

NSW ABORIGINAL SEXUAL HEALTH RESOURCE

Cultural Respect & Communication Guide

A resource to assist sexual health service delivery
to Aboriginal communities





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Overview

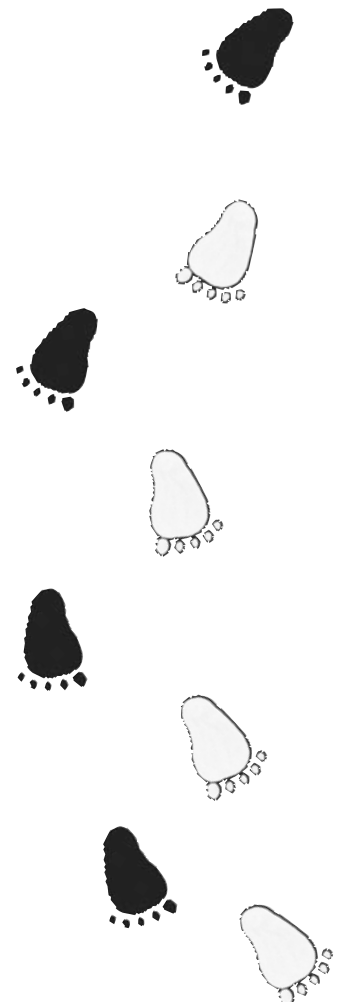
This guide aims to provide a resource for health professionals to gain a better understanding and knowledge of Aboriginal communities, how to work together with communities and how to provide culturally appropriate sexual health services for individuals and communities.

Sexual health is a pertinent issue for Aboriginal communities due to the high number of sexually transmitted infections (STIs) present and the complexities of providing sexual health services to these communities.

In terms of sexual health, there are many barriers that prevent Aboriginal people accessing services. This guide identifies and highlights some of the barriers while also providing some suggestions for change and improvement.

The guide also examines the importance of cultural respect, community engagement and appropriate communication for service providers in achieving and improving sexual health outcomes for Aboriginal people in NSW.

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Introduction

Trace the history of Aboriginal people in Australia and you will find it is full of injustice, discrimination and persecution. This turbulent experience is clearly evident through documentation of the invasion by white settlers and their introduction of new diseases.

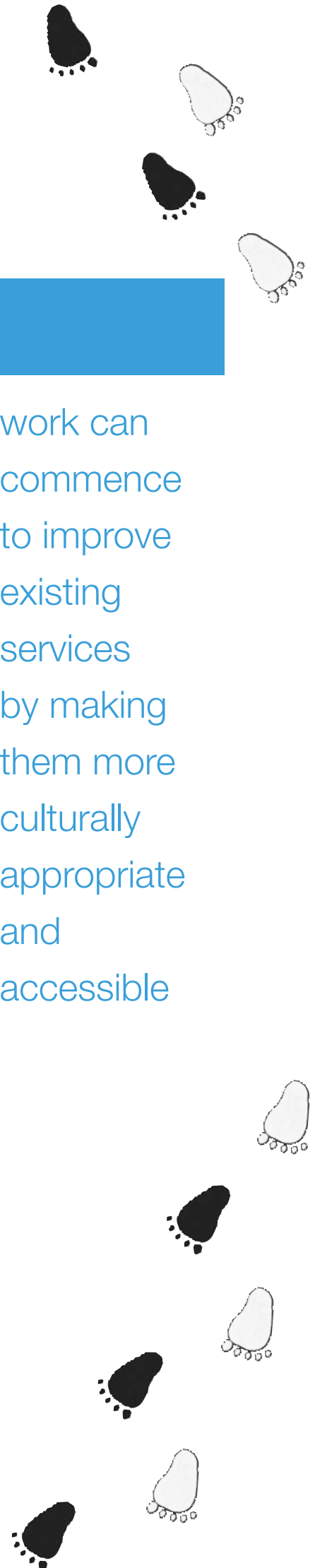
While the situation may have improved, it remains complex. Aboriginal people were given the right to vote in 1967 and this overdue legislation proved to be a turning-point in government policies and the overall approach of government to Aboriginal people. Since this point several policies have slowly been and continue to be put into place, in order to improve the way Aboriginal people are treated and enhance outcomes for Aboriginal people.

Despite the initiatives and policies that have emerged over the years, Aboriginal people are often victims of discrimination and disadvantage. Numerous inequities between Aboriginal and non-Aboriginal people can be identified through socio-economic factors such as lower incomes, poorer education, higher rates of unemployment, higher levels of isolation and shorter life expectancy than their non-Aboriginal counterparts¹.

In relation to health, Aboriginal people also fare worse than non-Aboriginal people. Research data has shown that Aboriginal people have higher comparative rates of general health concerns and chronic conditions which are all serious issues and are being addressed at state and national levels².

A further important area of Aboriginal health that continues to evoke alarm, and is the focus of this resource, is that of sexual health. Data obtained over recent years show higher rates of STIs & BBIs in Aboriginal populations. These include HIV, chlamydia, gonorrhoea, syphilis and HCV in comparison to the non-Aboriginal population³. In some cases, rates are three to four times higher than those identified in non-Aboriginal populations. However, due to the under-reporting of STIs & BBIs and other compounding issues pertaining to data collection, these rates may in fact be much higher. Therefore, Aboriginal people are now

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identified as a priority population in both national and state STI strategies and policies.

Sexual health is a complex area and can encompass a number of different aspects. It is often overlooked when discussing general health concerns and is often considered *embarrassing* or *shameful* for Aboriginal people. These associations, e.g. shame, result in people being reluctant to seek help for sexual health concerns. While this is also true for the non-Aboriginal population, the situation is compounded for Aboriginal populations due to additional barriers that are encountered.



These, whether they be physical barriers such as location and appearance, or perceived barriers such as service delivery approaches and communication styles/abilities, greatly affect Aboriginal people's access to sexual health services. The barriers also affect willingness or ability to access general health services to discuss sexual health matters. Access to these services and information is crucial if the issue of Aboriginal sexual health is to be brought to the forefront in order to be adequately addressed.



For health service providers, whether it be in a sexual health service or a more general health service such as a GP surgery, the first step in improving the situation is to identify the existing barriers which place limitations on Aboriginal people accessing services. Once the barriers and the reasons behind them have been identified and understood, practical steps can be taken to overcome or lessen the barriers and hence, improve access and correspondingly health outcomes. Practical ideas can be incorporated into service delivery regardless of how big or small the service or practice is. However, to aid in this process, a knowledge and understanding of Aboriginal history and overall culture is needed, which in turn involves developing a sense of cultural respect and sensitivity.



Community engagement, and the establishment of communication and trust, can have a big impact on service development and improvement, and in turn, the perceived accessibility of services. Engaging with the Aboriginal community can be daunting, complex and time-consuming. However, if successful, it provides the opportunity to build relationships of mutual respect and understanding. With these relationships in place, work can commence to improve existing services by making them more culturally appropriate and accessible for Aboriginal people. Engaging the Aboriginal community may also offer possibilities of working with Aboriginal people in ways which may better suit their cultural values and beliefs.



This resource should aid service providers in encouraging Aboriginal people to access services with regard to sexual health matters. Throughout the chapters, some of the barriers that impact on access are identified, practical solutions which can be employed to lessen or eliminate some of these barriers are provided, and the importance of community engagement, cultural respect and communication are emphasised. When looking at community engagement and the possibilities it holds in terms of service provision, suggestions and possible steps on how to engage Aboriginal communities are also included. With these suggestions on board, hopefully accessibility of services by Aboriginal people with sexual health concerns will increase, and with further education, cultural respect and communication, STI/BBI rates will decrease. It is further hoped that this will enable overall better health for Aboriginal people, eventually leading the way forward to a situation of equality with that of non-Aboriginal people.





Glossary

For the purpose of this document, the following words mean:

Aboriginal -	a person indigenous to Australia
AIDS -	Acquired immunodeficiency syndrome
Community –	identified group of people living in the same location
Culturally appropriate –	the accepted and traditionally patterned ways of behaving and a set of common understandings shared by members of a group or community. Includes land, language, ways of living and working, artistic expression, relationships and identity.
Elder -	Key person and keepers of various knowledge within Aboriginal communities of a rightful age.
Holistic –	an all-encompassing approach to health delivery. The delivery of more than one health intervention at a time.
Indigenous -	native to a place or area, originating in and characterising a particular region or country.
STIs -	Sexually transmissible infection/s
Torres Strait Islander -	person indigenous to Torres Strait Islands
BBI -	blood borne infections



A note on statistics

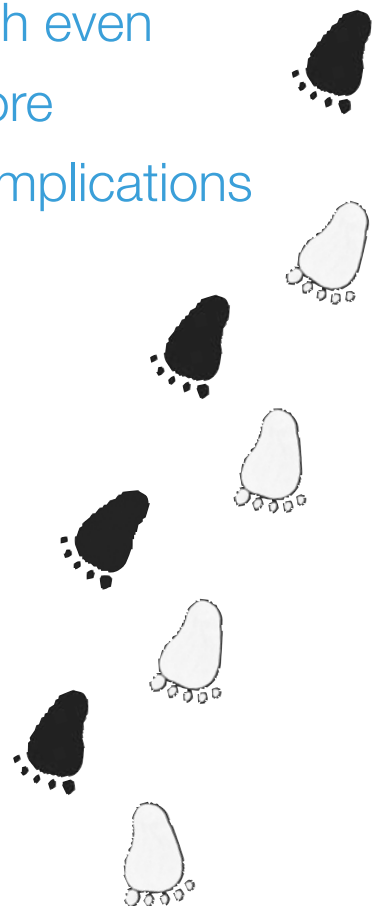
Throughout this resource a number of statistics have been used. These statistics have been utilised to paint a picture of some of the important issues associated with Aboriginal communities within Australia. While these statistics serve their purpose in highlighting issues that need to be taken into consideration, it is also important to remember that the statistics may be subject to various flaws.

Statistics can be unreliable at the best of times and statistics regarding the Aboriginal population are fraught with even more complications. In the past, when data has been sought from the Australian population, identification such as “Aboriginal” or “Torres Strait Islander” was often neglected, making it impossible to gain accurate statistics. This situation is slowly improving as more and more places and statistic-gathering exercises are providing an opportunity for people to identify themselves as Aboriginal persons. However, it is still sometimes overlooked. Even with data that has been collected where identification has been enabled, comparisons between the present situation and the past are complicated

Furthermore, when looking at the statistics, other difficulties come into play. In most cases where figures are being collected, identifying oneself as an Aboriginal person is voluntary. People may choose not to identify themselves as such for fear of persecution or discrimination, or may simply forget to fill out that part of the form. Difficulties can also arise due to the transient characteristic of Aboriginal populations and those that live in rural and isolated areas. Considering these possibilities, it is highly likely that the figures shown in the statistics in areas such as Aboriginal health could be much higher than those recorded.

In summary, it is important to remember that statistics can be very useful to gain impressions and insights into various issues. However, they must be treated with some caution due to their inherent potential flaws.

Statistics can be unreliable at the best of times and statistics regarding the Aboriginal population are fraught with even more complications



how,
why,
where
and
who?



How was this resource developed?

In response to the recommendations made in the *NSW HIV/AIDS, Sexually Transmissible Infections and Hepatitis C Strategies: Implementation Plan For Aboriginal People 2006-2009*, funding was provided to the North Coast Area Health Service from the NSW Department of Health to develop and implement an Aboriginal Sexual Health Cultural Respect and Communications package for NSW.

The project was managed by Jenny Heslop (Area Manager, HIV & Related Programs, North Coast Area Health Service) and Robert Monaghan (NSW Aboriginal Sexual Health Network Development Coordinator), and was coordinated and developed by Anabell Thoener (Project Coordinator, NSW Aboriginal Sexual Health Cultural Respect and Communication Package).

A committee was additionally established to guide the direction of the resource. The advisory committee included:

- Glenda Aubrey (HIV/Sexual Health/Hep C Registered Nurse, Grafton Clinic, North Coast Area Health Service)
- Jenny Heslop (Area Manager, HIV & Related Programs, North Coast Area Health Service)
- Barry Hoskins (Aboriginal Police Liaison, NSW Police)
- Jim Hurley (Senior Health Worker, Galambila Aboriginal Medical Service)
- Robert Monaghan (NSW Aboriginal Sexual Health Network Development Coordinator)
- Larrissa Smyth (Aboriginal Sexual Health Worker, Clinic 145, Tweed Heads)
- Anabell Thoener (Project Coordinator, NSW Aboriginal Sexual Health Cultural Respect and Communication Package)
- Estelle Wade (Aboriginal Sexual Health Worker, North Coast Area Health Service)



Various resources were utilised to inform the guide, including *One Talk (2005)*, *STI & BBI Guide, Early Detection and Treatment of Sexually Transmissible Infections and Blood Borne Infections (2006)*, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*, and *Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance Report 2007*.

Initial consultation workshops were conducted with various stakeholders to establish the content and develop the draft resource. The revised version of the draft was circulated to all members of the workshops and committee prior to further development.

The draft resource was focus-tested at three sites in NSW (Tweed, Kempsey and Armidale) comprising staff from a cross-section of services such as: local general practitioners (GPs), sexual health services, Aboriginal Medical Services, Alcohol & Other Drug Services and Mental Health Services. Feedback received from this process was then collated and incorporated into the final draft prior to forwarding to NSW Department of Health for final approval.

Why was this resource developed?

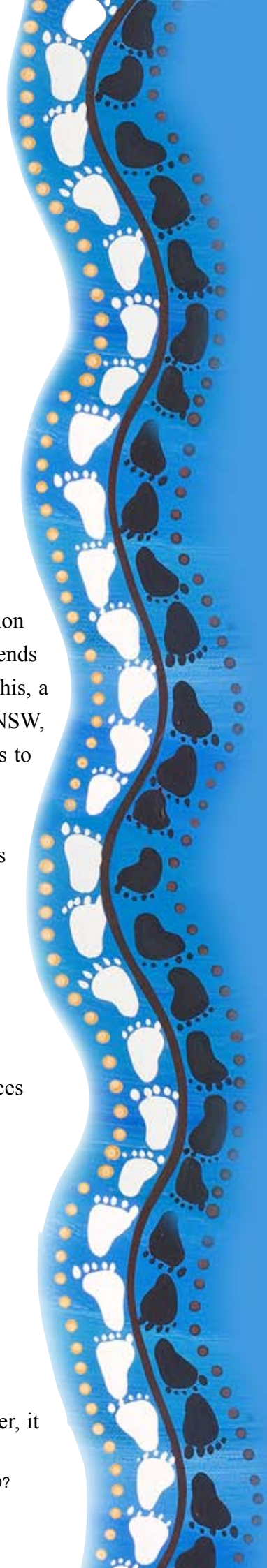
Objectives

There are many documents in circulation about the disadvantage, discrimination and inequity commonly experienced by Aboriginal people. This literature extends to the disparities faced by Aboriginal people within health services. Despite this, a gap in material appears to exist around the areas of Aboriginal sexual health in NSW, particularly in the form of practical guides about increasing Aboriginal access to sexual health services.

In line with this, the key objectives of this resource are to:

- increase Aboriginal cultural awareness, respect and communication skills of the HIV, STI and hepatitis C sectors;
- increase awareness, respect and communication skills of relevant health services (other than AIDS Program-funded services) around HIV, STI and hepatitis C-related issues for Aboriginal people;
- decrease stigma associated with injecting drug use;
- increase awareness of sexuality and related issues within all health services that work with Aboriginal people;
- provide a state-wide resource which is clear, functional and practical, including suggestions for service providers who work with Aboriginal people to gain a greater understanding of the cultural, social, and economic issues which may affect the way that Aboriginal people access services;
- increase the levels of Aboriginal people's access to services, particularly with regard to sexual health issues.

This guide has not been designed to be a prescriptive “law of the land”. Rather, it



aims to provide a deeper insight into some of the barriers and issues involved with Aboriginal people accessing sexual health services and provide some suggestions as to how these barriers can slowly be dismantled.

Aboriginal Population Overview

As of 30th June 2006, there were estimated to be 517,200 Aboriginal people living in Australia, equating to 2.5% of the total Australian population. NSW has the largest number of Aboriginal people of all Australian states and territories, with approximately 148,200 of the Australian Aboriginal population making NSW their home⁴.

The Importance of History

As has been noted in the introduction, the history of Aboriginal people in Australia is one fraught with conflict, discrimination and difficulty. While there has been an increasing recognition of Aboriginal disadvantage over the past 20 years, much of the disadvantage remains today⁵.

For service providers, in order to develop a better understanding and provide appropriate services to Aboriginal people, it is important to have a greater understanding and knowledge of Aboriginal history and its context. This understanding will lead to a deeper insight into Aboriginal culture and way of life. It is furthermore important to recognise and acknowledge the difficulties that may have been faced along with the continued discrimination, and how this may affect the current situation.

It is undeniable that history affects the present and future. For Aboriginal people, history and, for example, bad experiences with authority, may affect the way that Aboriginal people perceive or interact with authority figures in a given situation. This may act as a complex barrier to Aboriginal people accessing services and is discussed in more detail in the following chapter.

Some Important Dates in Aboriginal History

1700-1860

- Beginning of the occupation of Australia by the British, with immediate Aboriginal resistance.
- Settlers authorised to shoot Aboriginals.
- Pinjarra Massacre (1834), Myall Creek Massacre (1838), Slaughter House Massacre (1838), Fighting Hills Massacre (1840), Jaburra Massacre (1868).
- Floggings and sexual abuse of Aboriginals common.



1860-1900

- First Aboriginal missions created.
- Aborigines Protection Board established, forcing all Aboriginals onto “missions” or “reserves”.
- Beginning of cultural genocide. Traditional lifestyles are destroyed through institutions such as mission-controlled schools.



1900-1960

- Federation.
- Aboriginal populations are not included in the constitution.
- Due to a decline in health and increase in poverty, many believe the Aboriginal population will die out.
- Protectionist policies are introduced by the government.
- An assimilation policy is adopted by the Australian government.
- Aboriginal children are forcibly removed from their families.



1960-1970

- Assimilation policy abandoned for a Policy of Integration.
- Aboriginal people are given the right to vote (1967)



1970-1990

- Tent Embassy is established (1972)
- Aboriginal Land Right Act passed.
- Royal Commission into Aboriginal deaths (1987). There had been 99 deaths in custody. Approximately 50% of those victims had been separated from their families as children.



1990-Today

- Council for Aboriginal Reconciliation is established.
- Native Title Act passed.
- ATSIC established (now disbanded).
- National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families.
- National Sorry Day (13 February 2008).



The Current Situation

On all the major indicators such as health, education, income, employment and housing, Aboriginal people remain worse off than non- Aboriginal people

General Facts & Figures

- Aboriginal people are approximately half as likely as non-Aboriginal people to complete Year 12 at school.
- In the 2006 Census, 34% of Aboriginal households were living in dwellings that were owned by a member of the household, which is half the rate of home ownership reported by non-Aboriginal households.
- In 2006, approximately one in every two Aboriginal households were receiving some form of housing assistance.
- In 2006, more than half of Aboriginal households were renting, which is approximately double the rate for non-Aboriginal households.
- As of 30 June 2007, the Aboriginal imprisonment rate was 13 times higher than the non-Aboriginal rate.
- Between 2001 and 2006 the unemployment rate for Aboriginal Australians was more than three times the rate for non-Aboriginal Australians.
- The median weekly income in 2006 of Aboriginal Australians aged over 15 was \$278 per week, compared with \$473 for non-Aboriginal Australians.

Source: Information taken from The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008 pxxx1 – 14)

Why Aboriginal sexual health?

Health in Context

Health is an important issue for all Australians. At a global level, health systems and services in Australia are of a fairly high standard. However, when comparing the health of Aboriginal populations in other countries to Aboriginal people in Australia, a lot more work is needed. The health of the Aboriginal population remains poor in comparison with other Australians⁶. Aboriginal people face continuing vulnerability due to disadvantage in terms of social determinants of health. Poverty, social disadvantage, disempowerment, discrimination and isolation are all factors that have a major impact on the health of Aboriginal people⁷.

Recently a number of initiatives have been implemented to improve Aboriginal health. These include programs such as the Aboriginal Vascular Health Program (2000), the Aboriginal Maternal and Infant Health Strategy (2001) and the NSW Aboriginal Chronic Conditions Area Health Service

Standards (2005), among others⁸. However, there is still a long way to go.

In addition to much poorer general health, the Aboriginal population also has a disproportionately high number of chronic conditions⁹. This may be seen as a direct result of the ongoing liability of social, financial and environmental circumstances. Aboriginal people also tend to present late to services when already unwell, which means that treatment is often reactive instead of preventative, and they do not access services at rates that equate to need¹⁰ as data shows their life expectancy is much lower than that of the non-Aboriginal population.

Some General Health Statistics

- In 2004–05, Aboriginal Australians were twice as likely to self-assess their health as fair or poor compared with other Australians, and twice as likely to report their levels of psychological distress as high or very high.
- In 2005–2006, there were approximately ten times as many hospitalisations of Aboriginal males and eighteen times as many hospitalisations for Aboriginal females for chronic kidney disease than for non-Aboriginal males and females respectively.
- In 2001–2004, the proportion of low birthweight babies being born to Aboriginal mothers was more than double that born to non-Aboriginal mothers.
- The overall mortality rates for Aboriginal people are nearly three times those for non-Aboriginal people.
- In 2001–2005, the suicide rate for Aboriginal males was nearly three times that for non-Aboriginal males.
- In 2004–2005, Aboriginal people were three times as likely as non-Aboriginal people to report having diabetes.
- In 2004–2005, Aboriginal people were nearly twice as likely as non-Aboriginal people to report having some form of respiratory disease.
- Aboriginal life expectancy is estimated to be approximately 17 years lower than that of non-Aboriginal people.

Source: *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*

Aboriginal Sexual Health

Aboriginal sexual health is an area of significant concern. For a number of sexually transmitted infections and blood-borne viruses, higher rates of transmission continue to be recorded among the Aboriginal population than the non-Aboriginal population. This is so much the case that Aboriginal people have been recognised as a priority population in the *National HIV/AIDS Strategy 2005–2008: Revitalising Australia's Response*, the *National Sexually Transmissible Infections (STIs) Strategy 2005–2008*, and the *National Hepatitis C Strategy 2005–2008*. This recognition has also carried over

into state policies such as the *NSW HIV/AIDS Strategy 2006-2009*, and the *NSW Sexually Transmissible Infections 2006-2009* and the *NSW Hepatitis C Strategy 2006-2009*.

Sexual health is often used as an umbrella term encompassing a whole host of issues including HIV/AIDS, other STIs, hepatitis C and concerns around sexuality. It is an important area of health for all Australians that is frequently “*pushed under the carpet*” or neglected due to societal pressures which label the issue of sexual health as *embarrassing*. The stigma associated with sexual health means that people are reluctant to see a doctor about it. Service providers and GPs often avoid asking people about their sexual health. For example, If you go to a GP they might ask if you have a heart condition or any history of diabetes, but they often neglect to ask about any sexual health concerns. When looking at Aboriginal sexual health the issue is even further compounded by cultural values of what can be considered “*men’s*” or “*women’s business*” and “*shame*”. These cultural values can affect Aboriginal people’s willingness to access services for sexual health. A number of additional barriers also arise which impact on Aboriginal people’s accessing services for sexual health issues and these are discussed at length in the second section of this guide.

The high rates of STIs in the Aboriginal population have far-reaching consequences, especially considering the already high levels of chronic diseases and mortality in Aboriginal communities. In order to decrease rates of STIs within the Aboriginal community, much needs to be done. Increasing access to services for Aboriginal people with sexual health concerns is crucial. Without education, care and support, STI rates will continue to rise.

Common STIs & BBIs in Australia – What are they & how are they transmitted?

HIV/AIDS

HIV (Human Immunodeficiency Virus) is a virus that currently has no cure. AIDS (Acquired Immune Deficiency Syndrome) is a late stage of HIV infection that occurs when the immune system is too damaged to fight off infection. Many people with HIV are on treatment to slow down the progress of the virus.

HIV can be transmitted by:

- Vaginal intercourse without a condom
- Anal intercourse without a condom
- Reusing drug-injecting equipment
- An infected mother to her baby during pregnancy, at childbirth, or by breastfeeding
- Oral sex without a condom (rare)
- Fresh blood-contaminated sharp injuries (rare)

NB. Prior to 1985, HIV was also transmitted through blood transfusions.

Chlamydia

Chlamydia is a bacterial infection which can affect the genitals, anus or throat. Chlamydia is cured through a treatment course of antibiotics. If left untreated, chlamydia can lead to conditions such as pelvic inflammatory disease (PID) in women, and epididymitis in men.

Chlamydia can be transmitted by:

- Vaginal or anal sex without a condom
- Oral sex (rare)

Gonorrhoea

Gonorrhoea is a bacterial infection of the genitals, anus or throat. Gonorrhoea is cured through a treatment course of antibiotics. If left untreated, gonorrhoea can lead to conditions such as pelvic inflammatory disease (PID) in women, and epididymitis in men.

Gonorrhoea can be transmitted by:

- Vaginal, anal or oral sex without a condom

Hepatitis B

Hepatitis B is a virus which results in inflammation of the liver. There is a vaccine for hepatitis B and it is part of the National Immunisation Schedule. In theory, every child in Australia should now be vaccinated against hepatitis B.

Hepatitis B can be transmitted by:

- Vaginal, anal or oral sex without a condom
- Sharing needles and syringes
- Childbirth vertical transmission
- Sharing toothbrushes, razors, etc as they may lead to the exchange of bodily fluids such as blood or saliva
- Needlestick injury or non-sterile tattooing equipment

Hepatitis C

Hepatitis C is a blood-borne virus which causes inflammation of the liver. Unlike hepatitis B, there is no vaccine for hepatitis C. Hepatitis C can lead to liver disease such as cirrhosis, liver failure or liver cancer.

Hepatitis C can be transmitted by:

- Blood-to-blood contact such as sharing or reusing of drug-injecting equipment contaminated with infected blood, non-sterile tattooing procedures, needlestick injuries, body piercing, transmission through childbirth, and other blood-to-blood contact such as physical assault.

NB Prior to 1990, transmissions also occurred through blood transfusions.

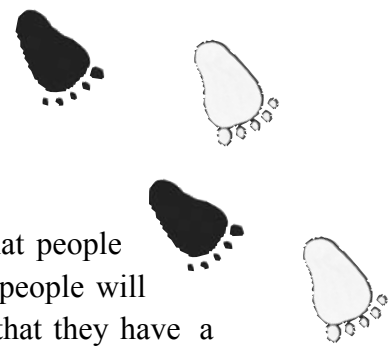
Syphilis

Syphilis is caused by a bacterial infection and can be treated by antibiotics. Syphilis can result in damage to internal organs such as the brain, spinal cord and heart.

Syphilis can be transmitted by:

- Vaginal, anal or oral intercourse without a condom
- Through pregnancy from an infected woman to the foetus

Source: Information taken from Australasian Contact Tracing Guide, ASHM 2006 p 16-39



Common Symptoms of STIs and BBIs

Many STIs and BBIs cause no symptoms, or if they do, they are so minor that people don't recognise them as symptoms. The difficulty with this is that commonly people will only present to a doctor if they are feeling unwell. Often people are unaware that they have a STI as they have no symptoms and therefore are at an increased risk of transmitting the STI to other people.

When symptoms do occur they may include the following:

- Men: discharge, pain on passing urine (dysuria), pain or swelling in the testes
- Women: vaginal discharge, lower abdominal pain, abnormal bleeding, pain with sex (dyspareunia)
- Both: any genital sores, lumps, rashes, itching or pain, rectal bleeding or discharge
- Pregnant women: vaginal discharge, bleeding or pain in early or mid pregnancy (threatened miscarriage), premature rupture of membranes, post-partum pelvic infections.
- Hepatitis: abdominal discomfort, nausea, intolerance to fatty foods or alcohol, dark urine, yellowing of the skin or eyes (jaundice)
- HIV: severe flu-like illness, any infection that looks unusual, is more severe or lasts longer than usual or doesn't respond to usual treatment.

Source: Taken from STI & BBI Guide, Early Detection and Treatment of Sexually Transmissible Infections and Blood Borne Infections, AH&MRC, 2006, pp16-17

Common STIs and BBIs among high-risk groups in Australia

RISK GROUP	STI & BBI
15- to 30-year-olds *	Chlamydia
Anyone who has ever been in a correctional facility	Hepatitis B Hepatitis C
Sharing equipment used to inject drugs, sharing tattooing or body-piercing equipment	Hepatitis B, Hepatitis C HIV
Men who have sex with men (MSM)	Gonorrhoea Chlamydia Syphilis HIV
All the above risk groups	Genital herpes Genital warts

** Other infections including gonorrhoea, syphilis, trichomonas and hepatitis B may also be common. Check local data to determine inclusion of these within early detection and treatment programs.*



There may be other groups at high risk in the community such as:

- People who misuse alcohol or other substances
- Sex workers or people who exchange sex for favours
- Homeless people
- People with poor mental health
- Heterosexuals with recent partner change.

It is important to be familiar with the priority groups in your community and which STIs and BBIS are common among them.

Source: Taken from STI & BBI Guide, Early Detection and Treatment of Sexually Transmissible Infections and Blood Borne Infections, AH&MRC, 2006, p16

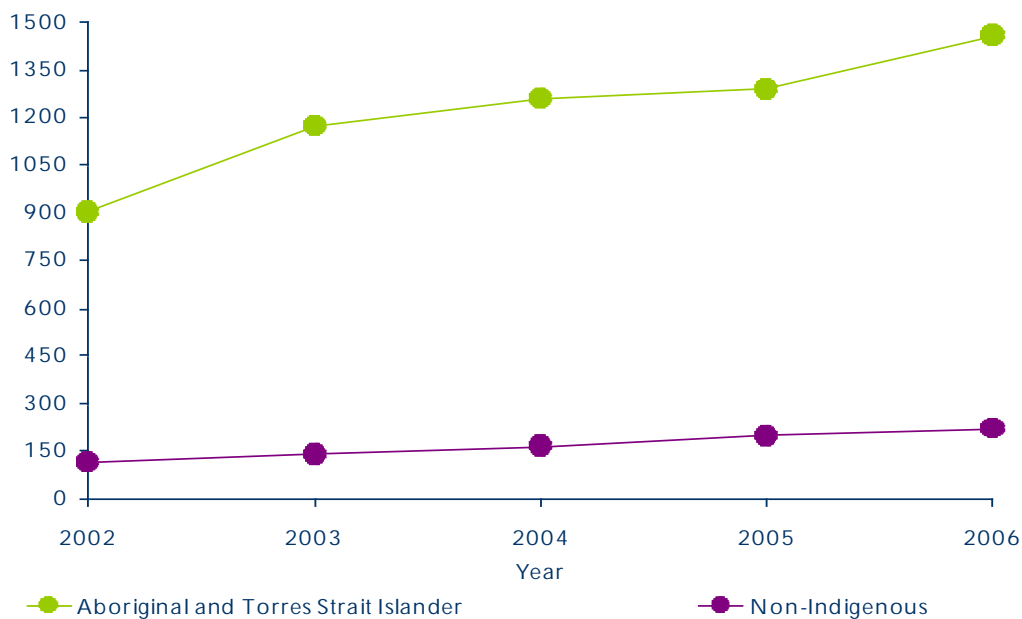
Rates of STIs & BBIs in the Aboriginal Population

Chlamydia

Chlamydia rates in the Aboriginal population are of immense concern. Of all notifiable conditions in Australia, chlamydia is the most frequently reported, and the comparative rates within the Aboriginal population are much higher than those of the non-Aboriginal population.

The graph below demonstrates reported chlamydia incidences in comparison to the non-Aboriginal population over the past few years. In some major cities of those areas, diagnosis rates were almost four times that of non-Aboriginal people, and in the remote regions of those areas, rates are nearly 13 times that of non-Aboriginal people¹¹.

Chlamydia by Aboriginal and Torres Strait Islander status and year.



Source: Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance Report 2007, p12 Jurisdictions in which Aboriginal and Torres Strait Islander status was reported for more than 50% of diagnoses (NT, SA, VIC and WA)

HIV/AIDS

During the period of 1997 -2006 the rates of diagnosis of HIV in the Aboriginal and non-Aboriginal population have been quite similar. However, there are important differences to be noted.

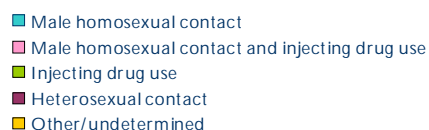
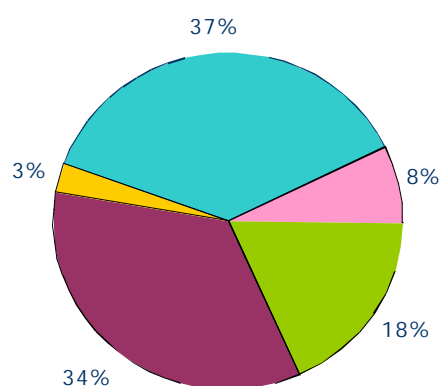
For service providers working with Aboriginal clients around the area of sexual health, it is important to recognise that modes of transmission may differ greatly from those of the non-Aboriginal population.

For example, when looking at HIV, the most common mode of transmission, making up 64% of HIV diagnosis for the non-Aboriginal population, is male homosexual contact. However, in the Aboriginal population, only 37% of diagnosis is attributed to male homosexual contact, and 34% of HIV diagnosis is attributed to male to female contact.

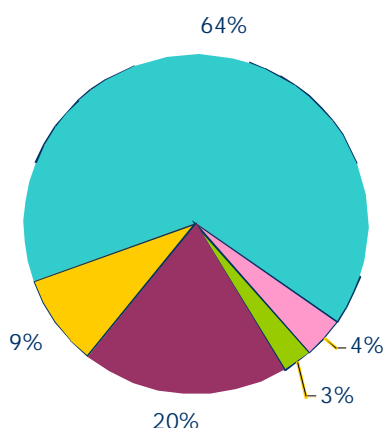
These differences in modes of transmission have the potential to impact greatly on the way in which services and education need to be provided in order to be appropriate and effective.

HIV diagnoses, 2002-2006, by Aboriginal and Torres Strait Islander status and HIV exposure category

Aboriginal and Torres Strait Islander



Non-Aboriginal



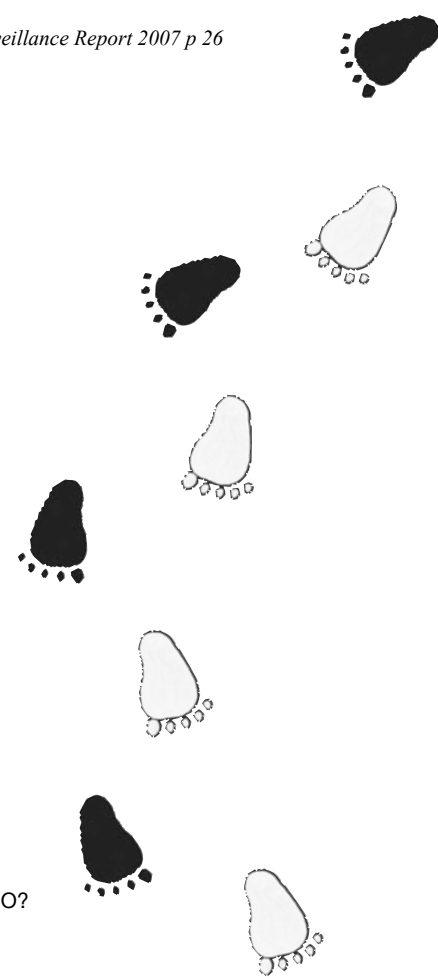
Source: Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance Report 2007 p25

Another point of interest is that while the HIV rates in the Aboriginal population may be quite similar to those reported in the non-Aboriginal population, the diagnosis of AIDS in the Aboriginal population is higher than in the non-Aboriginal population. This may reflect later presentation to services and poorer overall health and again demonstrates the importance of increasing Aboriginal people's access to sexual health services.

AIDS incidence by Aboriginal and Torres Strait Islander status and year



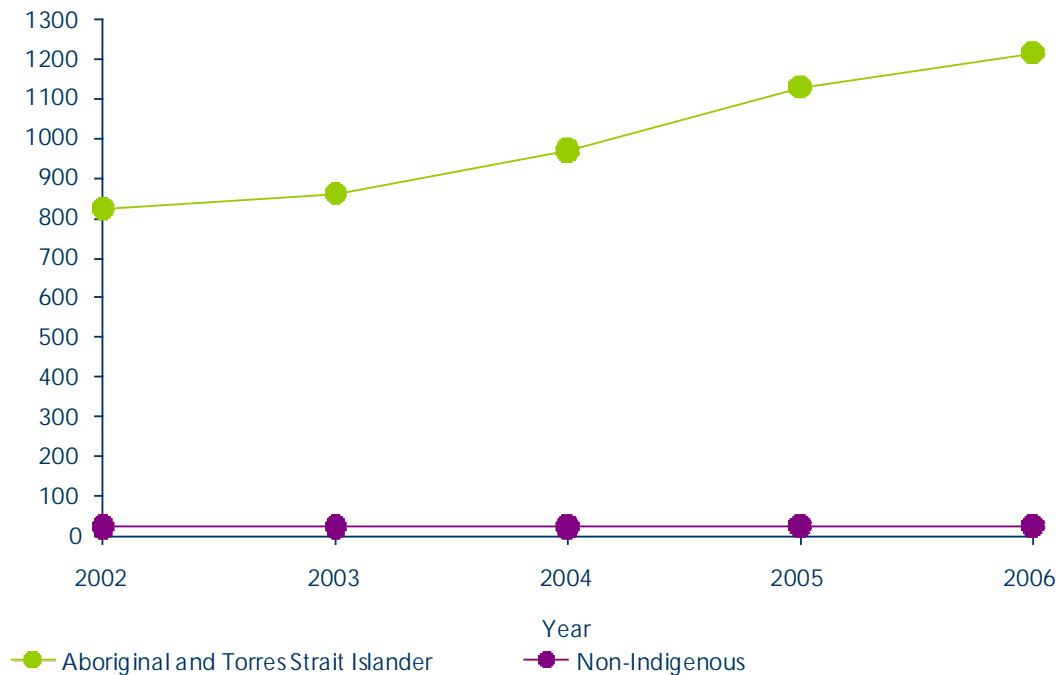
Source: Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance Report 2007 p 26



Gonorrhoea

As demonstrated by the graph below, gonorrhoea rates in the Aboriginal population are at much higher ratios than those exhibited by the non-Aboriginal population and are still increasing. In 2002, diagnosis rates were at 41 times those in the non-Aboriginal population, and by 2006, the rates were 46 times as high. As with HIV, the transmission modes in the Aboriginal population also appear to differ, with the gender ratio suggesting that transmission occurs mainly through heterosexual contact, whereas in the non-Aboriginal population it is believed that male homosexual contact is the main mode of transmission. It is also important to note that in 2006, 77% of diagnosis in the Aboriginal population was from people under 30 years of age, while in the non-Aboriginal population, under-30s only made up 49% of those diagnosed¹².

Gonorrhoea by Aboriginal and Torres Strait Islander status and year

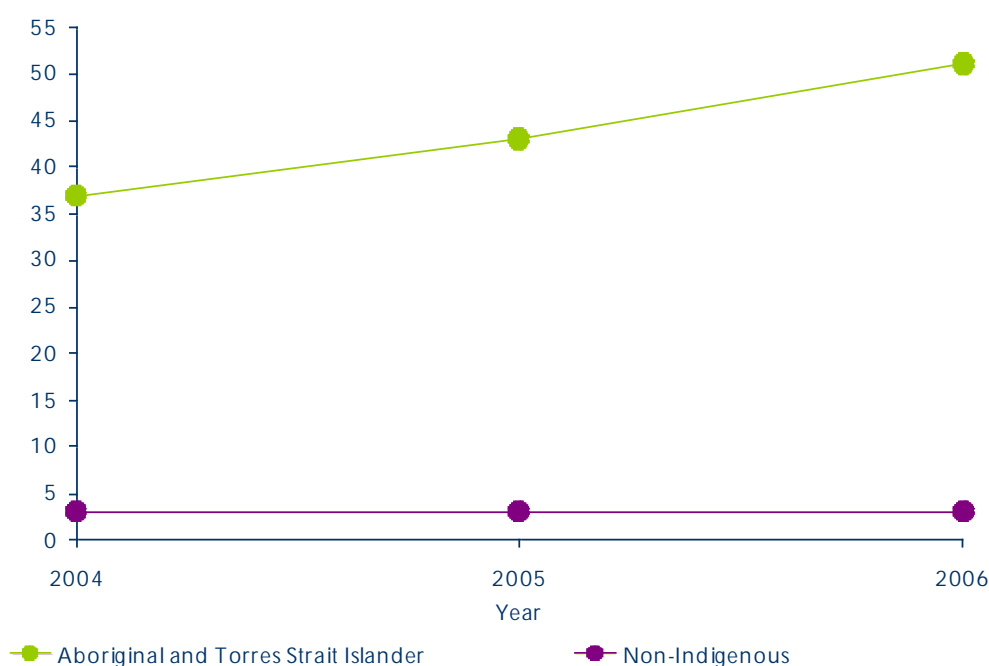


Jurisdictions in which Aboriginal and Torres Strait Islander status was reported for more than 50% of diagnoses (NT, QLD, SA, VIC and WA)
Source: *Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance Report 2007* p16

Syphilis

Syphilis diagnoses were first reported nationally in 2004. During the two-year period graphed below, the diagnosis rate for the Aboriginal population increased from 37 to 51 per 100 000. The rate of diagnosis in the non-Aboriginal population remained stable at 3 per 100 000. 73% of the diagnoses in the non-Aboriginal population in 2006, compared with 22% of diagnoses in the non-Aboriginal population, were among those aged under 30. Again, as noted with many of the STIs in the Aboriginal population, it is believed that transmission occurs mainly through heterosexual contact, whereas in the non-Aboriginal population, the main mode of transmission is through male homosexual contact¹³.

Infectious Syphilis by Aboriginal and Torres Strait Islander status and year



Jurisdictions in which Aboriginal and Torres Strait Islander status was reported for more than 50% of diagnoses (NSW, NT, QLD, SA, VIC and WA)

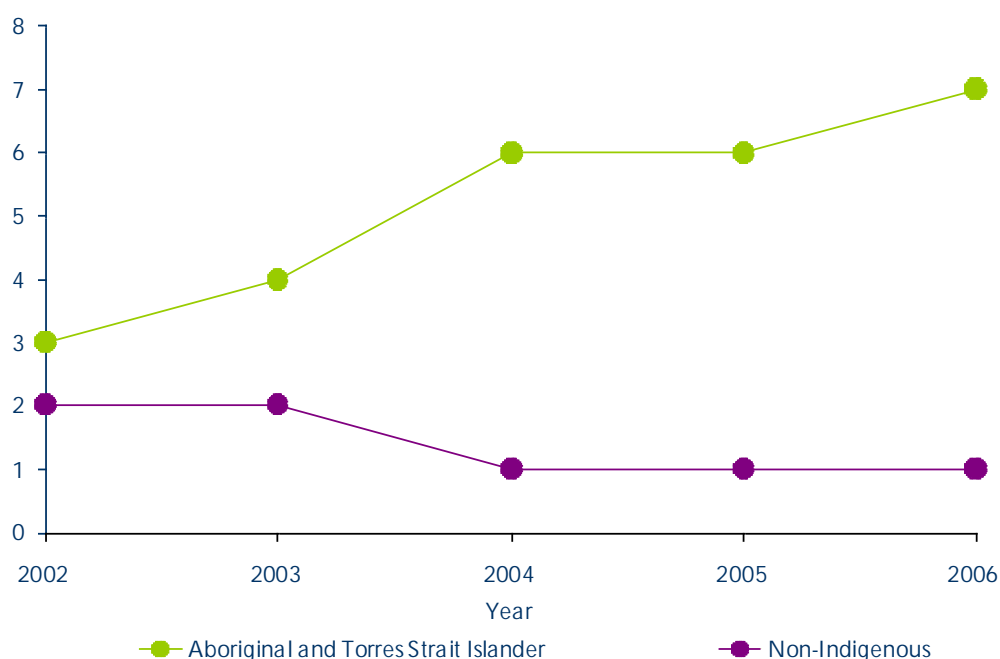
Source: *Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance Report 2007* p20

Hepatitis B

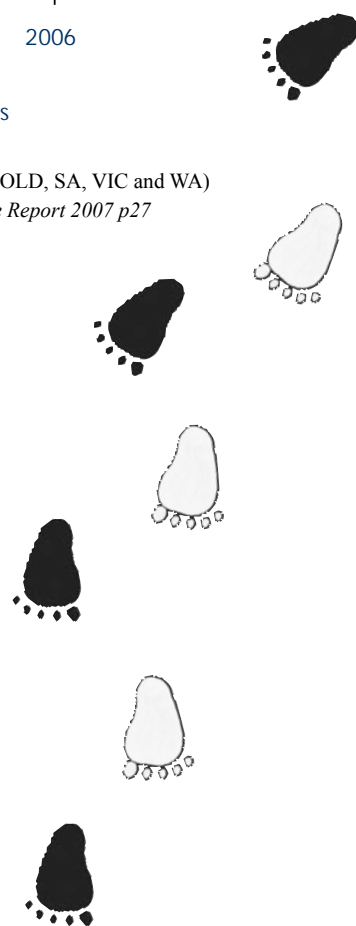
While the rate of hepatitis B infection in Australia is relatively low, it is still an issue that service providers need to be aware of.

Despite the small numbers, diagnosis rates of newly acquired hepatitis B infection have more than doubled in the Aboriginal population over the past five years. In the non-Aboriginal population rates have declined¹⁴. Interestingly, in the Aboriginal population, women between the ages of 30-39 had the highest rates of diagnosis, and even in the 20-29 age group the diagnosis rate for Aboriginal women was 6.6 times the rate recorded for non-Aboriginal women.

Newly acquired hepatitis B infection by Aboriginal and Torres Strait Islander status and year



Jurisdictions in which Aboriginal and Torres Strait Islander status was reported for more than 50% of diagnoses (NSW, NT, QLD, SA, VIC and WA)
Source: *Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance Report 2007* p27



Hepatitis C

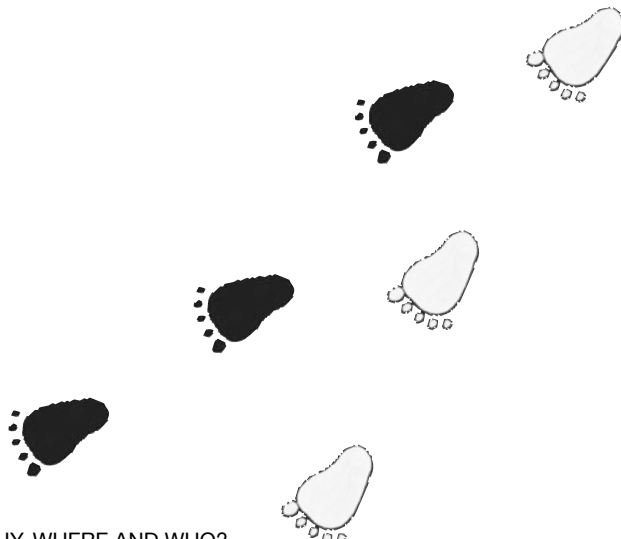
Hepatitis C infection in Aboriginal communities remains of great concern. As can be seen below, rates of newly diagnosed hepatitis C in the Aboriginal population rose from 122 per 100 000 in 2002 to 163 per 100 000 in 2006, while the rate of diagnosis in the non-Aboriginal population remained stable at approximately 52 per 100 000 population. In the age groups of 13-19 and 20-29, the rates of diagnosis in the Aboriginal population were 5 times and 3.3 times higher than those recorded for the non-Aboriginal population¹⁵.

It is also important to recognise that the percentage of infections occurring through injecting drug use in the Aboriginal population has increased, which can also contribute to rises in HIV infection¹⁶.

Hepatitis C by Aboriginal and Torres Strait Islander status and year



Jurisdictions in which Aboriginal and Torres Strait Islander status was reported for more than 50% of diagnoses (NT, SA, and WA)
Source: *Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance Report 2007* p30



Who is this resource targeted at?

This resource is targeted towards health care providers and services within NSW. The term “health care provider” can include members of numerous professions such as:

- GPs
- Nurses
- Aboriginal Sexual Health Workers
- Aboriginal Health Education Workers
- Area Health Service Staff
- Social Workers
- Other Allied Health Staff
- Dentists
- Aboriginal Medical Services
- Justice Health Staff
- Family Planning Services

For the purpose of this guide, the term “health care provider” will be utilised to describe all those who provide health care services to Aboriginal communities, whether they be government, non-government or independent services.

For example:

A new GP relocates to a rural area where there is a large Aboriginal population. This would be the resource to assist the GP in getting their service to respond appropriately to the needs of that community and encourage the community to access services for sexual health education and concerns.



barriers
to service
delivery &
ways to
overcome
them



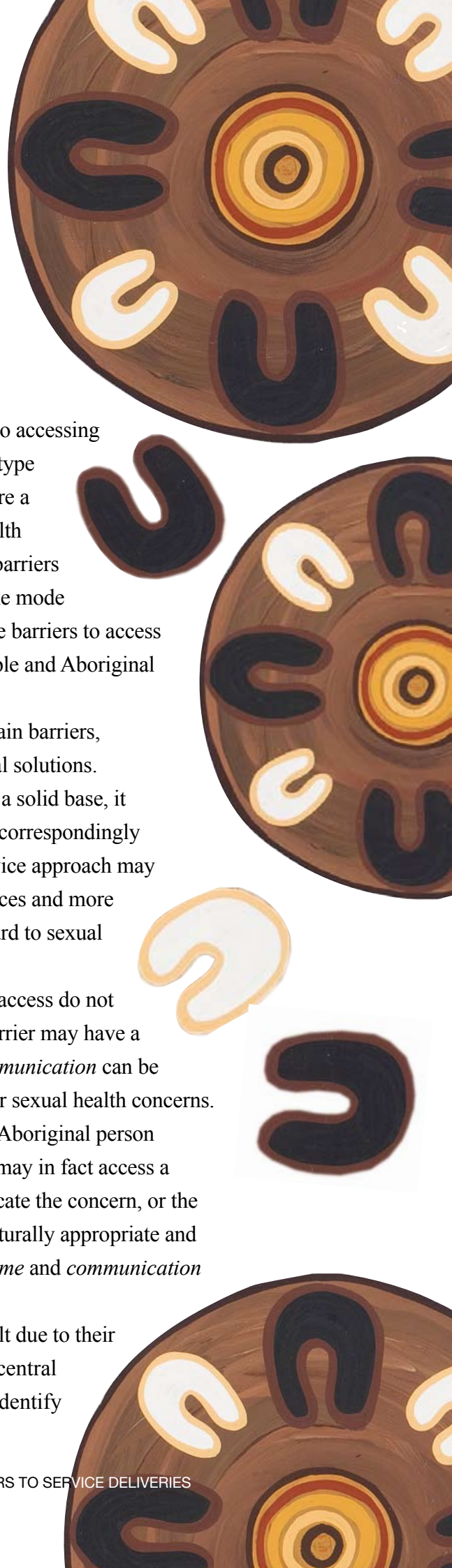
Overview

Aboriginal people often experience a large number of barriers to accessing health services. These barriers can be applied to accessing any type of health service. However, compounding these impediments are a host of further barriers which arise when addressing sexual health and accessing services for sexual health issues. Some of these barriers are structural or practical in nature, while others can relate to the mode of service delivery, socio-economics or cultural aspects¹⁷. These barriers to access and care can greatly affect health outcomes for Aboriginal people and Aboriginal communities.

This section aims to identify and outline some of the main barriers, discuss the issues involved and propose some potential practical solutions. While a knowledge and understanding of these barriers creates a solid base, it is the link between this and behaviour change and action¹⁸ that correspondingly improves approaches to service delivery. These changes in service approach may lead to increased numbers of Aboriginal people accessing services and more responsive and effective service delivery, particularly with regard to sexual health issues.

It is furthermore important to recognise that barriers to access do not exist in isolation. Barriers are intertwined and one identified barrier may have a big impact on other barriers. For instance, both *shame* and *communication* can be identified as barriers to Aboriginal people accessing services for sexual health concerns. *Shame* may act as a barrier in itself, in that shame may stop an Aboriginal person accessing a service altogether. However, an Aboriginal person may in fact access a service but due to shame that person may not clearly communicate the concern, or the service provider may not be skilled in a way that allows for culturally appropriate and respectful communication around shame issues. Therefore, *shame* and *communication* combined stop effective service delivery from taking place.

While the separation of the barriers is extremely difficult due to their overlapping nature, this guide attempts to identify some of the central barriers on paper and create an opportunity for discussion to identify them with more ease.



Intertwined: Some of the Central Barriers to Service Access

Each barrier can affect other barriers.



Cultural Respect

Before investigating some of the central barriers, cultural respect must first be addressed.

A lack of cultural respect can act as an overarching barrier, as without cultural respect it is impossible to overcome any other barriers. Cultural respect can determine the way services present and conduct themselves and as a result can determine the effectiveness of a service. The Australian Health Ministers Advisory Council defines cultural respect as:

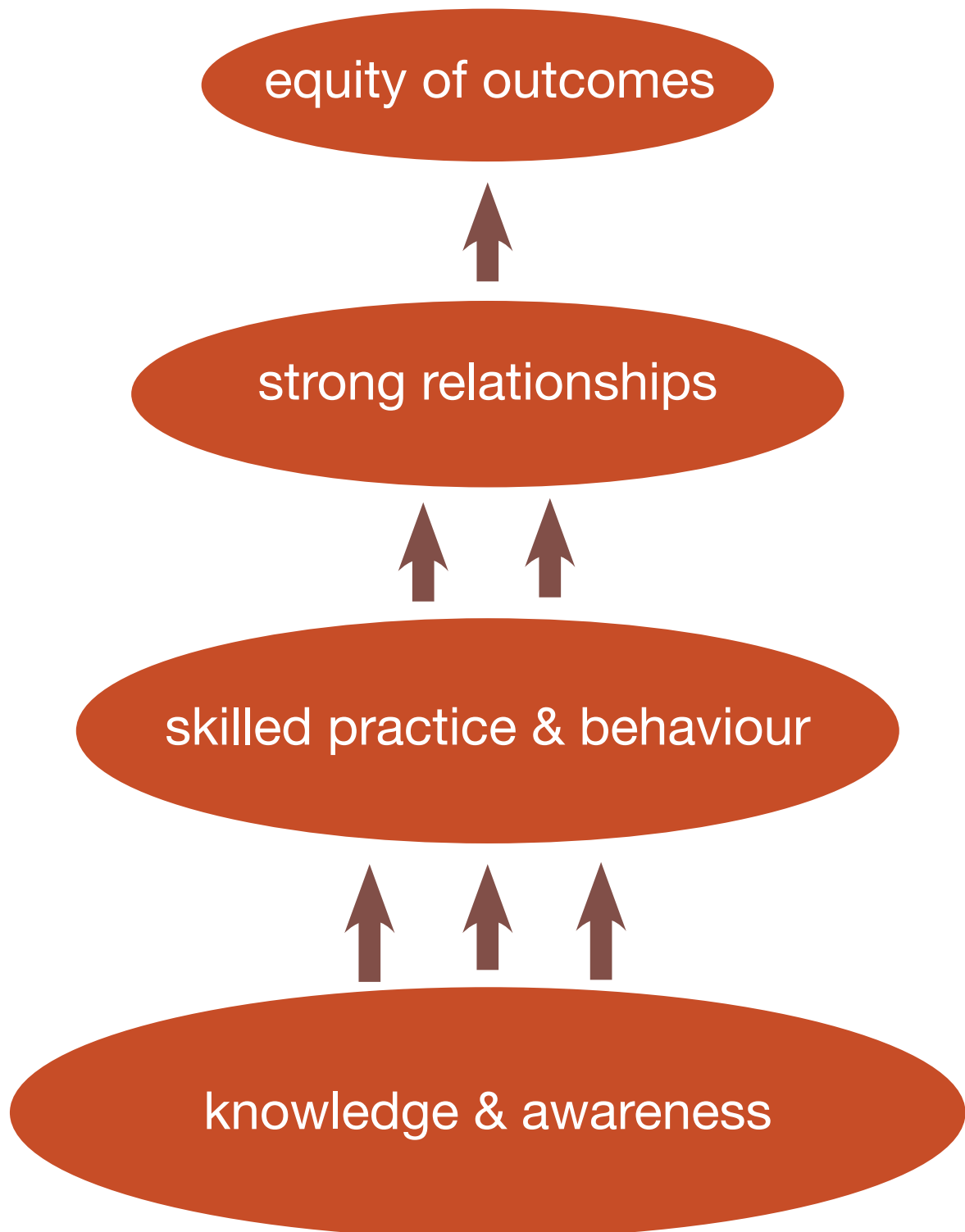
“recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander people achieved when the health system is a safe environment for Aboriginal and Torres Strait Islander people and where cultural differences are respected”¹⁹

When working with Aboriginal communities, it is important to display a certain level of respect and understanding of Aboriginal culture. This does not mean that you have to know everything about Aboriginal languages, belief systems and cultural practices. It is more about being aware that Aboriginal culture differs from non-Aboriginal culture, and that this culture may impact on the way that health and illness is perceived, how Aboriginal people communicate, and which services they are willing to access. It is about being willing to learn and being open to new ideas, beliefs and priorities.

Developing culturally appropriate services means developing culturally responsive services that meet the needs of Aboriginal people. Hanging a piece of Aboriginal artwork in the reception area does not necessarily demonstrate cultural respect or the fact that the services provided are culturally appropriate or responsive. Cultural respect needs to be backed up through all aspects of the service. Having an understanding of Aboriginal history and culture, and how this may impact on how Aboriginal people perceive and utilise services, will provide a grounding to address barriers which affect Aboriginal people accessing services for sexual health, and the effectiveness of the services provided.

Hint: To assist in this, ensure that all staff attend cultural awareness training.

The Dimensions of a Cultural Respect Framework



Source: Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009, Australian Health Ministers' Advisory Council p10

Communication

How you communicate with people, or the effectiveness of a communication between two people, can determine whether or not a person will revisit a service. Due to word of mouth, ineffective communication with one person may lead not only to that one person not attending the service again, but possibly the whole Aboriginal community of that area staying away as well. Clearly, this could have far-reaching consequences in terms of general health and also possible STI transmissions. The use of appropriate communication demonstrates respect for the other party, and if applied effectively, it can put someone at ease in what may be an embarrassing and uncomfortable situation.

There are many aspects of communication including verbal and non-verbal cues. When working with Aboriginal people, in addition to adhering to general rules of polite communication such as open posture, attentiveness and active listening, other aspects of your communication style or your interaction should be taken into consideration.

Introductions & Rapport Building:

The first few minutes of your initial interaction with a new Aboriginal client are crucial. If it does not go well, it may prove to be a lost opportunity. If you are unable to make someone feel comfortable, which can be an incredibly difficult task particularly in the area of sexual health, then it is likely that that person will not communicate their concerns honestly and openly, and may not revisit the service. When working with Aboriginal clients, the building of rapport is essential. Building rapport with someone often involves finding some common ground. We find ourselves doing this daily in our social activities with friends or colleagues but sometimes forget to transfer this skill to our working relationships with clients.

If an Aboriginal client who lives in a rural area walks through the door you might initially think that you wouldn't have anything in common. Yet regardless of how different that person's life might be, most of the time through active listening you will find that there is something you



have in common which could be as simple as sharing a particular value or view. However, establishing rapport is not only about finding some common ground. In terms of a service provider and client, the starting-point to building rapport is by demonstrating and acknowledging that you have a level of understanding and respect for the client and their uniqueness.



It is also important to remember that building a solid rapport is a process that requires consistency and continued effort. Just because you get along with someone the first time you meet does not necessarily mean that a strong rapport has been built. Proper rapport and trust may need to be established over a long time-frame.



Building rapport with an Aboriginal client to the point where they are able to discuss their sexual health concerns with you involves understanding and demonstrating respect for their cultural values and history. If you have an understanding of these things and respect the fact that Aboriginal people may respond better to a different way or style of communicating from non-Aboriginal people, the possibility of a positive interaction is increased. It is about being flexible and responsive, while at the same time creating an environment which is safe and open.



Language:

While it is well known that non-verbal communication is of utmost importance, the language you use in verbal communications and interactions can also determine the way an interaction progresses, whether that be to produce positive or negative outcomes.



Medical terminology and statistics can act as a real deterrent to Aboriginal people if they don't understand what is being said. Things need to be stated simply and clearly²⁰. It is important not to assume that somebody has understood what has been said simply because they have said "OK, that's fine" or something similar. People are often too embarrassed to admit that they don't understand something. Aboriginal people are also often more visual and verbal than non-Aboriginal people in today's world, which is often more numerated.



Using too much medical terminology also creates more of a power imbalance and helps to make people feel inadequate. Many Aboriginal people who walk into a service are very aware of the power imbalances. Due to Aboriginal history and the continued discrimination, Aboriginal people often feel unequal to service providers. This is particularly true if the service provider is non-Aboriginal. The use of medical terminology risks enhancing that feeling or perception. It is important to note that while it is imperative to use appropriate language when communicating with Aboriginal clients, ensure that you do not mimic Aboriginal patterns of talk or Aboriginal slang, as this may come across as very condescending and insulting²¹.



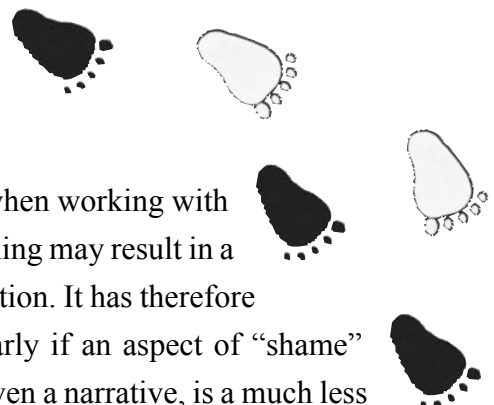
Additionally, service providers need to be aware that within the Aboriginal population, there are varying degrees of literacy and numeracy. This needs to be considered when seeing Aboriginal clients. The use of interpreters may be considered in certain cases.



Communication Style:

The style of communication you undertake can greatly affect the outcome of a consultation with a client.





In a study conducted by Westerman (2004) it was noted that, when working with issues where “shame” is involved such as sexual health, direct questioning may result in a hasty and untrue “yes” or “no” response just to get away from the question. It has therefore been suggested that when working with Aboriginal people, particularly if an aspect of “shame” may be involved, open-ended and “positively phrased” questions, or even a narrative, is a much less threatening approach, and as such, much more constructive and productive²².

Generally speaking, open-ended questions provide people with more options. It is important to remember that people may also present stating that they have some simple concern without initially disclosing their real reason for attendance out of “shame” or embarrassment. Often, after gentle probing with some open-ended questions, the more pertinent concerns will be uncovered.

While your communication style does need to be open, straightforward and honest, if it is too direct this may frighten people away. In terms of body language ensure that your posture is open yet non-confrontational. You may also notice when working with Aboriginal clients that some may be reluctant to make eye contact. Unlike in the non-Aboriginal population, where making eye contact is seen as being polite, some Aboriginal people view making eye contact as asserting power over or reprimanding someone. Therefore, if an Aboriginal person is not making eye contact, do not interpret this as a sign of rudeness or bad communication. It may simply be a sign of respect²³.

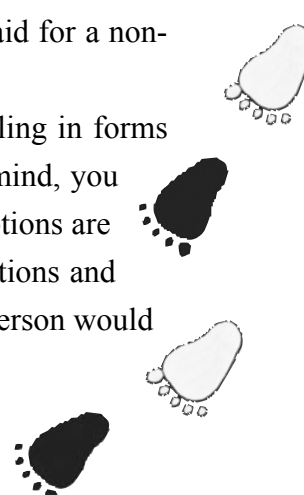
Written Material:

Additional material can often assist in communication, particularly if people are finding verbal communication difficult. Printed resources, flyers and visual aids can be of great assistance for encouraging understanding and awareness, or as an aid to explain something more thoroughly. For example, you could use a poster of a body and point to body parts. Written material for clients to take home can be helpful, as taking in everything at once may prove too difficult. When putting together written resources for Aboriginal people it is important firstly to make them culturally appropriate, and secondly, to take into account people’s varying reading and general literacy abilities. For example, a poster may be more effective if it comprises more pictures than words.

Forms

It is important to keep in mind the varying literacy levels of Aboriginal people in terms of other service aspects as well. Take for example the forms people are required to fill out when accessing a service, such as a registration form. If you have an Aboriginal client attempting to access a service, there is a chance that they may be unable to read or write. While the same could be said for a non-Aboriginal person, literacy levels are much lower among the Aboriginal population.

If someone is unable to read or write, or has very limited literacy abilities, filling in forms is not only difficult but can also be very embarrassing and intimidating. With this in mind, you may need to simplify registration forms and ensure that no jargon is included. Other options are also worth considering. For example, is it possible for the receptionist to ask the questions and fill out the forms on someone’s behalf? Or perhaps the reception staff could ask if the person would



be happy to fill out the form on their own, or if they would prefer the receptionist fill it out for them. This way no assumptions are made and people are also able to keep their pride. If these options are incorporated and questions are asked out loud, privacy must also be taken into consideration. A further option would be that forms are sent out to people prior to their appointment so that they can fill it out before the appointment, ask others for assistance if required, and then bring it with them to their appointment.



Some hints for effective communication:

- Remain open and honest.
- Allow enough time for the appointment or consultation so that the client does not need to be rushed.
- Avoid technical language and medical jargon.
- Always check to ensure that people have understood what is being said. You may need to repeat information.
- Acknowledge that you understand that certain issues may be embarrassing or difficult to talk about.
- Speak quietly if other people are around.
- Adopt non-threatening body language and tones.
- Be patient.
- Do not make assumptions about sexuality and/or behaviour.
- Adopt a non-judgemental attitude and approach.
- Provide the opportunity for the client to have a support person or family member present.
- Simplify forms and written information as much as possible.
- Try to use open-ended probing questions when attempting to obtain a sexual history.
- Emphasise the confidentiality of the conversation but also be upfront about the limits of this confidentiality.
- Consider using visual aids (e.g. a picture of a body and pointing to various body parts) to assist in questioning or when trying to explain something.

Use the KISS Principle – “Keep it Simple Sweetheart”



Questions/Statements to Avoid

Example:

1. Are you sleeping around?
2. How many people have you slept with?
3. Do you have or have you had any diseases?
4. Do you use drugs?

Possible Alternatives

Examples:

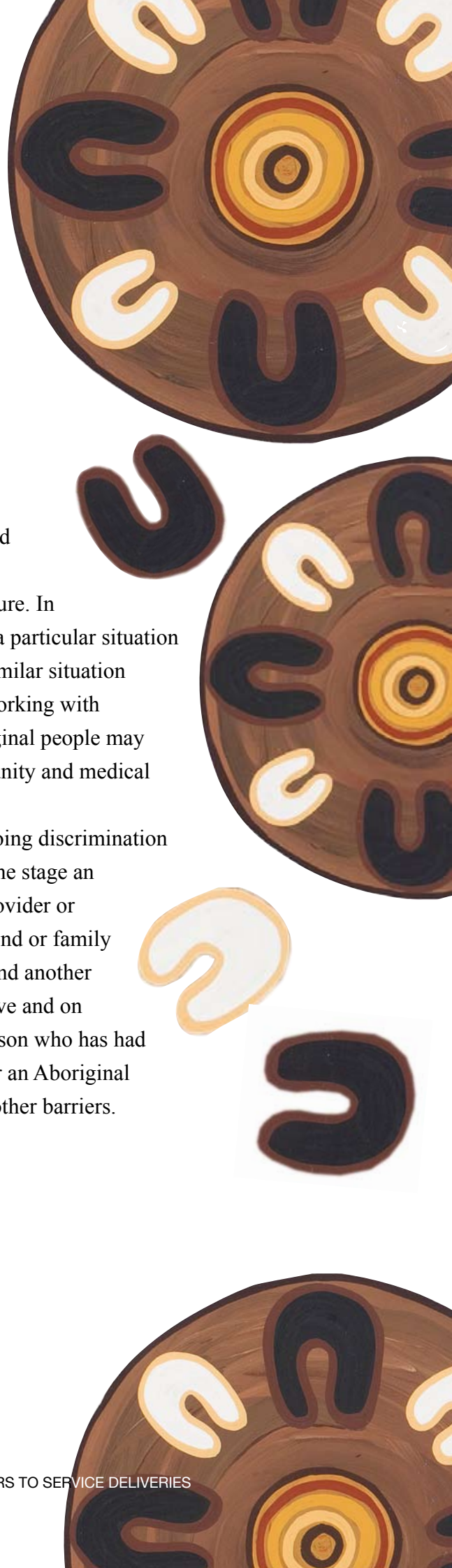
1. Have you had any sexual relationships outside your current relationship?
2. How many relationships have you had in the past 12 months?
3. Have you ever been tested for any sexually transmitted infections in the past?
4. Have you ever taken drugs in the past? If so, how were they taken?

Past experiences

A common barrier when working with Aboriginal clients is overcoming or breaking through negative past experiences and history.

It is undeniable that history affects the present and future. In simple terms, if for example you have a bad experience with a particular situation in the past, that might affect your outlook on being put in a similar situation today. The same needs to be taken into consideration when working with Aboriginal people. Due to bad experiences in the past, Aboriginal people may fear authority figures or have a distrust of the medical community and medical services.

In the context of Aboriginal history and the often ongoing discrimination experienced, both direct and systematic, it is likely that at some stage an Aboriginal person has had a bad experience with a service provider or doctor. This may have been experienced in person or by a friend or family member. Naturally, this may make that person hesitant to attend another health service, or if they do attend, they may be more defensive and on guard. While this would also be true for a non-Aboriginal person who has had a bad experience previously, it may be a lot more complex for an Aboriginal person when taking into account history, cultural values and other barriers.



Workforce

Male / Female workers

Numerous documents highlight the fact that in some Aboriginal communities, some health issues are classified as either “*men’s business*” or “*women’s business*”²⁴. Sexual health issues definitely fall into this category. This means that Aboriginal men with a sexual health issue or concern may only feel comfortable talking to a male health care worker, with the reverse being true for Aboriginal women.

Accommodating this cultural value can be one of the most difficult problems facing service providers. Obviously time and resource restrictions, especially in smaller services or more rural services where there may only be one worker, play a big part in being able to meet this cultural need.

Suggestions to consider:

- Where possible, offer an Aboriginal person the opportunity to see either a male or female worker.
- If a choice of male or female worker is not possible, explain this to the client and ask them whether they would prefer to be referred elsewhere (Hint: have an established list of referral phone numbers/names of the closest services to be used for these occasions).
- If for example you only have a male worker at a service, is it possible that you can make links with another local service, so that you can perhaps have access to a female worker when required and provide the reverse service to them if needed.

Aboriginal / non-Aboriginal Workers

In addition to seeing a health care worker of the same gender, some people believe that Aboriginal people only want to see an Aboriginal worker. This, however, is highly contested. Some service providers believe that Aboriginal people only want to see an Aboriginal worker as they feel that they, and their cultural values and related perspectives, are better understood in such a situation. Others, however, have said that Aboriginal people often don't want to see an Aboriginal worker, particularly around areas of sexual health as they have the fear of that person then knowing "their business", and the fear that this information might then make its way back to their community²⁵.

Whether or not an Aboriginal client would prefer to see an Aboriginal service provider is a personal preference and impossible to know without asking. In many cases, as with seeing a service provider of the same gender, this may simply not be an option. At the same time, however, it is something that as a service provider you need to be aware of.

Suggestions to consider:

As with the previous section,

- Where possible, offer any Aboriginal people the option of either seeing an Aboriginal or non-Aboriginal service provider.
- If a choice of an Aboriginal or non-Aboriginal worker is not possible, explain this to the client and ask them if they would prefer to be referred elsewhere (Hint: have an established list of referral phone numbers/names of the closest services that could meet these needs).
- If for example you only have a non-Aboriginal worker at the service, is it possible to make links with another service that has an Aboriginal service provider who may be able to assist when needed?

Shame

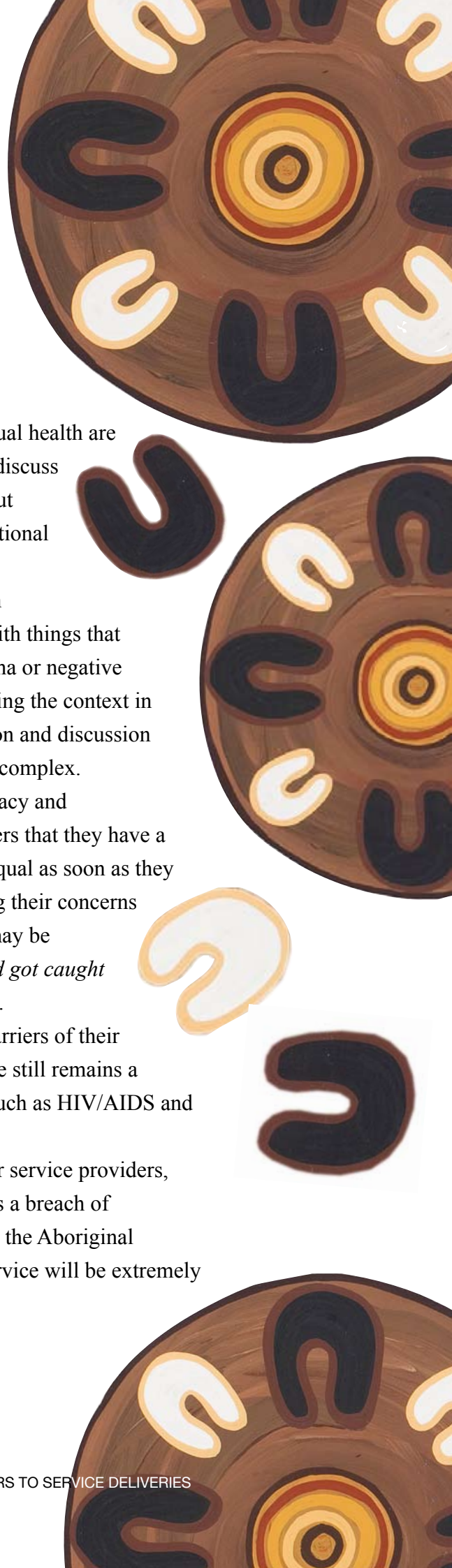
As has been noted previously in this guide, issues around sexual health are often considered private issues which people find difficult to discuss openly out of *shame*. This is true for the general population but compounding this further in Aboriginal communities are additional cultural beliefs, attitudes, and sensitivities²⁶.

In the Aboriginal community *shame* is a word that can have many meanings but more often than not it is linked in with things that are considered embarrassing, private, or have associated stigma or negative connotations. It is about culturally defined boundaries informing the context in which sex can or cannot be discussed. *Shame* makes education and discussion necessitated by sexual health programs very problematic and complex.

Due to *shame*, and corresponding feelings of inadequacy and embarrassment, many Aboriginal people are afraid to tell others that they have a STI. Aboriginal people often struggle with feeling less than equal as soon as they walk through the door of a health service, so that even raising their concerns with a service provider brings up shame. For example, they may be worried that it will be considered that they are “*not clever and got caught (with a STI)*” or that they were “*dooly*” enough to catch a STI.

Shame, mistrust and a lack of knowledge can all be barriers of their own accord, although they are often inextricably linked. There still remains a lot of misunderstanding and stigma surrounding many STIs such as HIV/AIDS and other sexual health issues, and *shame* can arise out of this.

Shame is also linked with issues of confidentiality. For service providers, maintaining confidentiality is of utmost importance. If there is a breach of confidentiality, or even a perceived breach, gaining trust from the Aboriginal population and encouraging them to continue to utilise the service will be extremely difficult, if not near impossible.



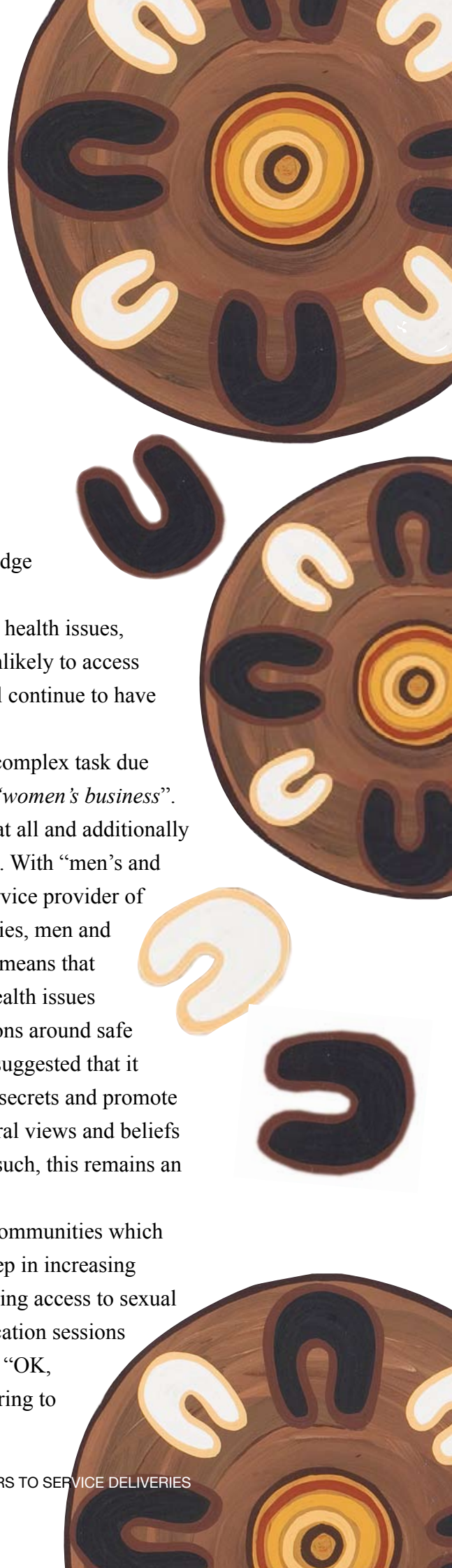
Lack of Knowledge

Another barrier that prevents many Aboriginal people from accessing services for sexual health issues is a lack of knowledge around issues of sexual health.

If people lack knowledge and understanding of sexual health issues, their importance and their potential consequences, they are unlikely to access appropriate services. Correspondingly, the spread of STIs will continue to have severe repercussions in Aboriginal communities.

Educating Aboriginal people about sexual health is a complex task due to “*shame*” and the cultural values of “*men’s business*” and “*women’s business*”. Shame can make people reluctant to talk about sexual health at all and additionally involves negative connotations which are difficult to overturn. With “*men’s and women’s business*”, in line with the preference of seeing a service provider of the same gender is the fact that in some Aboriginal communities, men and women will not talk about sexual health issues together. This means that men may have very little understanding of women’s sexual health issues and vice versa, and also means that discussions and negotiations around safe sex are extremely problematic. Some service providers have suggested that it is time to place the men and women together to get rid of the secrets and promote open discussion²⁷, although this would mean overriding cultural views and beliefs which are of high importance to some Aboriginal people. As such, this remains an issue of contention.

Providing outreach education sessions in Aboriginal communities which incorporate sexual health issues could be an important first step in increasing knowledge around sexual health and STIs, and in turn increasing access to sexual health services. However, conducting outreach clinics or education sessions within Aboriginal communities is not as simple as just saying “OK, let’s go!”. It requires solid preparation and planning and adhering to



appropriate protocols so as not to offend the Aboriginal community you are trying to work with. Section Three on Community Engagement will revisit this topic in more detail, and will suggest various steps which should be taken when wanting to engage the Aboriginal community.

Some possible ways forward:

- Provide community education sessions incorporating sexual health issues.
- Attempt to normalise “sexual health” issues and STIs.
- Make a point of talking to all Aboriginal clients about sexual health issues in the context of keeping healthy and looking after yourself.
- Display sexual health information around the service where you work. This provides education but also lets people know that it’s okay to raise sexual health issues there.



Access: The practical side

Access to sexual health services for Aboriginal people is often restricted not only by cultural issues, as has already been noted, but also in practical terms. Access can be limited due to transport, cost and location. Some of these barriers and possible strategies to overcome the restrictions are discussed below.

Transport

Transport remains a constant difficulty when accessing services. Many people do not have their own transport and do not want to ask another family member to borrow the car for fear of having to explain where they are going. Other considerations to take into account include being able to provide appointments which fit into people's schedules of picking up children from school etc. Also, if people are reliant on public transport, it can make getting to appointments difficult or "too much hassle", depending on how easy public transport is to access and negotiate.

Some transport options to consider:



- Community transport

Most areas these days have some form of community transport available. These services are often available free of charge or at minimal cost. If the service you work with is not aware of what options exist, or how to go about making a referral to community transport, contact the local hospital (the Social Work department often has details). Other community services also sometimes offer transport options that can be tapped into. Do a bit of a ring around to other services to find out how they deal with transport difficulties.





- IPTAAS

If clients need to attend specialist appointments that are a fair distance away, they may be able to access IPTAAS. IPTAAS is a travel scheme that heavily reduces travel costs if certain requirements are met. Be aware that the IPTAAS form will need to be signed by the treating doctor.





Cost

Cost is often a major hindrance to the accessing of services. If services do not offer bulk billing, this will greatly lower the number of Aboriginal people accessing the service. It is important to note that the average household income for Aboriginal people is approximately equal to 56% of the national average, and they are three times as likely to be unemployed compared with the national average²⁸. As one health worker stated, health issues, particularly sexual health, can become a very low priority when your house is falling down around you. It takes the position of “*if it’s not going to kill you today, it can wait*”.






Even if services offer bulk billing, with sexual health there are further difficulties. For example, if a young Aboriginal girl has actually approached a service for something like chlamydia, the chances are that she will be on her mother’s health care card. If she is given a prescription to be filled at the chemist, she may not be able to afford the full price of the prescription, yet does not want use the health care card because then she would have to tell her mother about what happened, which is where the *shame* factor comes into play. There is also shame attached to getting a script filled at the chemist as then the chemist is aware of “*what you have*”.



Practical Suggestions:



- Offer bulk billing, or even better, a free service. GPs and other services are often, understandably, reluctant to offer bulk billing. However, if services are serious about wanting more Aboriginal people to access them so as to improve Aboriginal health outcomes, offering bulk billing is a positive first step. If services are made available free of cost, people would be more inclined to access them as it does not take away funds from things that are considered a higher priority.
 - Be aware of any other funding bodies/schemes that may assist Aboriginal people to afford medical services. For example: discount prescription schemes, travel assistance schemes etc.
 - If your service prescribes antibiotics etc, try to stock free supplies of medication to avoid the shame associated with filling in a script.
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Location

The location of a service may act as a hindrance to the service being accessed. For example, services located some way out of town with no public transport options would be accessed with much greater difficulty than a service somewhere in town. Also, a service which is located next to somewhere like a police station or courthouse is likely to find that Aboriginal people are hesitant to access it.

While it is possible and greatly encouraged to consider location when originally setting up a service, most people will find themselves in a position where the service is pre-existing, and therefore unable to alter or improve the location. If the service you work for or run is badly located, there are options that you can explore to make the service more accessible to Aboriginal people such as conducting home visits and outreach clinics.

Outreach clinics will be discussed further in Section Three: Community Engagement.

Appearance

The appearance or presentation of a service can also greatly affect whether Aboriginal people will access the service. In terms of accessing services for sexual health, issues such as the level of privacy available and types of windows and doors, or closed-off areas, can also have an impact²⁹.

Suggestions to improve the appearance of a service:

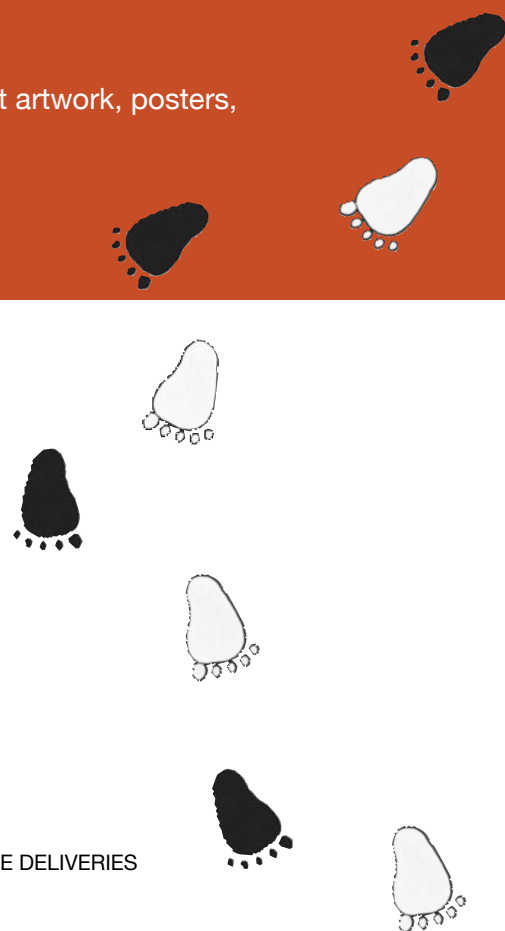
- Ensure that signage to the service is appropriate
- Ensure that privacy can be maintained through the type of room used for the consultation

Provide alternative waiting areas in discreet locations

Provide separate entry and exits to clinic

Always consult with community to establish cultural needs e.g. relevant artwork, posters, pamphlets and internal signage

Wherever possible employ Aboriginal personnel



Approach to service deliveries

Holistic Care

Aboriginal culture as a whole is holistically based, meaning that the physical, mental, emotional, spiritual and cultural³⁰ are all intrinsically intertwined and linked. Each affects the other. Health, in Aboriginal culture, is no different.

To Aboriginal people, health is viewed in a broad sense and comprises physical, cultural and spiritual aspects. As noted in the Cultural Respect Framework 2004-2009, identity and culture are central to Aboriginal understanding of health and ill health³¹. As such, when looking at Aboriginal health and hence, sexual health service delivery, a holistic and comprehensive approach to care must be adopted.

Part of this holistic view of health, and the role of community within it, means that some work such as education may be more effective if conducted with the entire community as opposed to the individual. Even when working with the sexual health concerns of an individual, many more people may need to be included, as in many Aboriginal communities responsibility extends beyond the nuclear family unit, which means that discussions need to go beyond this unit³².

If someone holds a very strong view of health as being holistic, they may not even be able to easily identify what is wrong with them, as they may see anything that is “wrong” with their body as a consequence of something they have done wrong. It can be believed that once this wrong has been righted, the body too will be healed.

In the context of sexual health, if taking a holistic approach to care, this essentially means not concentrating discussions on sexual health alone but placing it within the broader health context³³. Translating into education, this means looking at broader health promotion strategies and policies.

Informal Service Delivery

An aspect of service delivery is the extent to which it is formalised. It has been noted that Aboriginal people often respond better to an informal mode of service delivery³⁴ as this resonates better with their culture.

Suggestions on how to achieve informal service delivery:

- Having a presence at community events such as sporting carnivals, cultural events, health expo's, community BBQs
- One-on-one opportunistic engagement
- Community outreach
- Drop-in service with no appointments
- Develop community peer educators and/or advocates

Meeting an Aboriginal client for the first time

- Have an understanding of the local community
- Make them feel welcome
- Provide a non-threatening environment
- Ensure adequate time to engage in discussion
- Offer assistance in filling out relevant forms
- Allow others to accompany client
- Don't try to do everything in the first visit

Training Chapter 1:

Barriers to Service Delivery & Ways to Overcome Them

Learning Objective: 1.1	Understanding modes of effective communication and rapport building
Learning Objective: 1.2	Recognise and acknowledge the historical impacts endured by Aboriginal Australians
Learning Objective: 1.3	Understanding the Aboriginal health workforce
Learning Objective: 1.4	Understanding of the cultural beliefs, attitudes, and sensitivities associated within Aboriginal society
Learning Objective: 1.5	Understanding the levels of knowledge regarding sexual health within Aboriginal communities
Learning Objective: 1.6	Recognising and overcoming barriers to sexual health services for Aboriginal people
Learning Objective: 1.7	Understanding and implementing alternative service delivery models to encompass holistic health

Skills

On completion of this resource, individuals will have developed:

- An increase in confidence and ability to communicate and understand Aboriginal society, conduct assessments and discuss sex, sexuality and sexual issues with Aboriginal clients.
- An increased awareness of BBV and STI epidemiology in the regional, national and local context to develop understanding of the risk factors for exposure to BBV's and STI's among Aboriginal communities and how these differ to the wider population.
- Increased understanding of the cultural sensitivities to screening for BBV's and STI's in Aboriginal community.
- An increased ability to effectively manage BBV's, STI's and associated issues in Aboriginal communities.
- The ability to develop a BBV/STI checklist, for use during consultations with at risk clients ensuring a culturally sensitive and comprehensive sexual history and risk assessment is taken, and that appropriate screening and follow-up is performed.
- An increase in confidence to use culturally appropriate methods to engage with Aboriginal people in BBV and STI issues.
- Increased knowledge of locally available resources for Aboriginal people pertaining to BBV's and STI's.

Record of Assessment

Name of organisation

Name of Person conducting assessment

Use the checklist below as a basis for

Aboriginal Community Communications assessment:

Yes **No** **N/A**

- | | Yes | No | N/A |
|---|--------------------------|--------------------------|--------------------------|
| • Were culturally appropriate protocols recognised when engaging the Aboriginal community? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Were effective communication strategies used throughout the discussion to ensure the required information is accessed or messages communicated? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Were areas of cultural sensitivities identified and addressed during the process to ensure no cultural conflict? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Were specific cultural and communication needs of the community or client identified? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Was an opportunity provided to include all community people in the communication process? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Was an appropriate communication strategy developed to establish trust and accurate exchange of information? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Was feedback provided and advice given to the community in a way which reflects current identified needs in relation to BBV's and STI's? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Was alternative service delivery models used to encompass holistic health including BBV's and STI's? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Were appropriate referrals to BBV and STI services made to ensure duty of care responsibilities were met? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Were opportunities provided to explore all relevant issues regarding BBV's and STI's in the community? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Did the assessment meet the required standard? **Yes** **No**

Notes

community engagement



Overview

Community engagement can be a crucial step towards being able to provide an adequate and effective health service targeted towards a specific population. In terms of Aboriginal communities, community engagement is of particular importance due to their strong community focus and values.

Involving communities in decisions about their life and health provides them with a sense of self determination³⁵, ownership, power and control, which in turn fosters better working relationships and better health outcomes. The sharing of power and knowledge further enables the creation of a joint understanding of issues³⁶. If you are able to engage successfully with the Aboriginal community, this will in turn result in higher numbers of people accessing your service.

Engaging with Aboriginal communities is far more complex than just walking into a community and beginning a conversation. The process of engagement can require a lot of groundwork but in the end, the results can be very satisfying³⁷. Relationships of trust and respect need to be established, requiring service providers to display a high level of cultural respect, discussed in the previous chapter. It will also necessitate a continued effort and ongoing engagement with individuals and Aboriginal communities generally.

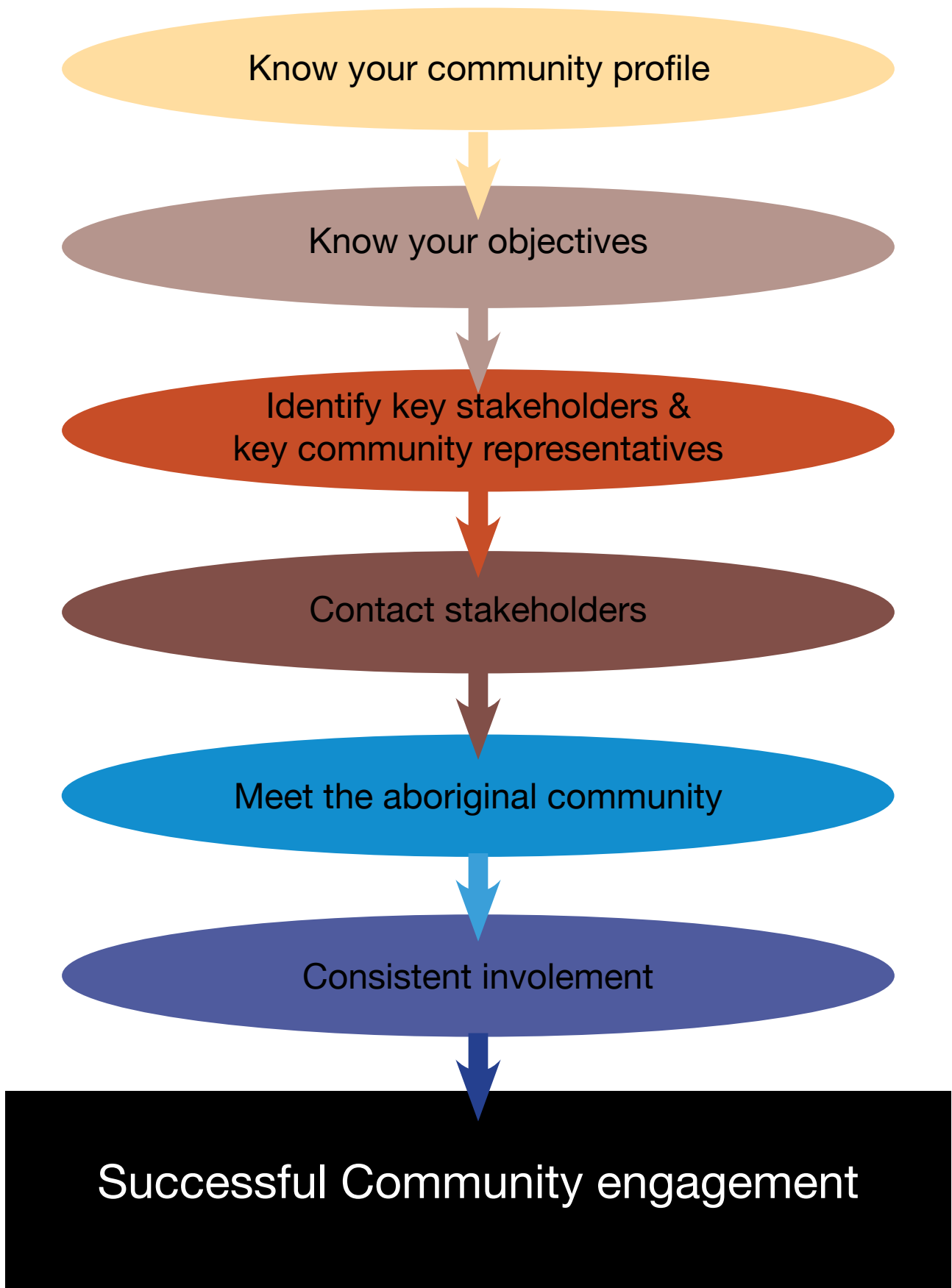
The following pages detail the process of beginning community engagement. Steps to community engagement or entering an Aboriginal community for the first time are discussed. There are various protocols for entering an Aboriginal community and engaging with Aboriginal people, and while it is advisable to check with your local stakeholders as they may differ from region to region, many of the general principles will remain the same.

The chapter also discusses outreach services and community education strategies and the benefits these may provide.

Whether you are looking to engage with an Aboriginal community as a way of introducing yourself locally and attracting people to your service, or with the aim of conducting outreach services of some kind, consistency and commitment to community engagement are crucial.



Summary of steps to Community Engagement



Steps to community engagement

STEP ONE: Know Your Community Profile

The first step in encouraging community engagement and/or starting up outreach clinics is getting to know your Aboriginal community³⁸.

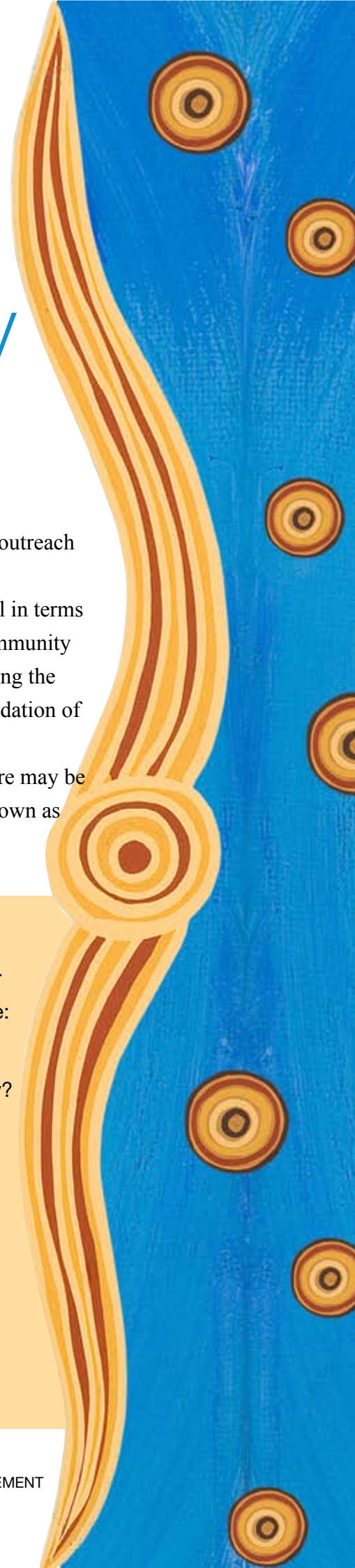
Getting to know the Aboriginal community in your area is crucial in terms of what kind of service provision might be needed, in what areas the community priorities might lie and what obstacles may need to be overcome. Knowing the demographics of the Aboriginal community in your area provides a foundation of knowledge that can greatly assist with engaging the community.

It is important to recognise that in one local government area there may be a number of separately identified communities. Communities may be known as missions, settlements or reserves.

Tips:

Find out as much as possible about the Aboriginal communities in your area. Start with the following questions to begin building up your profile:

- Where are the majority of the local Aboriginal community located?
Is the community centralised or dispersed and living quite separately?
- What kind of housing/living arrangements are there? Do people have access to shelter, water, electricity etc?
- Are they a very mobile community or an established community?
- Is it a growing community?
- What is the percentage of males versus females?
- What is the median age?
- What are the current issues for that community?
- What services are currently available to that community?



Community & Demographic Profile Template

This template can be used to assist you in developing a community profile.

Community Name:	
Language Group:	
Key Community Representatives' Names:	

Age	Males		Females		Persons	
	No.	% of Males	No.	% of Females	No.	% of Persons
0-4yrs						
5-14yrs						
15-24yrs						
25-44yrs						
45 + yrs						
Total						

Source: Adapted from One Talk: Queensland Health's Aboriginal & Torres Strait Islander Community Engagement Guide 2005 p64



STEP TWO: Know your objectives & methods of consultation

Prior to engaging the Aboriginal community you will need to determine what you are hoping to accomplish. It may be that you are interested in simply meeting people, or getting the word out as to what health services are available etc. If you have already met people previously, you may only be interested in dispersing some new information. You need to be clear as to your objective so that you know what kind or level of engagement is required. For example, meeting and getting to know the community may require numerous and ongoing visits to a community, whereas if you already know the community and only want to gather information on one issue, it may be possible just to conduct a survey or hold a meeting.

Consulting and negotiating with the Aboriginal community can provide you with a wealth of information that will assist you in providing a more appropriate sexual health service to Aboriginal people.

Below are some potential methods of consultation and negotiation.

Which Consultation Method is the Best?

There are a number of methods that can be used to conduct consultation with the Aboriginal community. All of the methods or approaches have their strengths and weaknesses.

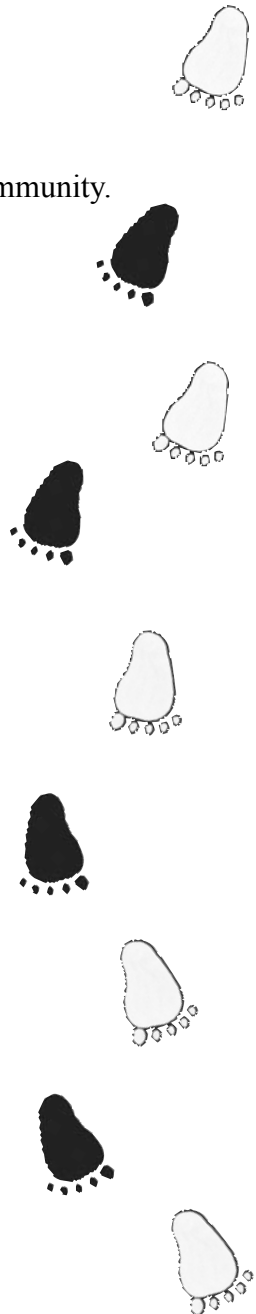
Committees

Benefits:

- Can provide useful ongoing feedback on numerous issues. E.g. It might be constructive to establish a committee that can meet on a regular basis (eg monthly or bi-monthly) to support and advise on service practices or difficult issues
- Allow for detailed feedback and dialogue
- Give the community a sense of ownership with involvement
- Give a broader range of solutions
- Enhance cultural sensitivity with involvement

Downfalls:

- Committees can be extremely time-consuming
- One person's voice may not be very representative of the entire Aboriginal community
- Factions within community
- Community members have personally driven agendas



Community Visits

Benefits:

- Informal method of consulting with the Aboriginal community which may fit in better with their cultural values and way of life. N.B. In order to make visits to an Aboriginal community, protocols must be followed and trust must be established
- Of irreplaceable value in terms of establishing networks and having the opportunity to make members of the community feel comfortable with you and the health services you can offer
- A presence builds rapport and trust within the community
- Community members are more at ease within familiar surroundings and are much more likely to engage in conversation

Downfalls:

- A very informal process and therefore not very easily evidenced
- The environment is not controlled
- Documentation needs to be formal with any consultation
- Time-consuming if the communities are rural and remote

E-Consultations

E-Consultations are among the newer methods available. They involve tools such as interactive websites and online forums.

Benefits:

- Allow people to remain anonymous
- Ability to reach people who live long distances away and would normally be inaccessible
- Do not require access to physical venues
- Allow the freedom to search the Web
- Allow the service to interact with the age bracket within the target population
- Introduce and encourage new technology in communities

Downfalls:

- This method is restricted to those who have internet access and computer skills.
- High levels of literacy difficulties in the Aboriginal population need to be taken into account

- Does not build trust or a rapport within the wider community

Focus Groups

Benefits:

- Can be very beneficial when dealing with a specific issue
- Can be quick and relatively easy to organise
- Enable more in-depth responses and more opportunities to explore people's responses
- Due to their smaller nature, people may also feel more comfortable with speaking up in focus groups than a public meeting
- Enables the community to have input into the way services are delivered in their community

Downfalls:

- They require a skilled facilitator to keep discussions on track
- May be unrepresentative of the wider population
- Even though groups are smaller, people may still feel too uncomfortable to discuss issues of sexual health in front of others
- Gender could be an issue if you have males and females in the same group
- Difficulties in getting all the group together at the same time

Interviews

Benefits:

- Enable collection of in-depth information
- Offer the opportunity to discuss in greater depth issues that may arise through general interview responses
- Reach a personal level for the interviewee
- Have a much greater trust and confidentiality aspect
- Enable personal goals to be set

Downfalls:

- Very time-consuming, therefore the number of potential respondents is limited
- The interviewer must be very skilled, because as with all methods, the responses will only be as good as the questions
- Could turn into a long-term dependency

- Could unearth underlying issues that are outside the service’s capabilities

Public forums

Benefits:

- Provide the opportunity to consult with a range of age groups, with immediacy of responses
- Offer the opportunity to present a wider range and quantity of information in a short time frame
- Allow every community member to have a say and voice their opinion
- The process extends across the whole of the community

Downfalls:

- Could create an atmosphere of community versus service provider, and as such require a very strong facilitator
- It can be very intimidating talking in front of a number of people, so often it is the opinions of a few vocal people that are heard
- Due to their public nature, they are unlikely to work for sexual health issues except for possibly information dispersion
- Necessitate a meeting space such as a function centre or large hall

Surveys/Needs Assessments

Benefits:

- Surveys and questionnaires are probably one of the longest-standing consultation tools, many people are familiar with this method
- Surveys and questionnaires can also have the advantage of anonymity
- Can be conducted via mail, telephone, face to face or email
- Can be particularly beneficial if you require statistical data
- Have the advantage of responses requiring only a low level of literacy (e.g. yes or no)
- Can have a wide distribution area, and therefore have the added benefit of obtaining a broad sample of a community, not simply those who are very vocal in their opinion or active in the community
- Provide a space for the “*everyday person*” to have a say
- Can be carried out in conjunction with cultural events
- Can be carried out and results collated on the same day

Downfalls:

- Can be very restrictive as they often don't allow for detailed responses
- There is no opportunity to respond to feedback
- Can be quite time-consuming, have a long turnaround, and often have a low response rate if done by means other than face to face
- Varying levels of literacy within the Aboriginal community need to be considered



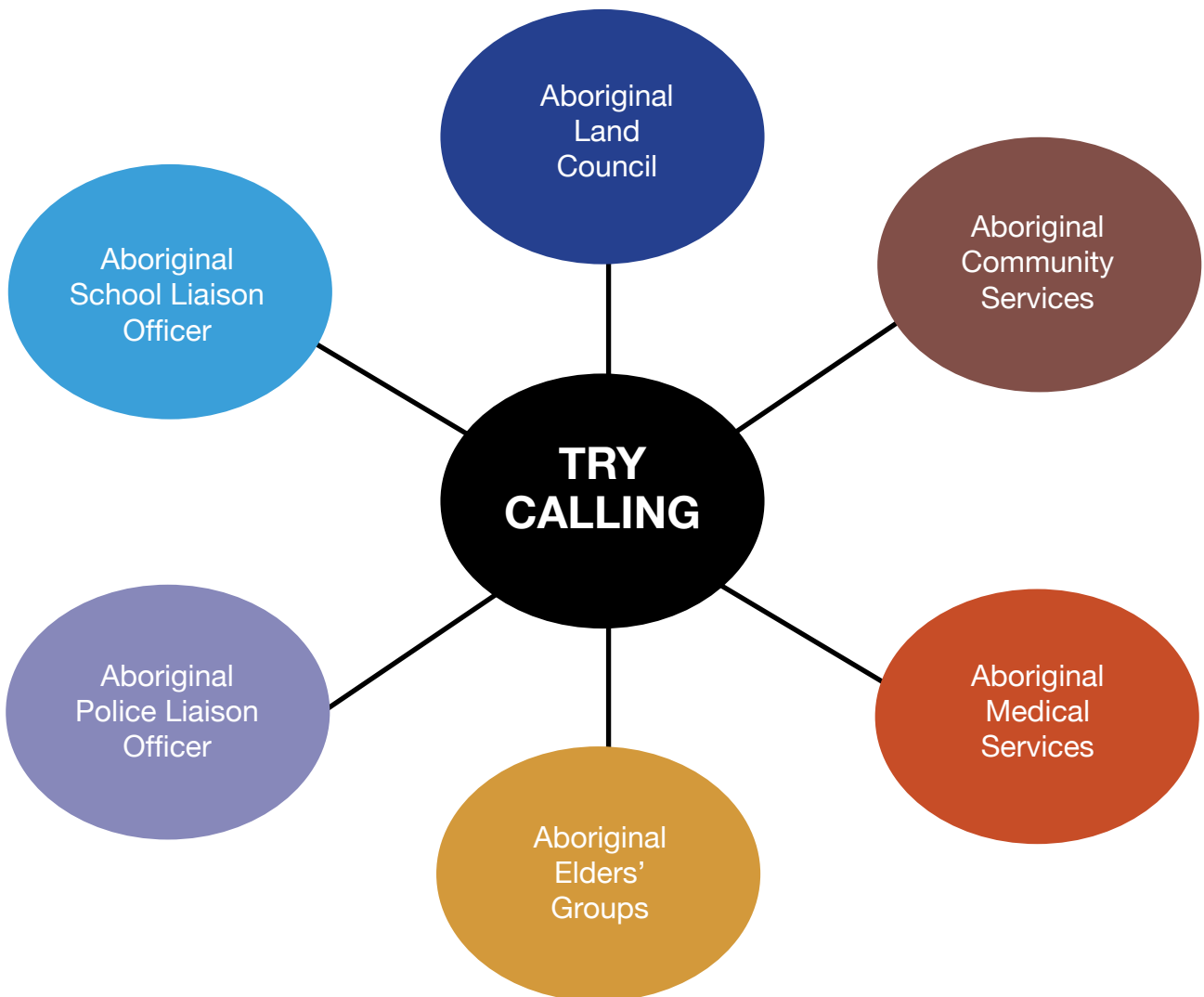
As has been demonstrated, there are many methods that can be applied to conduct consultation. Each, however, has its limitations. Which method of consultation you decide upon will depend on the topic you want to address, who with, and what resources are available to you. Once you have committed yourself to a particular method, you will need to be aware of its limitations and attempt to reduce these as much as possible. It is particularly important to remember that if using written material or surveys, literacy issues need to be considered. If utilising methods such as interviewing, language barriers will need to be addressed. This is true regardless of what type of community or population you are working with, but is particularly true for Aboriginal communities due to cultural and language differences.

It is also important to note that most of the consultation methods listed above require meeting the Aboriginal community beforehand, and that there will be a need to build trust and rapport with that community. The steps noted throughout this chapter will assist you to do that.

STEP THREE: Key community representatives

Once you have established a basic knowledge of your local Aboriginal community in your area and have identified what your objectives are, this will determine the consultation methods you may wish to use. The next step is to locate key community representatives. The process of engaging with the community is complex and at times difficult ... Key community representatives will be able to guide you on how to go about engaging with the Aboriginal community and may be able to assist you through their existing links with and/or knowledge of their community. The key representatives could be Aboriginal Elders or other important community figures such as Aboriginal Health Workers, Aboriginal Liaison Officers and lands council co-ordinators.

Finding out who the key figures are in your local Aboriginal community does not have to be a difficult task. Call the following places as a starting point:



STEP FOUR: Contacting Stakeholders

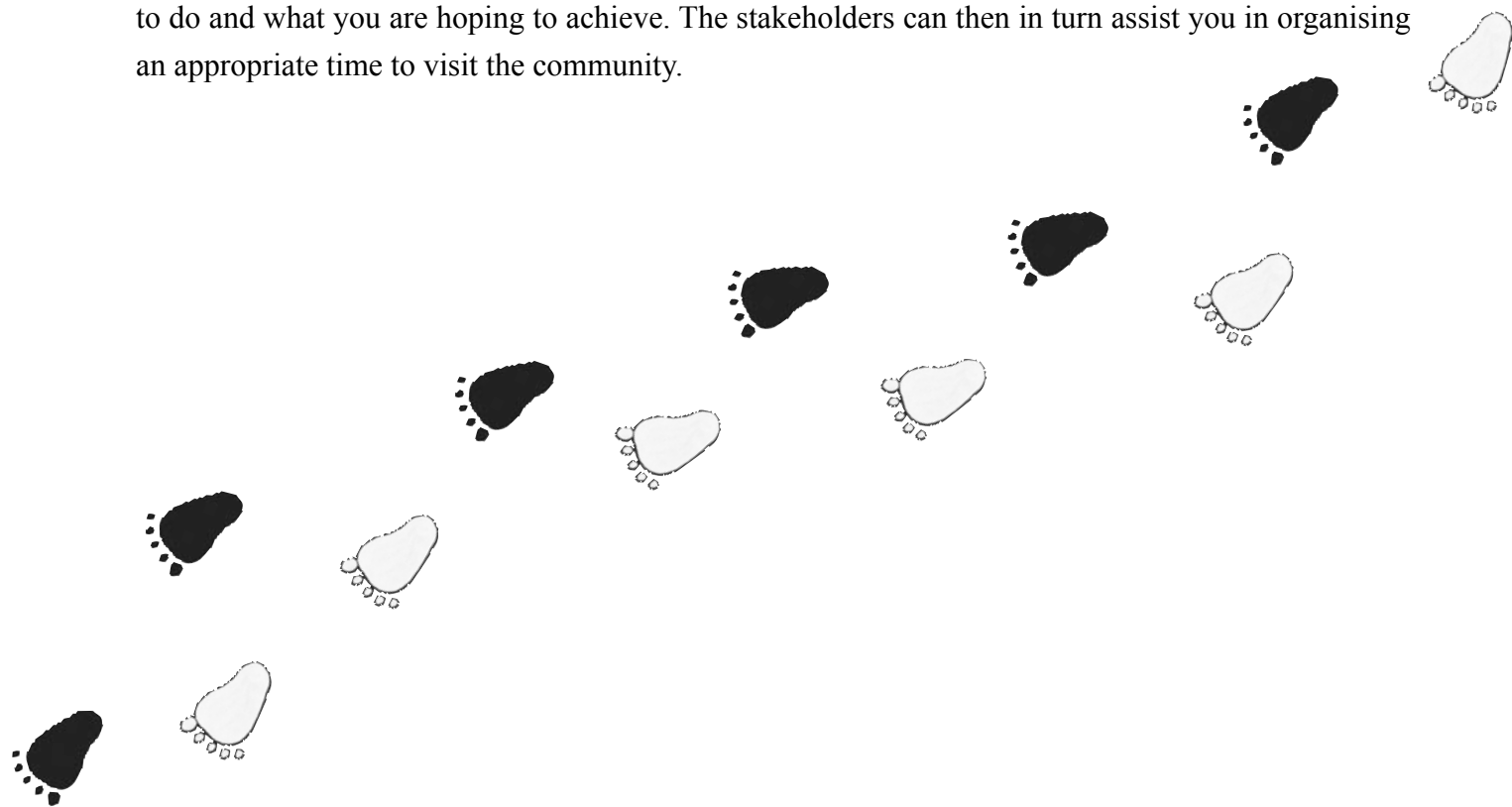
Once you have identified the key stakeholders, you will need to make contact with them.

How you go about making contact with the stakeholders very much depends on who they are and if you or your organisation have any existing links with them. You will need to rely on your own judgement as to which method is the most appropriate to use, depending on the situation.

For example:

- If one of the key stakeholders is a member of the Aboriginal Land Council and is unknown to you, it might be best to begin with a more formal communication such as a letter introducing yourself and your service, followed up with a phone call.
- If the stakeholder is an Aboriginal health worker, with whom a colleague of yours has had some dealings, it might be enough to simply make a phone call to them directly, and then perhaps confirm in writing.
- If one of the stakeholders you want to make contact with is an Elder, perhaps one of the other stakeholders identified such as an Aboriginal health worker will be able to inform you of the best way to contact them. It might be that in such a situation the Aboriginal Health Worker is able to set up a meeting and make the introductions personally.

When writing or speaking to a stakeholder to request a meeting with them with the aim of gaining access to an Aboriginal community, it is important to explain clearly who you are, what it is you want to do and what you are hoping to achieve. The stakeholders can then in turn assist you in organising an appropriate time to visit the community.



Example of a letter which could be used to make contact with a stakeholder

Insert Date

Insert Name

Insert Position/Organisation

Insert Address

Dear (insert name),

My name is Dr _____ and I have recently relocated to Coffs Harbour and established a GP surgery in Kent Street.

I am aware that the Coffs Harbour region has a large population of Aboriginal people. I am keen to make my services more culturally appropriate to the Aboriginal community, particularly with regard to increasing access around sexual health issues and concerns.

I would like to seek your support for my endeavours by way of assisting me to meet and build a rapport with the local Aboriginal community. Being able to meet with the Aboriginal community would enable me to gain a more thorough insight into the community's needs, allow me to provide a more appropriate service to the community which addresses these needs, and in turn foster more productive working relationships.

If you are able to assist me with this request, and would be willing to discuss this further, you can contact me on 02 6658 4692.

I look forward to hearing from you.

Yours sincerely,

Dr _____

STEP FIVE: Meeting with the community

Often the best way to visit and meet an Aboriginal community for the first time is to be introduced in the company of a stakeholder, whether it be an Aboriginal Elder or an Aboriginal health worker, etc. By conducting a visit in this way, less resistance may be observed.

As when you are contacting a stakeholder, before visiting an Aboriginal community you should prepare yourself as much as possible.



Make sure that you:

- have a clear understanding of why you want to conduct the visit and of what you hope to achieve by doing so
- know how you will be able to achieve your objectives
- find out if any other organisations or services are involved with the community and if so, make sure that they are aware of your intended visit to reduce potential duplication of service delivery
- think about what barriers might influence your objectives and outcomes, and
- don't make promises to the community that you can't deliver on as this will undermine the entire process

Helpful hints for when you are visiting an Aboriginal community:

- Emphasise common interests
- Respect community ways/values
- Accept and understand their culture
- Demonstrate an understanding of different communication styles that may be used
- Be open and honest in your approach
- Be open to new ideas

Adopted from Protocols for Consultation and Negotiation with Aboriginal People 1999 p25



When visiting an Aboriginal community there are also a number of other issues that you should take into consideration, such as:

- It is important to remember that in many Aboriginal communities, the separation of “men’s business” and “women’s business” is of utmost importance. In line with this, ensure that you don’t ask men about issues such as childbearing, or women about subjects such as circumcision. If you need to cover any of these types of topics, gain prior permission.
- Be wary of those people who appear to reject their old ways and take up your ideas too quickly. More often than not, these people do not hold power within the community³⁹.
- Elders are of utmost importance in Aboriginal communities. Many people will look up to the



Elders and value their opinions, so it is crucial that you do not alienate them, but try to get them inside⁴⁰.

- Those in the community who are considered to be leaders will often be silent if they feel that their views are unlikely to be heard. This silence will be noted by the rest of the community⁴¹.
- Choose the right time to discuss the purpose of your visit. It is not always best to discuss this right at the beginning. Let the community leaders set the pace⁴².
- Remember that cultural responses to time concepts are different. Furthermore, plans may change very quickly out of response to community issues such as funerals⁴³ or conflicts.

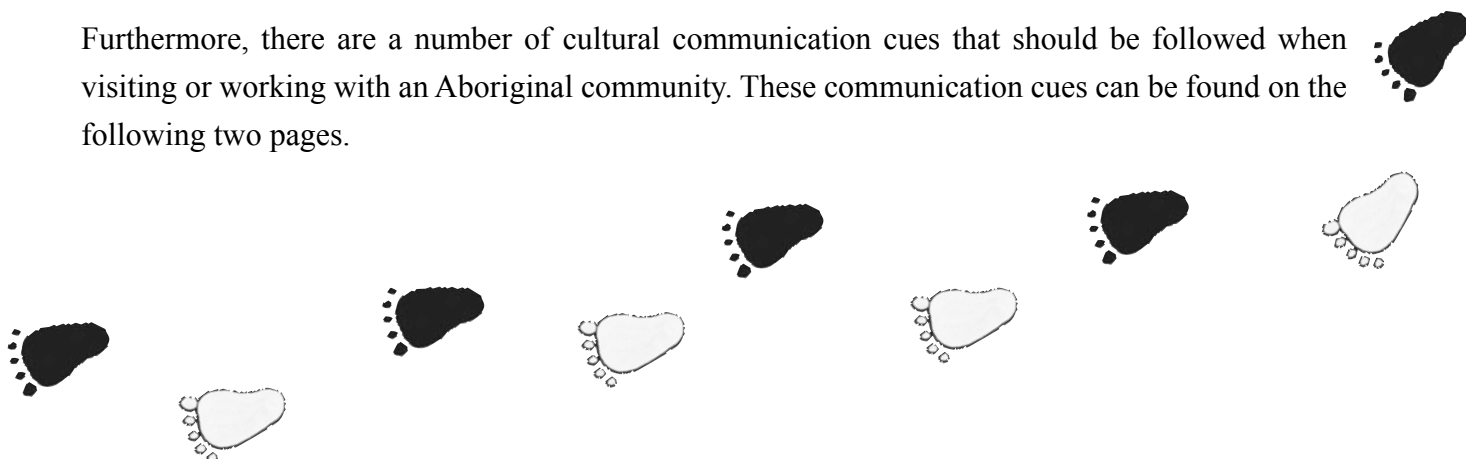
Principles of community engagement

Below are five examples of principles identified as guiding community engagement, which can be adapted for our purposes here. The principles identified were:

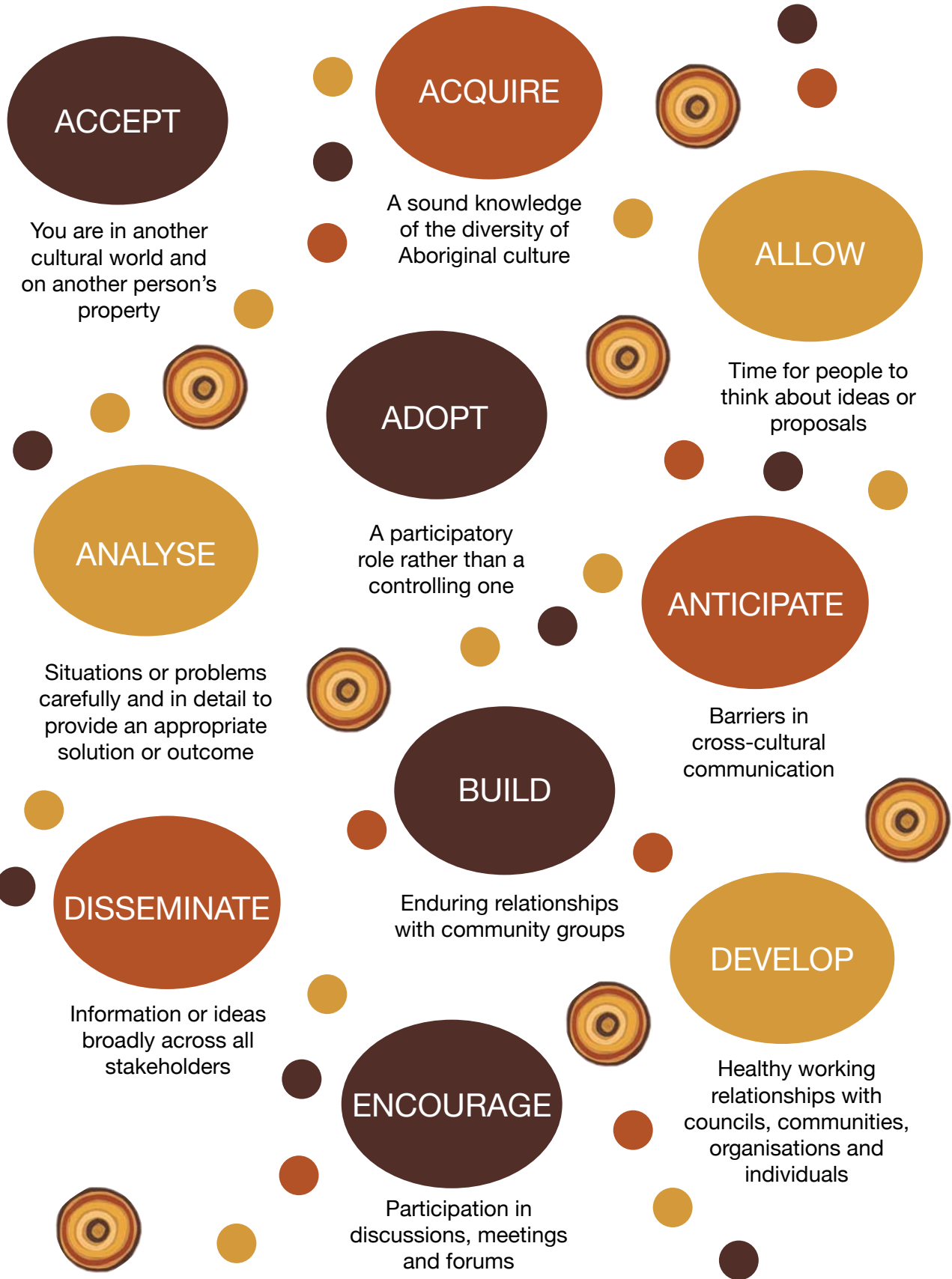
- that a shared understanding of issues is developed, and that this type of relationship requires developing trust and mutual respect
- that an effective working partnership is developed where the contribution of each side is valued through the recognition of knowledge and expertise of each side
- that an integrated approach to community engagement is adopted
- that the process of community engagement is inclusive and is reflective of the diversity of social, cultural, economic, linguistic, physical and geographical characteristics (this may require the development of new, innovative approaches to ensure that all community members have the opportunity to engage), and
- that barriers to engagement are removed so that practical implementation of community engagement strategies can take place. These barriers can include those described in the previous chapters.

It is important to abide by these principles when looking at engaging Aboriginal communities.

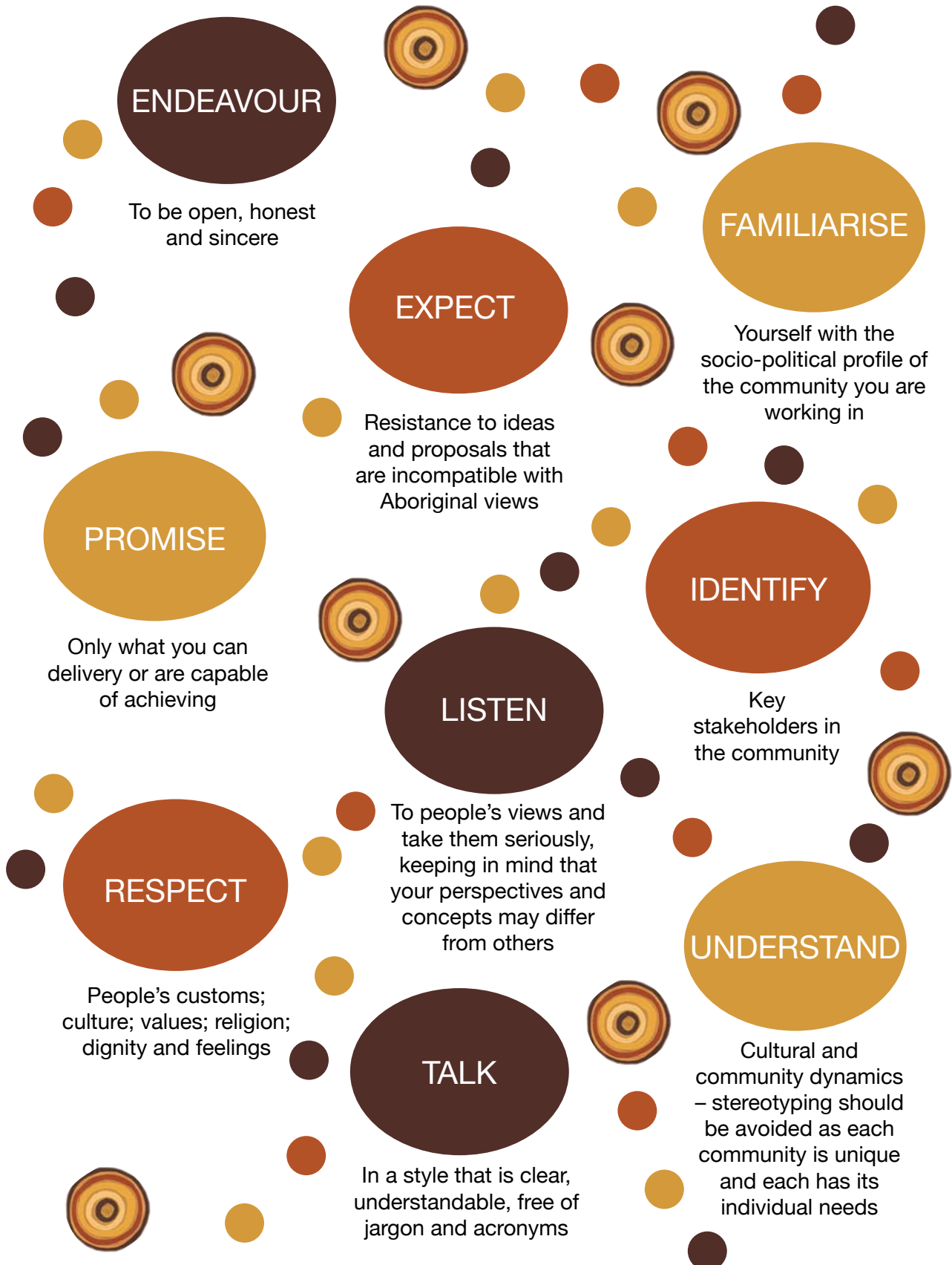
Furthermore, there are a number of cultural communication cues that should be followed when visiting or working with an Aboriginal community. These communication cues can be found on the following two pages.



Cultural Communication Cues⁴⁴



Cultural Communication Cues



Information taken from: Protocols. For consultation and negotiation with Aboriginal people


STEP FIVE: Consistent involvement

Constructing relationships of trust and respect takes time. Don't expect that after one or two visits you will be accepted or trusted. Aboriginal communities have become familiar with people coming into their communities, getting the "information" they need and leaving. Many people that have "engaged" with Aboriginal communities in the past have left bad impressions due to not following through on issues, making promises they are unable to uphold, or not informing the Aboriginal community of what they are doing or the outcomes achieved. As a result, some Aboriginal communities have become disillusioned by promises of "help", distrustful of the motives of people visiting their communities, and very resistant to "consultation". Therefore a consistent approach is required.

Ongoing efforts on a regular basis may be time-consuming and hard work but the pay-offs can be very rewarding. It is about building up a relationship of trust, commitment and understanding. If the community sees that you are willing to stick around and put in the time, they will be more willing to recognise your motives as genuine and may eventually form a productive relationship with you.

Helpful hints:

- Consistency and open communication are the keys
- Think of different ways to become involved with the community. Think outside the square
- Support important dates/events for Aboriginal communities and take part in community activities. e.g. NAIDOC week
- Take part in health days e.g. Well Persons Health Check etc
- Only make promises that you can deliver on
- Collaborate with other services and go out to the community in a group, e.g. men's health, women's health, diabetes etc. This destigmatises the issue of sexual health and places it within a more holistic approach to health
- Take the focus off health occasionally e.g. host a BBQ



Significant Dates for Aboriginal Communities

26 January Survival Day/Australia Day

For many Aboriginal people this day represents European invasion.

21 March Harmony Day

An Australian government initiative designed to build relationships and address racism.

26 May National Sorry Day of Healing


Marks the anniversary of the tabling of the Bringing Them Home report, which was the result of an inquiry into the removal of Aboriginal children from their families. The day focuses on the healing needed to achieve reconciliation.

27 May – 3 June National Reconciliation Week

Offers the opportunity to focus on reconciliation and to learn about the culture and history of Australian Aboriginals.

3 June Mabo Day

Commemorates the High Court decision in 1992 that recognised the existence of native title rights of Aboriginal Australians.



Significant Dates for Aboriginal Communities

1st Week of July (Sun to Sun) NAIDOC (National Aboriginal and Islander Day of Celebration) Week

Celebrates the history, culture and achievements
of Aboriginal people.

9 August International Day of the World's Aboriginal People

Celebrates the achievements and contributions of
Aboriginal people in the global community.

10 December Human Rights Day

Marks the adoption of the Universal Declaration of
Human Rights by the United Nations

*Adapted from: Engaging with local Aboriginal communities. A resource Kit for Local
Government in New South Wales 2007p 39-40*

Modes of service delivery

Outreach Clinics

Outreach clinics have been proven to be a useful way of providing culturally appropriate sexual health services to Aboriginal communities.

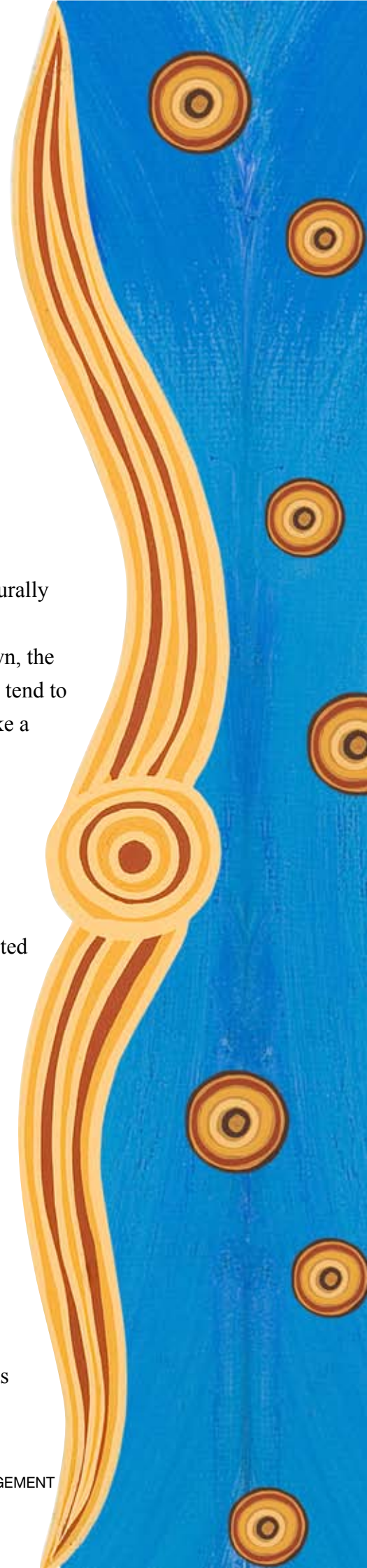
Where a community is located a considerable distance from town, the development of an outreach service may be necessary. Outreach clinics tend to be mobile services and not in static locations. Outreach services can take a variety of forms, including:

- a health bus or van, e.g. breast screening bus, Needle Syringe Program bus
- a car with workers conducting home visits

Outreach services involve all of the previously mentioned community consultations and processes, but it is imperative that if outreach is adopted as a mode of service delivery, it is consistent (e.g. the outreach service might be held every Monday from 1-4pm), realistic and beneficial to the community. Outreach services also need to be regularly evaluated for effectiveness to ensure that the services meet and are reflective of community needs.

The benefits of conducting outreach services include:

- increased access to health services
- meeting community needs
- reducing isolation
- placing health services in a familiar setting for community members
- reducing barriers such as transport and socioeconomic issues, e.g. bus fares





- providing a greater scope for opportunistic screening
- decreasing stigma associated with accessing services for sexual health concerns, and
- enabling the establishing of relationships of trust between service providers and the community



Outposts (Satellite services)

Outposts or satellite services are often defined as a part-time service operating from a static facility. This may include utilising a room within an existing service such as an Aboriginal Land Council, community hall or Aboriginal Medical Service, etc. Like outreach services, outposts also require a standardised timetable. For example, the outpost service will be available every Tuesday from 10am to 3pm.



Many of the benefits identified on the previous page for outreach services can also be applied to outposts. Additionally, outposts have the benefits of:

- service providers being less isolated and having the opportunity to call upon other staff if needed
- encouraging partnerships to be constructed between different services, and
- enabling sharing of resources such as computers, clinical equipment, telephones and often even administration staff



Static Clinics

Static clinics can include: GP surgeries, Aboriginal Medical Services, Sexual Health Services and specialist clinics within community health or hospital settings. If you run, or are working for, a static clinic you must be aware of the numerous barriers that affect Aboriginal people's access to services for sexual health concerns and work towards diminishing these barriers. It is also important to note that while you may be working for a static service, this does not mean that you are unable to get out into the community. Providing an ongoing regular outreach service may be one way that your service could provide an accessible and culturally appropriate service to the Aboriginal community or communities in your local area.



Partnerships

In today's world, with most services and organisations finding themselves working within a no-growth budget, networking and partnerships can be of the utmost importance.



To build a working relationship with these services:

- Ask to be kept updated with all current information
- Offer to be part of consultations in the area
- Ask to participate in relevant staff in-service training
- Ask for resources, publications or conference materials
- Get to know a particular staff member and build a relationship with them to ensure access to information or services as required, and
- Ask them to conduct workshops for your organisation.

Source: Taken from The Management of HIV/AIDS: A resource guide for Aboriginal primary health care organisations, ANCAHRD 2000, p42

Partnerships need to be developed across all levels including government departments, non-government and community-based organisations as well as Aboriginal communities. Only when this is achieved will effective service delivery take place that is culturally appropriate and accessible to Aboriginal people and adequately meets the needs of Aboriginal communities.

Training Chapter 2:

Community Engagement

Learning
Objective: 2.1

Recognising and understanding the cultural protocols to access and engage Aboriginal communities

Learning
Objective: 2.2

Understanding of culturally appropriate service delivery models for Aboriginal communities

Skills

On completion of this resource, individuals will have developed:

- An increase in confidence and ability to communicate within Aboriginal communities.
- Have an understanding of the cultural requirements to engage with Aboriginal communities.
- Increased understanding of the cultural sensitivities of screening for BBV's and STI's in Aboriginal communities.
- The ability to develop a program or service in partnership with an Aboriginal community which meets their community needs.
- An understanding and increased confidence in the use of culturally appropriate methods to engage with Aboriginal communities in topics such as BBV's and STI's.

Record of Assessment

Name of organisation

Name of Person conducting assessment

Use the checklist below as a basis for

Aboriginal Community Communications assessment:

	Yes	No	N/A
• Were culturally appropriate protocols recognised when engaging the Aboriginal community?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Were effective communication strategies used throughout the discussion to ensure the required information is accessed or messages communicated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Were areas of cultural sensitivities identified and addressed during the process to ensure no cultural conflict?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Were specific cultural and communication needs of the community or client identified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Was an opportunity provided to include all community people in the communication process?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Was an appropriate communication strategy developed to establish trust and accurate exchange of information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Was feedback provided and advice given to the community in a way which reflects current identified needs in relation to BBV's and STI's?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Was alternative service delivery models used to encompass holistic health including BBV's and STI's?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Were appropriate referrals to BBV and STI services made to ensure duty of care responsibilities were met?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Were opportunities provided to explore all relevant issues regarding BBV's and STI's in the community?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

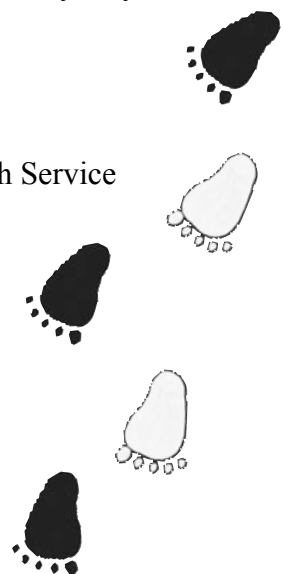
Did the assessment meet the required standard? **Yes** **No**

Notes



Endnotes

- 1 Australian Bureau of Statistics 2008, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*, Australian Institute of Health and Welfare, Australian Bureau of Statistics, Canberra, pp1 – 14
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- 3 National Centre in HIV Epidemiology and Clinical Research 2007, *Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance Report 2007*, Sydney, Australia
- 4 Australian Bureau of Statistics 2008, *op.cit.*, pp3-5
- 5 Vicary, D & Westerman, T 2004, 'That's just the way he is': *Some implications of Aboriginal mental health beliefs* Australian e-Journal for the Advancement of Mental Health, Volume 3, Issue 3, 2004, p1
- 6 Australian Health Ministers' Advisory Council 2004 *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009*, Australian Health Ministers' Advisory Council, Department of Health, South Australia, p3
- 7 NSW Department of Health 2007 *NSW HIV/AIDS, Sexually Transmissible Infections and Hepatitis C Strategies: Implementation Plan for Aboriginal People 2006-2009*, North Sydney, pp 4-5
- 8 NSW Department of Health 2006, *Annual Report 2005/06*, Sydney p iii
- 9 NSW Department of Health 2005, *NSW Aboriginal Chronic Conditions Area Health Service Standards*, Sydney, p1
- 10 *ibid.*, p1
- 11 National Centre in HIV Epidemiology and Clinical Research 2007, *op.cit.*, p11



- 12 *ibid.*, p16
- 13 *ibid.*, p20
- 14 *ibid.*, p27
- 15 *ibid.*, p30
- 16 *ibid.*, p30
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- 19 ACT Health 2004 *Cultural Respect Implementation Plan: Aboriginal and Torres Strait Islander Health Unit 2006-2009*, Aboriginal and Torres Strait Islander Health , ACT Health, ACT, p1
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- 21 Department of Aboriginal and Torres Strait Islander Policy and Development, Queensland Government 1999, *Protocols for consultation and negotiation with Aboriginal People*, Queensland p 26
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- 23 Australian Government, Department of Health and Ageing, 2007, *Alcohol Treatment Guidelines for Aboriginal Australians*, p31
- 24 National Centre in HIV Social Research 1999, *Aboriginal and Torres Strait Islander Sexual Health Promotion Initiatives in NSW*, Sydney, Australia p4
- 25 Vicary, D & Westerman, T 2004, *op.cit.*, p8
- 26 NSW Department of Health 2007 *NSW HIV/AIDS, Sexually Transmissible Infections and Hepatitis C Strategies: Implementation Plan for Aboriginal People 2006-2009* , North Sydney, p5
- 27 National Centre in HIV Social Research 1999 *op.cit.*, p16
- 28 Australian Bureau of Statistics 2008, *op.cit.*, p xxi
- 29 Commonwealth Department of Health and Aged Care, 1999, *op.cit.*, p48

- 30 Westerman, T 2004, *op.cit.*, p3
- 31 Australian Health Ministers' Advisory Council 2004, *op.cit.*, p6
- 32 Department of Aboriginal and Torres Strait Islander Policy and Development, Queensland Government 1999, *op.cit.*, p22
- 33 National Centre in HIV Social Research 1999, *op.cit.*
- 34 National Centre in HIV Social Research 1999, *op.cit.*
- 35 NSW Department of Local Government 2007, *Engaging with local Aboriginal communities. A Resource Kit for Local Government in New South Wales 2007*, Australia, p166
- 36 Queensland Health 2005 *One Talk: Queensland Health's Aboriginal & Torres Strait Islander Community Engagement Guide*, Queensland, p14
- 37 *Ibid.*, p14
- 38 Community Cultural Development NSW 2003, *Respect, Acknowledge, Listen: Practical protocols for working with the Aboriginal Community of Western Sydney*, Liverpool, Australia
- 39 Department of Aboriginal and Torres Strait Islander Policy and Development, Queensland Government 1999, *op.cit.*, p28
- 40 National Centre in HIV Social Research 1999
- 41 Department of Aboriginal and Torres Strait Islander Policy and Development, Queensland Government 1999, *op.cit.*, p28
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