Youth workers trained in sexual health are better positioned to provide accurate advice, make appropriate referrals and identify opportunities to improve young people's sexual health. Young people will benefit from more efficiently directed funding for local training than the current model, which limits access in remote and very remote settings. There is value in ensuring that training is provided locally with prior and ongoing community consultation to optimise youth sector attendance and relevance to the local setting. Supporting continued coordination and capacity building efforts from leadership, including peak body organisations, remains a crucial element in sexual health training provision in remote and very remote settings.

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