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The Oral Health and Well-Being Experiences of Indigenous South Australians: A Qualitative Study

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ABSTRACT

Objectives: To explore the perceptions of Indigenous South Australian adults regarding their oral and general health, social and emotional well-being and dental care experiences.

Study Design: Qualitative study; interviews with Indigenous South Australian adults involved in a non-randomised implementation and service-delivery project evaluating provision of culturally safe, comprehensive dental care. Study governance was provided by an Indigenous Oral Health Unit Reference Group with Indigenous leadership to centre cultural authority and cultural safety across all study dimensions.

Participants Setting: Semi-structured interviews were conducted with 136 Indigenous South Australian participants at a location of their choosing (e.g., their home, a community centre, a research facility), which were held at baseline (1 July 2022–15 December 2023) and 12-month follow-up (1 March 2024–31 March 2025).

Intervention: The overarching study consisted of a pre–post assessment of oral health embedded in routine dental care with oral epidemiological examinations and assessment of systemic health biomarkers (blood glucose, inflammation, cholesterol, kidney function). This was followed by semi-structured interviews at 12-month follow-up.

Main Outcome Measure: Qualitative outcomes—participant experiences, understandings and recommendations around supporting oral health, social and emotional well-being and culturally safe dental care for Indigenous South Australians.

Results: Reflexive thematic analysis was used to analyse interview data, from which five themes were developed. Participants described the importance of oral health for overall health, aesthetic and functional impacts and judgement and discrimination related to poor oral health, all of which were linked to social and emotional well-being. Culturally safe care that includes oral health assessments alongside assessments of biomarkers for systemic health were suggested to promote self-confidence, reduce feelings of shame and empower communities.

Conclusion: This study highlights the need to incorporate holistic approaches in promoting Indigenous oral and systemic health and in supporting social and emotional well-being.

Trial Registration: Australian New Zealand Clinical Trials Registry (ACTRN1262600046303; retrospectively registered)

JEL Classification: Indigenous health, Statistics, epidemiology and research design, Health services administration, General medicine, Health occupations

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Plain Language Summary

The known: Indigenous Australians experience greater barriers in accessing oral healthcare that is culturally safe, addresses systemic health disparities and considers oral health in relation to social and emotional well-being.

The new: Indigenous participants shared concerns around perceived poor oral health, including aesthetic and functional issues and experiences of discrimination or shame, impacting their social and emotional well-being.

The implications: In supporting Indigenous oral health and well-being and closing the gap in health inequities, these findings emphasise the need for culturally safe dental care, outreach and mobile dental care, integration of oral health within primary health services and interdisciplinary collaboration.

1 | Introduction

Oral diseases (e.g., dental caries, periodontal disease) are among the most common non-communicable diseases globally, impacting about 3.5 billion people [1]. Studies have identified links between oral health and systemic health [2, 3]; for instance, periodontal disease is considered a risk factor for several chronic diseases, such as diabetes [4], cardiovascular disease [5, 6] and chronic kidney disease [7]. Like many non-communicable diseases, oral conditions are socially patterned, meaning that marginalised groups are often most impacted [8].

For Indigenous Australians, the mouth has long been seen as an integral part of well-being, where in some communities, teeth have a central role in practices such as initiation, weaving, fishing and men's business [9, 10]. Studies suggest that Indigenous communities did not typically have dental caries or periodontal disease until after the arrival of European colonisers to Australia, with the introduction of refined carbohydrates, sugar consumption and disruption to subsistence livelihoods which supported the well-being of Indigenous communities for thousands of years prior [9–11]. Colonisation further resulted in impoverishment, and disruption of social networks and quality of life, and continues to greatly impact well-being for many Indigenous Australians [9]. Such factors have contributed to Indigenous Australians experiencing a higher prevalence of chronic disease and greater likelihood of untreated dental caries and periodontal disease compared with non-Indigenous Australians [12, 13].

For many Indigenous communities, well-being is conceptualised as social and emotional well-being, encompassing seven domains that consider healthy connections to: body and behaviours; mind and emotions; family and kinship; community; culture; Country and land; and spirituality and Ancestors [14, 15]. Poor oral health-related outcomes may be linked to poor social and emotional well-being among Indigenous communities [16]; however, there is limited research that considers the perceptions of Indigenous Australians and their oral health experiences in relation to their health and well-being. Additionally, norms around how teeth should appear (e.g., straight, white, none missing) stem from primarily Eurocentric views [17].

Pressure to adhere to these norms may also impact well-being, with the limited research among Indigenous Australian populations suggesting some people may feel dissatisfied with the appearance of their teeth, impacting their mental health [16, 18]. It is important to consider how oral health, general health and social and emotional well-being can be supported in culturally safe ways, specifically in the South Australian context, as access to such supportive care may improve both well-being and oral health for Indigenous communities [19]. This study explored the following research questions: How does oral health influence social and emotional well-being for Indigenous South Australians? What are the impacts of providing culturally safe dental care on Indigenous South Australians' social and emotional well-being?

2 | Methods

2.1 | Positionality Statement

Our team is composed of non-Indigenous and Indigenous researchers, academics and clinicians, both with and without the lived experiences that guide the aims of this study. The first author is non-Indigenous and has over 5 years of experience conducting qualitative research with diverse groups in relation to well-being and health services. The broader non-Indigenous team comprises clinicians and/or researchers who have led and worked on various projects involving comprehensive dental care for Indigenous Australians, with over 20 years of combined experience in oral health research. The research team was led by Senior Aboriginal Research Officer and Director of the Indigenous Oral Health Unit at Adelaide University, Joanne Hedges, a proud Yamaji woman with over 15 years of experience working in Indigenous health research. She has a Master of Public Health and experience as a dental nurse and clinical coordinator within Aboriginal community-controlled health services. Aboriginal Research Officers, Emma Flanagan (Kurna, Narungga, Kokatha, Wirangu), Tiyanne-Marie Mastrosavas (Kokatha, Wirangu) and Ebony Wallace (Wuthathi, Lardil), worked alongside the Senior Aboriginal Research Officer in proposing culturally safe research protocols and leading discussions with the team around critical reflection of positionality.

2.2 | Design and Data Collection

The qualitative findings reported in this paper are part of a broader mixed methods study (see Jamieson et al. [20] for study protocol). The qualitative component aimed to understand the experiences of Indigenous South Australians participating in a culturally safe dental care intervention (see also Aiyar et al. [13], Nath et al. [18, 21]). In the intervention component, oral epidemiological examinations were conducted at baseline (1 July 2022–15 December 2023) and 12-month follow-up (after receiving formal dental care; 1 March 2024–31 March 2025). To assess biomarkers of systemic health, participants provided blood drops via finger pricks for point-of-care testing for blood glucose levels (glycated haemoglobin), inflammation (C-reactive protein) and cholesterol (lipid panel [low-density lipoprotein, high-density lipoprotein, total cholesterol]) and a urine sample to test kidney function (albumin-to-creatinine ratio). Participants involved in the study at follow-up were offered the opportunity

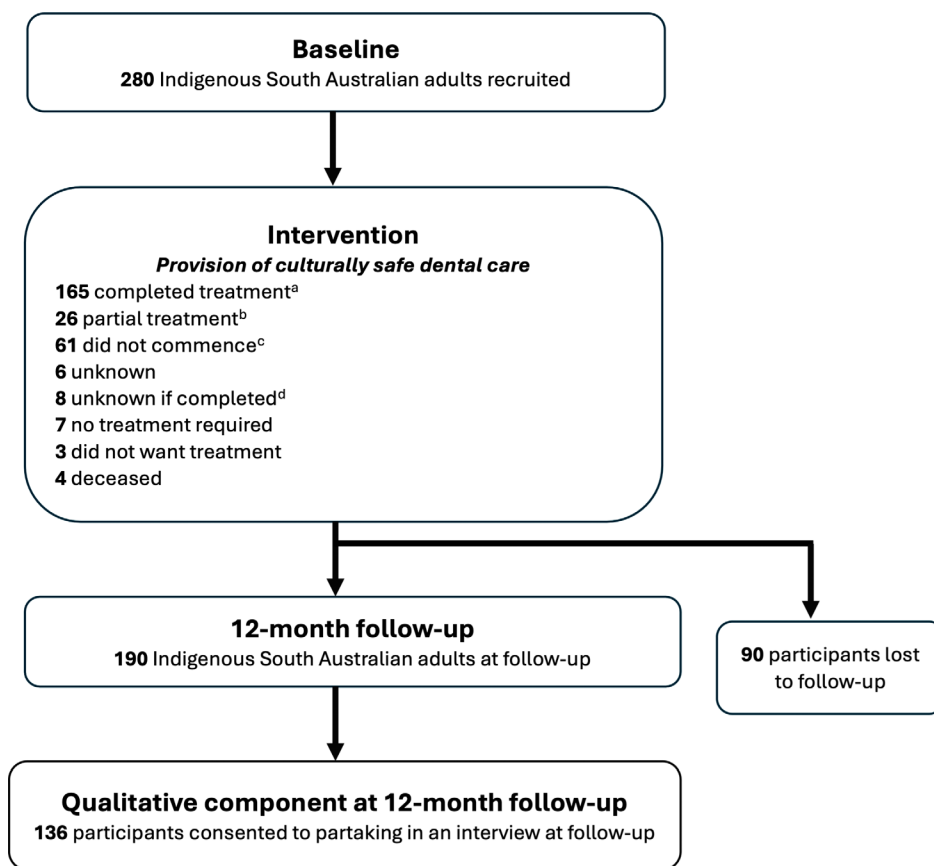


FIGURE 1 | Study flow diagram. ^aTreatment status for private referrals was considered ‘complete’ if participants received all recommended treatment from their initial treatment plan. For those referred to public clinics, ‘complete’ treatment status was determined based on their questionnaire answers or details provided by the referring public clinic. ^b‘Partial treatment’ was assigned to participants who received minimal treatment on their treatment plan in private clinics. For those referred to public clinics, ‘partial’ treatment status was also determined based on their questionnaire answers or details provided by the referring public clinic. ^cParticipants were assigned ‘did not commence’ treatment if they answered ‘no treatment’ in their follow-up questionnaires, if there were no invoices or records of them at private clinics, or if the public clinic noted they had not attended their appointments. ^dFor participants who had received referrals to public clinics and who were lost to contact but had clinic notes on attending some appointments, ‘unknown if completed’ was assigned.

to partake in semi-structured qualitative interviews (Figure 1). This paper adheres to the Standards for Reporting Qualitative Research (Supporting Information).

In the intervention, culturally safe care included: research staff booking participant appointments with dental clinics; taking time to ensure all components of care would be provided in a culturally safe way (in most instances by an Indigenous oral health provider); continuity of care; treatment at no cost; providing dental and health examinations at a location of the participant’s choosing; organising transportation; Indigenous representation and leadership within the research team; oral health promotion; and prioritising trust-building in supporting long-term relationships with communities [20].

Adult participants were eligible to participate if they: (i) were aged 18 years or older; (ii) identified as Aboriginal or Torres Strait Islander; and (iii) resided in South Australia. Participants were recruited via convenience and snowball sampling, with study information disseminated via local Indigenous and non-Indigenous health and community organisations, and social media. The opportunity to provide feedback through a qualitative, semi-structured interview was offered to participants

involved in the 12-month follow-up. Interview duration ranged from 2 to 40 min (average 10 min) and was audio-recorded and transcribed. To support confidentiality, participants were deidentified using randomised identification numbers that do not correspond with a sequential order.

Interviewing authors engaged in cultural safety sessions led by the Senior Aboriginal Research Officer, which included guidance on relational yarning (i.e., respectful connection, knowledge or experience sharing through narrative) and cultural protocols within interviews. Questions asked in interviews related to participants’ experiences with the current project, perceptions regarding their own oral health and wellbeing, and suggestions for culturally safe dental care. As recognition of participants’ time, a shopping voucher and oral health pack was provided to each participant.

2.3 | Analysis

Data were analysed using reflexive thematic analysis [22]—the primary analytic approach used for the qualitative component and associated qualitative publications [13, 18]. Template

thematic analysis was employed in a separate study within this research project (see Nath et al. [21]), but it did not inform the analytic procedures reported here. The six phases of reflexive thematic analysis involved the research team: (i) engaging in data familiarisation through transcription and by repeatedly reading transcripts; (ii) generating codes at the semantic level, with codes relating to participant perceptions around their oral health, well-being and physical health, with the research team highlighting text, indicating codes and noting personal reflections on transcripts in Microsoft Word; (iii) compiling codes for initial theme generation using spreadsheets to organise extracts; (iv) constructing and reviewing themes to ensure they highlighted significant patterns across the dataset; (v) defining and naming themes; and (vi) bringing together the analytic narrative [22]. Methodological rigour and trustworthiness were ensured through: selecting data generation and analytic approaches that meaningfully cohered with the qualitative paradigm; thick description of participant accounts; and multivocality, whereby the overarching project centred multiple and diverse voices and perspectives (Indigenous governance, Elders, community leaders, service partners, researchers) [23].

2.4 | Ethics and Governance

Ethics approval was granted by the Aboriginal Health Research Ethics Committee and the Adelaide University Human Research Ethics Committee (approval number for both committees: 04-22-990).

This study was conceived as a mixed-methods, non-randomised implementation and service-delivery project evaluating provision of culturally safe dental care. Prospective registration in a clinical trials registry was not required by the ethics committees and trial registration was not raised as a mandatory condition of approval during ethics review. In line with current best-practice expectations and at the Journal's request that all prospective intervention studies be registered, the study was retrospectively registered with the Australian New Zealand Clinical Trials Registry (registration number: ACTRN12626000046303). The lack of prior prospective registration is acknowledged as a limitation. Steps taken to ensure transparency within the research include publication of the full protocol before recruitment, dual Indigenous and institutional ethics approvals, and commitment to publish study findings irrespective of outcome. The trial was completed in March of 2025 with some findings published [13, 18, 19, 21, 24]. Further publications are in preparation, including an analysis of study implementation, and qualitative analyses of participant experiences in relation to dental service sectors, dental prosthetics, promoting child oral health, and diet and oral health.

Study oversight was provided by an Indigenous Oral Health Unit Reference Group offering guidance across project dimensions, including staff recruitment, participant engagement, data collection protocols, analytical processes and community feedback mechanisms. The research praxis was guided by the Consolidated Criteria for Strengthening Reporting of Health Research Involving Indigenous Peoples [25] ([Supporting Information](#)).

3 | Results

The qualitative component involved participation of 136 adults (80 female, 56 male; see Table 1) in semi-structured interviews. Gender (i.e., reflective of identity, psychosocial and/or cultural factors), age and location were self-reported.

Five themes were developed from the data. The first three relate to how oral health influences social and emotional well-being for Indigenous South Australians. The final two describe the impacts of providing culturally safe dental care on Indigenous South Australians' social and emotional well-being.

3.1 | Theme 1: 'The Mouth is Your Gateway to the Body'—Good Oral Health Is Important for Overall Health

Participants acknowledged the connection between oral health and overall health, describing the importance of looking after the mouth in promoting wellbeing and preventing disease: 'And you know there's links between [oral health] and wellbeing how they impact each other, so the mouth is your gateway to your body right? You've gotta look after it' (Participant 292).

Some participants were made aware of the significance of oral and broader health from personal experiences and interactions with general health services. Cardiovascular health was a pertinent concern in relation to monitoring oral health:

I've got a young son and he's got a heart problem...one of the things that the doctor kept reminding him was his teeth, 'Always get your teeth checked, always brush your teeth, which can affect your heart'... I think your teeth are right up there [in importance]...So if you're not looking after your teeth, it's not like you're looking after your whole body.

(Participant 195)

TABLE 1 | Demographic information for qualitative interview participants.

Characteristics	Number (percentage)
Total number of participants	136 (100%)
Gender	
Female	80 (58.8%)
Male	56 (41.2%)
Location at time of interview	
Metropolitan and inner regional	117 (86.0%)
Outer regional, remote and very remote	19 (14.0%)
Age group (years)	
< 30	30 (22.1%)
31–45	38 (27.9%)
46–60	45 (33.1%)
> 60	23 (16.9%)

Participants also spoke to the need for timely access to dental care, particularly for Indigenous communities who may be at higher risk for certain health concerns:

...’cause we obviously have a high stake—high risk of getting chronic diseases, diabetes, heart disease, RSV—dental care should be made a lot more available on a quicker aspect for us because we are at risk, our ancestors were at risk, our kids are at risk because it’s in the genes.

(Participant 438)

Overall, participants shared holistic views around oral health that were strongly linked to broader health. When considering oral health among Indigenous South Australians, this theme emphasises the importance of connection to the ‘body and behaviours’ domain of social and emotional well-being.

3.2 | Theme 2: ‘Deadly Inside and Outside’—Aesthetic and Functional Impacts of Oral Health on Social and Emotional Well-Being

Participants highlighted that the appearance of their teeth, gums and smile were important in terms of feeling confident or feeling shame: ‘...it affects the person’s emotion, affects everything. Vanity, ego. You name it. You’ve got bad teeth, you don’t look deadly. Good teeth, you’re deadly inside and outside... It has the impact greatly on social and emotional wellbeing big time’ (Participant 96).

Having ‘good’ teeth was perceived as having teeth that were typically white in appearance, with no malalignment, and none visibly missing. Some participants felt cultural implications around the social norm of having a ‘clean’ or ‘white’ smile:

...from a cultural sense, when I go places where I know I’ll be interacting with mob and things, I don’t feel judged by them but I feel self-conscious in myself...I want to put like, my best self forward and I don’t always feel like I can do that.

(Participant 349)

Participants reinforced that ensuring optimal oral health was also important from a functional perspective (e.g., chewing, speaking):

...I think it’s really important and I think appearance-wise, but I also think practical-wise too in terms of being able to chew your food and your diet and things, what you can eat, how you can eat, all that sort of stuff as well.

(Participant 206)

For participants, the health of the teeth and gums were interlinked with the appearance of teeth and gums, and both worked to influence social and emotional well-being, specifically, the three domains of ‘mind and emotions’ (self-confidence), ‘culture’ (pride and belonging) and ‘community’ (social inclusion, relationships).

3.3 | Theme 3: Judgement and Discrimination Based on the Appearance of Teeth

Participants shared experiencing judgement or discrimination in social situations due to the appearance of their teeth. This had implications regarding confidence and how people felt in relation to opportunities such as employment or relationships:

Talking about some of these kind of social and emotional well-being issues that are related to dental health...if you don’t feel confident in kind of what you’re presenting to the world, you might feel like you don’t really have the kind of socioeconomic opportunities other people have, people with that nice clean, white smile.

(Participant 476)

Some felt embarrassed to visit a dentist for fears they would experience judgement by practitioners, while also feeling self-conscious when interacting with others:

I hate anybody seeing my teeth, so I’m embarrassed to go [to the dentist]...[teeth] always been higgledy-piggledy and sticky out and growing all different directions...I’ve learned to smile with my mouth closed. I’m aware when I talk people will see that I’ve got hardly any teeth down the bottom.

(Participant 400)

Participants also recognised that overall health was intertwined with these experiences:

Not only can [oral health] impact you socially because you might not want to be seen and people seeing your teeth and mouth or bad breath or judgement like that but also, what it can do if you do have like abscesses like things that can go into your bloodstream and affect your heart.

(Participant 9)

Participants perceived that if their teeth did not conform to social norms, they could anticipate or experience judgement from others, with impacts to the social and emotional well-being domain of ‘mind and emotions’. Participants re-emphasised that social and physical impacts of oral health were intrinsically linked, recognising that while some may feel embarrassed or experience judgement (i.e., social aspects), issues such as abscesses (i.e., physical aspects) were also of concern, affecting the ‘body and behaviours’ domain of well-being.

3.4 | Theme 4: Access to Culturally Safe Dental Care Promotes Confidence and Breaks the ‘Shameless Cycle’

Some participants who felt shame around their oral health felt they could not access dental care. Among Indigenous communities, ‘shame’ is a widely known concept. Indigenous understandings of shame are often referred to as a noun (i.e.,

‘shame-job’). People may feel shame in instances of being singled out, receiving praise or attention, or fearing disapproval from a perceived wrongdoing (see Harkins [26]). While it may feel like a shame-job to access oral healthcare, participants spoke of the benefits of culturally safe dental care in supporting well-being:

So you've got to see the value even though it might be kind of like shame-job to reach out, get somebody to start looking at your teeth and start working towards a healthier mouth...the end result of that is so impactful positively that I think good teeth changes your life.

(Participant 69)

Feeling shame in accessing dental care and with oral health can manifest as a ‘shameless cycle’. Culturally safe care would better support community health and ‘break’ this cycle:

I think it's [dental care intervention] really good, definitely for our people, people can tend to feel shame sort of thing and it can break the cycle of the shameless... breaking the shameless cycle it's really good...make it more culturally appropriate, that's what we need out there for our people.

(Participant 49)

Confidence was also a key outcome of providing culturally safe dental care: ‘I think this is a very important project because not only does it build self-esteem and confidence and your perception of yourself, but when you're feeling good, your family feels good around you...I can smile now’ (Participant 375). This had clear impacts on the social and emotional well-being domains of ‘body and behaviours’, ‘mind and emotions’ and ‘community’.

3.5 | Theme 5: ‘Closing the Gap’—Empowering Mob Through Oral Healthcare and Health Assessments

The current intervention included health assessments to ensure a holistic focus on oral health. A service which focuses on managing oral health and assessing health markers for further referral and specialised management was described as an important step in ‘closing the gap’ in Indigenous health inequities: ‘I can see it's made a difference to my health and wellbeing and longevity if we're looking at closing the gap’ (Participant 280). Another participant similarly noted how this approach supported Indigenous well-being: ‘...because I don't know if other blackfellas have told you this as well, it makes them feel good that they know what's happening with their teeth and their body’ (Participant 197).

All participants were provided with their health assessment results from baseline and 12-month follow-up and were encouraged to discuss results with their health practitioner, especially for those who had higher readings potentially requiring further screening:

...my inflammation was up and so like the last time it was under five and then this time it was up at fifty...I do have a doctor's appointment today because [research staff] said just take [results from assessment] in to your doctors...I will get all of that checked out.

(Participant 406)

Connecting with Indigenous communities and providing holistic care involving oral health examinations, assessments for systemic health biomarkers, and overall health promotion was described by one participant as: ‘...really interesting to know because I've got a family history of diabetes, kidneys, and heart, so it was really very refreshing’ (Participant 197). Participants therefore highlighted the importance of this study in empowering mob and ‘closing the gap’ in oral and systemic health inequities and described positive outcomes for the social and emotional wellbeing domains of ‘body and behaviours’, ‘mind and emotions’, ‘family and kinship’, ‘community’ and ‘culture’.

4 | Discussion

Research centring lived experience Indigenous perspectives regarding oral health in relation to well-being is limited, as is research considering how culturally safe dental care may support social and emotional well-being. To our knowledge, this study is one of the first to address gaps in understanding perceptions around oral health and general health while considering impacts on social and emotional well-being for Indigenous South Australians.

A key finding was the importance participants placed on the mouth overall and its connection to the body in relation to chronic diseases, reflecting findings from a previous qualitative study with Indigenous Australian adults [27]. Participants also described social and physical implications related to oral health—specifically, that having a healthy mouth supports self-confidence, appearance and broader health. Discoloured, missing or broken teeth were seen as having a significant negative impact on social and emotional well-being, mirroring previous research [27]. Participants regarded optimal oral health—that is, the teeth and mouth free from disease or pain—as essential in supporting functional aspects such as eating, chewing and consuming nutritious food [27, 28].

Another key finding was the hesitancy described by participants in accessing dental services, fearing they would experience judgement by practitioners regarding the condition of their oral health or how well they looked after their teeth, and feeling shame about oral health. These fears and experiences further hindered access to services already considered inaccessible due to existing structural barriers such as cost, distance, waiting times and experiences of racism [29, 30]. Shame has been identified as a common barrier experienced by Indigenous Australian adults in accessing oral healthcare in a previous systematic review [30]. This was similar in terms of judgement (anticipated or actual) from dental practitioners, as well as from the public, with impacts to confidence and wellbeing in social interactions (e.g., smiling, talking [28, 31]). Shame and fear of judgement

around oral health status further indicate systemic issues and failure on the part of health services to consider cultural safety in supporting patients' health [32].

4.1 | Practice-Based Recommendations

Of importance, outreach approaches and connecting with communities were highlighted as key in reducing shame; for example, at-home oral epidemiological examinations and health assessments that the intervention provided were valued by participants. This model of care was described as supportive and destigmatising in instances where people had past negative experiences with healthcare, by providing a safe space for people to share concerns. Indigenous health workers employed by dental services may further reduce shame through the provision of basic dental care and as cultural brokers between Indigenous Australian patients and non-Indigenous practitioners [31–33].

Participants favoured the inclusion of health assessments alongside oral healthcare, supporting awareness around links between oral and overall health, and empowering communities to identify opportunities to further support their health moving forward [27]. Although many participants were aware of the connection between oral and systemic health, they noted that some community members may not be and would benefit from supportive health promotion and education—currently lacking within many health services. This may be achieved through harnessing outreach in connecting with Elders and community leaders regarding locally owned ways of promoting community oral health and regularly yarning with communities to ensure they receive personalised care to support their health.

Findings also suggest a need for oral healthcare to be considered within primary healthcare, given the importance of oral health to general health, particularly for Indigenous Australians and in supporting their social and emotional well-being. Integration of oral health support alongside chronic disease assessment and within primary health services may be achieved through interdisciplinary collaboration, where training in oral health promotion is provided to healthcare workers (e.g., diabetes nurse educators). Employing Indigenous health workers with oral health training and employing dental community health representatives may also bridge the gap between the dental and primary health sectors [33]. These changes can better support chronic disease screening and management to reduce health disparities and other barriers to accessing healthcare among Indigenous Australian communities.

4.2 | Limitations

This study highlights lived-experience perspectives of Indigenous Australian adults residing in South Australia from a diverse range of Nations and communities. The voices of those residing in other states and territories were not explored, which is a limitation of this study, given potential variation in the healthcare and cultural contexts for Indigenous Australians in other regions. Additionally, we did not explore the perceptions of oral health practitioners and Indigenous health workers. The

study provided broad insight into Indigenous perceptions surrounding oral health and social and emotional well-being, but a limitation was that we did not explicitly explore the social and emotional well-being experiences of participants specifically diagnosed with chronic health issues that have known links with oral health (e.g., people living with diabetes or chronic kidney disease).

5 | Conclusion

A holistic view of health shapes Indigenous South Australians' understandings around oral health, such that oral and general health have an influence on social and emotional well-being. Judgement and discrimination based on the appearance of teeth and aesthetic or functional impacts of oral health were found to impact social and emotional well-being greatly—specifically, feelings of confidence and shame. Further research is required to explore Indigenous health workers' and oral health practitioners' experiences to understand any systems-level impacts influencing the provision of systemic health assessments alongside oral health care. In supporting oral and general health and, in turn, promoting well-being for Indigenous Australians, primary health care must prioritise provision of culturally safe care which considers outreach approaches, integration of systemic health assessments alongside oral healthcare and oral health promotion to empower communities, minimise shame and improve health outcomes.

Author Contributions

Ria Aiyar: methodology, formal analysis, investigation, writing – original draft, writing – review and editing, project administration. **Sonia Nath:** methodology, formal analysis, investigation, writing – review and editing, supervision, project administration. **Joanne Hedges:** conceptualisation, formal analysis, investigation, resources, writing – review and editing, supervision. **Gina L. Guzzo:** methodology, formal analysis, investigation, writing – review and editing, supervision, project administration. **Kostas Kapellas:** methodology, formal analysis, investigation, writing – review and editing, supervision, project administration. **Alexander Pham:** formal analysis, investigation, writing – review and editing. **Emma Flanagan:** formal analysis, investigation, resources, writing – review and editing. **Tiyanna-Marie Mastrovas:** formal analysis, investigation, resources, writing – review and editing. **Ebony Wallace:** formal analysis, investigation, resources, writing – review and editing. **Lisa M. Jamieson:** conceptualisation, methodology, formal analysis, investigation, writing – review and editing, supervision, funding acquisition.

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Disclosure

Not commissioned; externally peer reviewed.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The de-identified data analysed in this study are not publicly available due to privacy and ethical considerations.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** Standards for reporting qualitative research (SRQR) and CONSIDER statement.