DJIYADI
Can we talk?

A resource manual for sexual health workers who work with Aboriginal and Torres Strait Islander youth

ashm

NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION
NACCHO

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Djiyadi – Can we talk?
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Please note: if electronic links to resources listed in this resource do not work when using Internet Explorer, please try using an alternative browser such as Google Chrome or Firefox

Acknowledgements

This resource manual is for Aboriginal and Torres Strait Islander sexual health workers and other professionals who work with Aboriginal and Torres Strait Islander young people. It has been developed by the Australasian Society for HIV Medicine (ASHM), in partnership with the National Aboriginal Community Controlled Health Organisation (NACCHO).

ASHM also acknowledges the contributions of:

- the advisory committee that assisted in its development; and Kerry Arabena and other health professionals who contributed to the initial materials that were used in the development of this final version of the manual
- the Australian Health*infoNet*[1] staff who contributed to and edited the final version
- Aboriginal and Torres Strait Islander stakeholders and other health professionals working in the area of sexual and reproductive health who were involved in consultations and focus group discussions.

A full list of contributors can be found in Section 2 – *Background and supporting material*.

Funding

The resource was funded by the Australian Government Department of Health and Ageing.

1 http://www.healthinfonet.ecu.edu.au/

Artwork

About the artist

Donna Rioli, a young Tiwi–Nyoongar woman, is dedicated to the heritage and culture of the Tiwi people on her father's side and the Nyoongar people on her mother's side. Donna enjoys painting because it enables her to express her Tiwi and Nyoongar heritage, and she combines the two in a unique way.

About the artwork

Symbols

	This symbol represents an individual female
	This symbol represents an individual male
	This symbol represents families sitting around a campfire
	This symbol represents the health profession (e.g. doctors, health workers)
	The grey dots represent the interconnections between individuals, families and the health profession in sexual and reproductive health

The title of the resource 'Djiyadi' means 'Talk' in the Sydney language. We are grateful to and acknowledge the Metropolitan Land Council (MLC) who made the translation and consented to the use of Djiyadi for this resource. We also acknowledge Paige Dowd who facilitated communication between ASHM and the MLC.

Preface

This resource was developed as a joint initiative between the Australasian Society for HIV Medicine (ASHM) and the National Aboriginal Community Controlled Health Organisation (NACCHO). We recognised the great need to help address sexual health concerns in our Aboriginal and Torres Strait Islander young people. It's difficult being a teenager, but it's also a time of fun, excitement and experimentation. What we've tried to do in this resource is to explore sexual health in a way that is meaningful for those of us who work with young people. It can be difficult to talk about sex, health, relationships and the risks young people take when they are learning about their sexuality and how to relate to others in meaningful and respectful ways. This resource aims to try and make it easier to start those discussions, to open doors that will lead to better communication.

We are hearing a lot about Aboriginal and Torres Strait Islander health disadvantage; for example, we know that Aboriginal and Torres Strait Islander young people are more likely to contract a sexually transmitted infection than their non-Indigenous peers. We are also hearing a lot about strategies to close the gap. This resource is a positive step to trying to reduce that gap, to equipping our health workforce so that they can develop the confidence and skills to address these difficult issues head on.

This is a rewarding yet challenging area. Workers must tread a path through often competing demands, maintaining confidentiality and respecting cultural sensitivity for individuals and communities while balancing obligations in regard to contact tracing and mandatory reporting.

We hope this resource provides some assistance. It has taken a lot of work to get to this point. Many people have worked on this resource, and each has contributed to the refinement of its content, focus and presentation. The Australian Government Department of Health and Ageing supported the resource, and it has been developed in the context of the 3rd National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmitted Infections Strategy[2]. That strategy prioritises workforce issues, and this resource should contribute to addressing the issues confronting the Aboriginal and Torres Strait Islander health workforce. The resource should stand the test of time. It will, we are sure, become a foundation text for the new sexual health worker, as well as a handy reference for those with experience of working with young people.

Our organisations, staff and committees have enjoyed working together on this worthwhile initiative and we look forward to many more collaborative ventures. We have all learned from the experience and we have a great product to show for our efforts.

Levinia Crooks
Chief Executive Officer
Australasian Society for HIV Medicine (ASHM)

Donna Ah Chee
Chief Executive Officer
National Aboriginal Community Controlled Health Organisation (NACCHO)

2 http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-national-strategies-2010-atsi-bbv/$File/atsi.pdf (accessed 4 August 2011)

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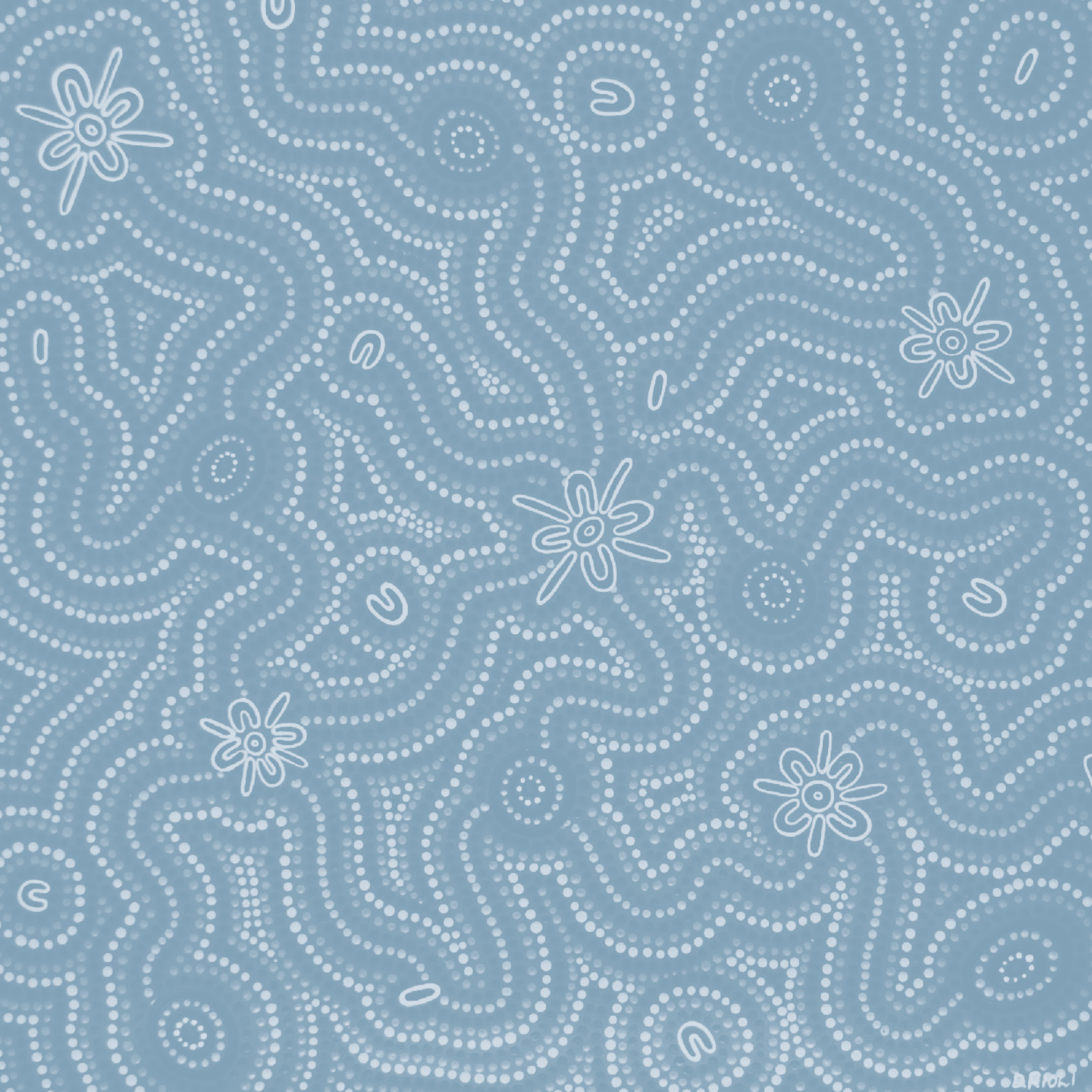
INTRODUCTION



Welcome to *DJIYADI – Can we talk?* This resource manual is for sexual health workers and other professionals[3] who work with Aboriginal and Torres Strait Islander young people.

Objectives of resource

DJIYADI – Can we talk? aims to promote positive sexual health among Aboriginal and Torres Strait Islander young people. The information and resources in this manual will help workers to give meaningful, accessible and culturally appropriate sexual health advice and care to young Aboriginal and Torres Strait Islander people.

Who is this resource for?

This resource has been developed for Aboriginal and Torres Strait Islander sexual health workers. Other people who work with Aboriginal and Torres Strait Islander young people will also find parts of this resource useful. Such people include Aboriginal and Torres Strait Islander health workers, nurses, health promotion workers, youth workers, teachers, drug and alcohol workers, and community development workers.

How to use the resource

This resource will not tell you how to do your job because every job is different, and every young person is different. Knowing what to do will depend on your job description and the needs of the young people you work with.

DJIYADI – Can we talk? is flexible — you can either read it from cover to cover like a book, or pick and choose the sections that are most suited to your situation. This resource is a guide only; it should not be used as a source of legal advice. If you are unsure about your legal responsibilities toward young people who are at risk of poor sexual health, you should seek legal advice in your state or territory.

DJIYADI – Can we talk? is not a clinical manual; therefore, it does not include information that will assist you in providing clinical care to patients. If you would like information on clinical practice, please see the resources listed below:

- Early detection and treatment of STIs and blood-borne infections (BBIs): A manual for improving access to early detection and treatment of STIs and BBIs within Aboriginal communities in NSW. Sydney: Aboriginal Health and Medical Research Council of NSW, 2006.
- Sexual health orientation package for endemic regions. Perth: Western Australian Department of Health, 2010.

Please also refer to the *Background and supporting material* for additional information and useful resources.

3 The sexual health workforce includes Aboriginal and Torres Strait Islander sexual health workers and many others whose work focuses wholly or mainly on sexual health, and people for whom sexual health is just one of their responsibilities.

Sexual health

Sexual health is a basic human right. This means that everyone should have control of their sexual health, and be free to enjoy a safe and healthy sexual life. Unfortunately, some people are not healthy sexually because they have acquired an infection through sexual contact. Violent sexual experiences and other factors can also make people's sexual lives unhealthy and unhappy.

Sexual health issues are particularly important for young people. It is therefore important that young Aboriginal and Torres Strait Islander people have all the help and support they need to enjoy good sexual health. As a sexual health worker, you can provide young people with this help and support.

Aboriginal and Torres Strait Islander sexual health workers

You are an important part of the sexual health workforce. You provide the vital link between the Indigenous community and health services by promoting healthy sexual practices and by helping Aboriginal and Torres Strait Islander people get access to specific health care services.

National and state or territory sexual health strategies for Aboriginal and Torres Strait Islander people acknowledge the important work you do. These strategies also call for there to be more of you in the community and for you to be provided with appropriate training and ongoing support.

You may take on a variety of tasks in the workplace, depending on your level of training and the requirements of the state or territory and the place in which you work. For example, some of you might focus on sexual health promotion, whereas others might provide clinical care.

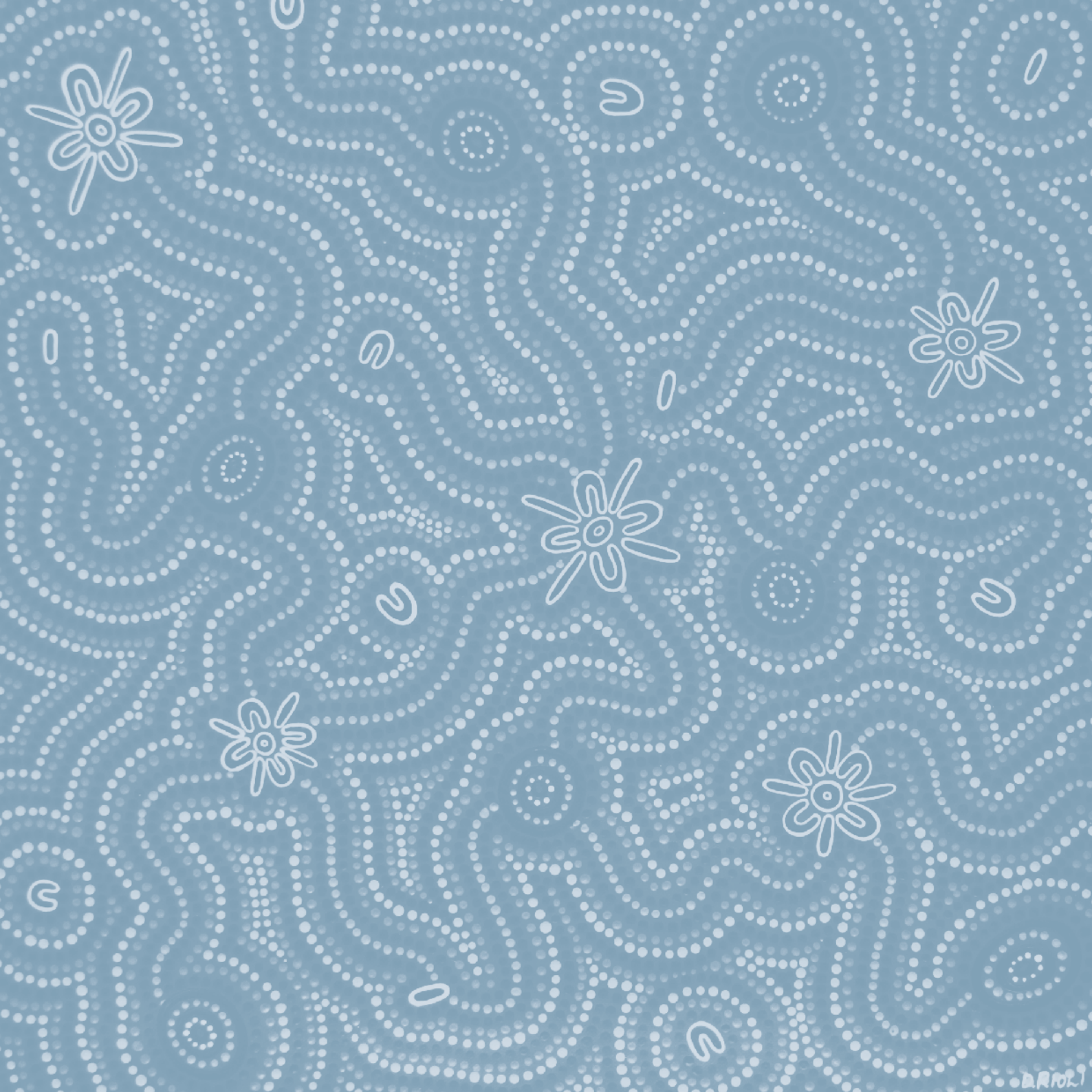
Your role can be difficult at times because sexual health is such a sensitive and complex issue. Therefore, it is important that you have access to lots of helpful information. It is for this reason that *DJIYADI – Can we talk?* has been developed.

Resource contents

This resource begins by looking at sexual health in Aboriginal and Torres Strait Islander society, focusing on issues such as sexually transmissible infections (STIs) and blood-borne viruses (BBVs), risk behaviours, and the growth and development of Aboriginal and Torres Strait Islander people. Chapter 2 discusses issues related to being a sexual health worker, including different aspects of sexual health work such as referral and the importance of self-care. Chapter 3 focuses on educating groups and individuals in sexual health, and Chapter 4 looks at ways of improving access to sexual health services with attention to cultural respect and sensitivity, community involvement and working holistically. The final two chapters of this resource discuss several sensitive issues in sexual health: taking a sexual history, contact tracing, child sexual abuse and sexual assault.

1

SEXUAL HEALTH IN ABORIGINAL AND TORRES STRAIT ISLANDER SOCIETY



1.1 Introduction

Sexual health and wellbeing are important if people are to enjoy responsible, safe and satisfying sexual lives.

In this chapter, we look at sexual health in the Aboriginal and Torres Strait Islander population. First, we talk about sexual health and infections that can be transmitted sexually (generally referred to as STIs) or via blood (generally referred to as BBVs). We then focus on sexual risk behaviours and the sexual health of Aboriginal and Torres Strait Islander people. Finally, this chapter provides information on the growth and development of young Aboriginal and Torres Strait Islander people.

1.2 What is sexual health?

The World Health Organization (WHO) defines sexual health as a state of physical, emotional, mental and social wellbeing in relation to sexuality. Thus, sexual health means more than being free of diseases or disorders that affect the body's sexual functioning. Sexual health includes reproductive health and sexuality; it is also about a person's ability to enjoy and control sexual experiences — free from coercion (being forced), discrimination or violence. The sexual rights of individuals must always be respected, protected and met.

As with all societies, sexual health for Aboriginal and Torres Strait Islander communities is embedded in culture. A holistic approach to health (and sexual health) includes not only the physical wellbeing of Aboriginal and Torres Strait Islander people, but also their cultural, emotional and spiritual wellbeing.

Cultural traditions are important in the context of sexual health

Aboriginal and Torres Strait Islander cultural traditions are important in the context of sexual health, because the traditions determine when sex and sexuality can be discussed. Men's business and women's business mean that some issues, including certain sexual matters, can only be talked about with people of the same sex. These cultural traditions may not be the same for each Aboriginal and Torres Strait Islander community, so it is important to talk to community members to find out what is appropriate.

1.3 Sexually transmissible infections

STIs are infections that are passed from person to person mainly through sexual activity; such activity can include vaginal, anal (bum) or oral (mouth) sex. Since many people who have an STI may not have any symptoms, it is important to get the facts about STIs, including:

- how STIs are passed from one person to another
- how to avoid infection
- the health risks if an STI is not treated
- where to go for help if a person thinks she or he may have an STI.

STIs are caused by organisms, particularly bacteria and viruses. Infections caused by bacteria include chlamydia, gonorrhoea, syphilis and donovanosis. Those caused by viruses include herpes (also called herpes simplex virus [HSV]), human immunodeficiency virus (HIV), human papillomavirus virus (HPV) and hepatitis B (see *Background and supporting material*, Section 3.2, for more detailed information).

1.4 Blood-borne viruses

BBVs are viruses that are present in the blood of an infected person. These viruses are passed on by coming into contact with the blood of a person who is infected with the virus. They can be spread in different ways, including having sex with a person who is infected, using unsterile (dirty) needles to inject drugs, or breast feeding. Examples of BBVs include hepatitis B and C, and HIV (see *Background and supporting material*, Section 3.2, for more detailed information).

1.5 Why are STIs so important?

Most STIs are easily treated with one course of antibiotics. So why the big fuss about them? These infections are important because they can:

- cause damage inside the body that leads to infertility in both men and women
- lead to long-term sickness
- help the HIV virus to get into the body through sex — there is no cure for HIV and it can make people sick for their whole life
- affect the health of babies, causing them either to be born early or to be born with sickness
- cause social problems because of the blame and guilt that can happen when partners get infected.

One of the important things to know about STIs and BBVs is that they often don't cause any symptoms, so people can be infected and not know that they are infected. Because the damage to people's insides and their general health can be going on without them knowing about it, it is important to get tested. With a simple test — often using urine or swabs that a person collects privately — it is easy to be diagnosed and treated for an STI.

1.6 Sexual risk behaviours

Behaviours that put young people at risk of STIs, BBVs and unwanted pregnancies include:

- having sex without a condom
- having many sexual partners
- having first sex at an early age
- having sex while drunk or under the influence of other drugs (i.e. being high)

- not going to the health clinic to get a check-up and treatment if there is the risk of infection with an STI
- not telling partners about an STI so they too can get checked and treated
- injecting drugs using unsterile injecting equipment.

1.7 Aboriginal and Torres Strait Islander young people and sexual health

As in the general population, most Aboriginal and Torres Strait Islander people become sexually active in their teenage years. It is during this time that young people also become aware of physical and emotional changes, and their own sexual responses. Young Aboriginal and Torres Strait Islander people need to deal with many challenges, including:

- getting accurate (correct) knowledge about sex and reproduction
- talking about consensual sex (both partners agreeing to the sexual activity) and safe sex
- talking about contraception (birth control)
- dealing with relationships (such as breaking up)
- gaining knowledge about STIs
- dealing with sexual assault and abuse.

There are often other influences on young Aboriginal and Torres Strait Islander people that may affect their decisions about their sexual health, for example:

- emotional and spiritual wellbeing
- cultural values about sexuality and reproduction
- family situations
- poverty
- attending school.

1.8 What do we know about the sexual health of Aboriginal and Torres Strait Islander people?

A variety of information is available about the sexual health of Aboriginal and Torres Strait Islander people. This includes information about pregnancies and birth, STIs and BBVs, and factors related to sexual health. Although some of this information is quite limited, it is clear that many aspects of sexual health are worse for Aboriginal and Torres Strait Islander people than they are for other Australians. (For more information about the sexual health disadvantage experienced by Aboriginal and Torres Strait Islander people, see *Background and supporting material*, Section 3.1.)

1.9 Adolescence in Aboriginal and Torres Strait Islander society

Youth (also known as adolescence) typically covers the ages between 10 and 24 years, and includes three stages of development:

- early: 10–14 years (typically known as puberty)
- middle: 15–19 years
- late: 20–24 years.

In general, this is a time of great physical, emotional, intellectual and behavioural change. Aboriginal and Torres Strait Islander people associate this stage of life with increasing self-reliance and sense of self. Over time, changes have occurred to life conditions for Aboriginal and Torres Strait Islander young people. These have included:

- changes in the traditional community working roles of young people
- increasing adoption of Western culture by young people
- changes in how marriage and relationships are understood by young people.

In comparison with non-Indigenous young people, Aboriginal and Torres Strait Islander young people are generally more disadvantaged and they may not have similar access to resources, opportunities and support. This statement is based on statistics that show young Aboriginal and Torres Strait Islander people are:

- more likely to be in the care of the state
- more likely to report their main source of income as government allowance
- more likely to be incarcerated (in prison)
- less likely to be participating in full-time education.

These disadvantages can lead to Aboriginal and Torres Strait Islander young people more often being in situations of high health risk. It also may lead to them developing independence at an earlier age than other Australian young people. Aboriginal and Torres Strait Islander young people have reported that being independent is more valuable to them than physical and mental health, and that getting a job is of equal value to their health. In comparison, non-Indigenous young people value physical and mental health more than both independence and getting a job.

In Aboriginal and Torres Strait Islander communities, roles for males and females and family and cultural norms (rules) for sexual behaviour may encourage young people to become parents at a relatively early age. At the same time, many young Aboriginal and Torres Strait Islander women may feel conflict about sex and pregnancy — they worry about unwanted pregnancies and about the reputation they may get from being sexually active.

To be able to help young Aboriginal and Torres Strait Islander people, you need to understand their attitudes and behaviours about their relationships, birth control methods and safe sex, and also their hopes for the future and parenthood.

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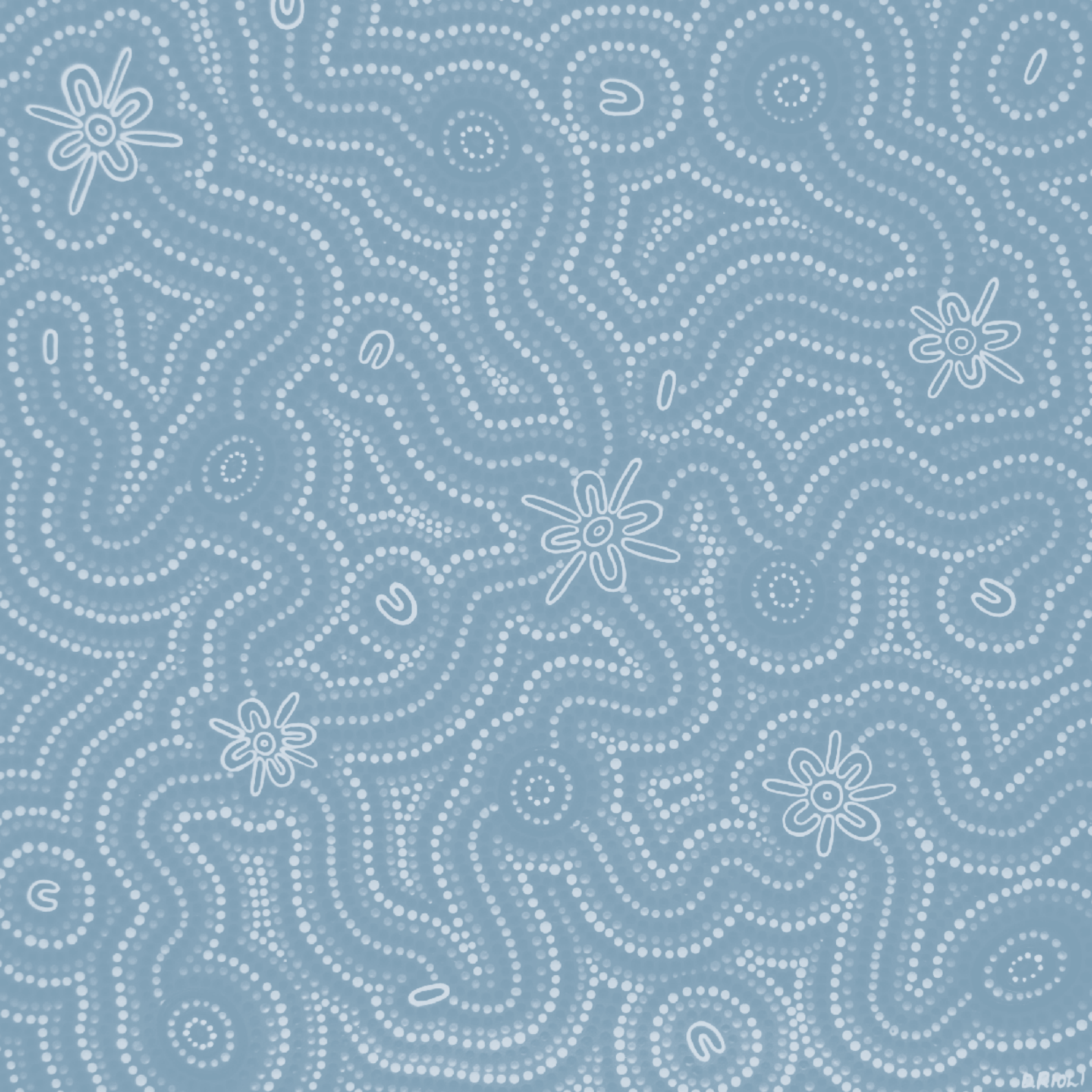
2

BEING A SEXUAL HEALTH WORKER



2.1 Understanding your role

There are many aspects to sexual health work. Your role will depend on where you work, your training, your experience, and the state or territory and region in which you work.

Many other professionals also have responsibility for this work. Some, such as nurses, provide clinical services but may not do much community education. Others, such as teachers and Aboriginal health workers, may occasionally educate young people about sexual health.

Whatever your core business, if you work with Aboriginal and Torres Strait Islander young people, you can play an important role helping them to find reliable sexual health information and services. It is sensitive and complex work, so you need training before you begin, and ongoing training to keep you updated and supported.

2.2 What are the goals of sexual health work?

Let's go back to the definition of 'sexual health' in Chapter 1. Sexual health is about:

- being able to enjoy and control sexual experiences and relationships — free from coercion (being forced), discrimination or violence
- being free of diseases or disorders that affect a person's sexual health and functioning.

Based on this definition, there are at least two important goals of sexual health work with Aboriginal and Torres Strait Islander young people:

- for young people to have the skills and knowledge needed for positive and healthy sexual relationships and protection from harmful relationships, STIs and unwanted pregnancy
- for young people to have access to clinical treatment if they are at risk of an STI or need other help with their physical or emotional health.

These are important and valuable goals that have social and emotional as well as clinical aspects. There is a need for both knowledge and skills in communication and relationships. This is why sexual health work is not limited to clinics and health workers. It is best to have a team working together to help young Aboriginal and Torres Strait Islander people achieve sexual health.

In an ideal world, the team would include health workers, teachers, counsellors and all those who can assist young people — including the young people themselves, their family and the wider community. However, in the real world, few people are directly involved with sexual health, and sexual health workers are likely to be working alone. Linking up with others and promoting the idea of working as a team will help you to share the load and improve the amount and quality of sexual health education and support that young Aboriginal and Torres Strait Islander people receive.

There is a need for both **knowledge and skills** in communication and relationships

2.3 Different aspects of sexual health work

Listed below are some of the duties included in sexual health work. You may have a job that covers all of these duties, or you may do just one or two of them. Duties include:

- education:
  - providing information to groups (e.g. giving talks or workshops about safe sex in schools or youth centres; running sexual health sessions for men's or women's groups)
  - running structured programs that teach skills and information (e.g. a 10-week program for young people aged 11–14 years that covers many aspects of growing up, including relationships, sexuality and safe sex; a safe sex program for young women that includes negotiation and consent skills)
  - being a source of good, reliable information and educating individual community members and families (e.g. through yarning with community members or clients; peer education)
- health promotion:
  - running community events, such as sexual health stalls at World AIDS Day and National Condom Day
  - running activities, such as sexual health poster design art competitions to engage young people in the topic in a creative way (e.g. the Western Australian AIDS Council's 'Art for Life' competition)
- providing health 'hardware':
  - making sure condoms are available in the community (e.g. asking the youth service to have a bowl of condoms on the front counter; getting a condom vending machine installed in the local service station)
  - making sure that sterile injecting equipment is available in the community
  - making a health service more youth friendly and sex positive (e.g. by putting up appropriate posters and by hosting youth events)
- liaison:
  - building relationships with organisations that service Aboriginal and Torres Strait Islander young people (e.g. schools, youth centres, prisons and juvenile justice centres, mental health services), and encouraging those service providers to offer sexual health education to their clients
  - advising other organisations and individuals about Aboriginal and Torres Strait Islander sexual health

  - building relationships with Aboriginal and Torres Strait Islander community members and organisations (e.g. offering to give a talk to the board members of local organisations; hosting a 'safe sex' sausage sizzle at your organisation so that locals get to know where you are and what you do)
- referral:
  - knowing what services are available and referring clients as needed
- clinical aspects[4]:
  - undertaking clinical work in a health service or through outreach (e.g. collecting urine (pee) samples, or swabs; assessing risk through taking a sexual history; making sure people receive treatment once they are diagnosed)
  - doing contact tracing (i.e. following up the contacts of someone who has been diagnosed with an infection so their partner or partners can be treated)
  - bringing people to the clinic for a check-up
  - keeping records of client contacts
  - helping to run outreach clinics at youth events or in places such as youth centres
  - educating health professionals (e.g. reminding doctors and nurses to offer STI tests to young people even though they have no symptoms; explaining how to be culturally sensitive in sexual health).

4 See Chapter 5 for more information about clinical aspects, including contact tracing

2.4 Your local sexual health network

Section 3.3 of *Background and supporting material* includes a table titled 'Aspects of sexual health work'. Completing this table will help you to think about your role, what training you need to do and who else can be a part of your local sexual health network or team. Building and maintaining relationships with other workers and organisations will keep you tuned in to local issues affecting young people and sexual health; it can also give you a support network for difficult issues.

People who may be a part of your network include:

- the teachers responsible for health education at the local schools
- the Aboriginal and Torres Strait Islander education workers or liaison officer at the school
- youth workers
- nurses, doctors and Aboriginal and Torres Strait Islander health workers in clinics
- health promotion officers
- community and public health workers.

Drop in and visit these people, take some leaflets or posters, and find out how you can help each other to keep Aboriginal and Torres Strait Islander sexual health on the local agenda.

You can also link into regional, state or territory and national networks (see *Background and supporting material*, Section 5.1 for a list of networks in various states and territories).

2.5 Working positively with your network

You need to be clear about your role and responsibilities, and how you are going to work with your colleagues. As far as possible, try to develop respectful relationships and a clear understanding of what your role involves. Let people know what your goals are, what training you have had and how you can work as a team. Good communication and clear expectations will help to avoid situations like those given in the box below.

'I sometimes hate working with the nurses. I have all their competencies and more in sexual and reproductive health. I have clinical experience and can work independently, but to them, no matter how hard I try to tell them different, I am just a glorified patient transporter. That's what I get paid to do, go around and pick up clients to bring them back for them to do the consult with. It's hard.' **Aboriginal health worker, NSW**

'Here I am looking for a health worker to help me, and they are never here. I go out the front to see if I can see them but they are off in the car somewhere. Again. I just need to know that the client knows what I am talking about. It is hard when the whole family is there for the consult too.' **Remote area nurse, NT**

2.6 Establishing referral pathways in your region

Building your local network will also help you to find out about referral pathways for clients. You and your clients will get far more benefit if you have a personal relationship with key service providers. For example, having a friendly relationship with a receptionist can improve your client's access to that health service.

Some tips for developing referral pathways are to:

- identify the key referring agencies
- find out the proper way to refer clients, particularly what you need to do if they need urgent attention
- develop relationships with the service providers at all levels, including office workers and clinical staff
- keep working on those relationships once you have made contact; for example, when you visit agencies, invite them to visit you so they can understand what your workplace is like.

If there is regular staff turnover, you will need to keep building these relationships and referral pathways. Keep getting out there and letting people know who you are, what your agency is, and what work you do. Keep accurate, up-to-date contact details of your network and referral pathways that can be easily found and used by others in your service.

When doing a referral, it is important to provide information about the client. Sometimes clients are not sure of the reason for the referral or are not able to communicate this clearly. Creating a written referral that has been discussed with the client will avoid this problem. You may prefer to email or post referral letters because clients might lose them.

Here are some examples of the services you may need to refer clients to:

- health clinics
- primary health care — general practitioners (GPs), nurses, health workers and allied health professionals
- specialist care — hospital and clinic based
- hospital emergency departments
- advocacy — social and legal services
- interpreters
- patient travel services
- government support agencies such as Centrelink
- other social services
- nongovernment agencies
- mental health services
- antenatal and postnatal services
- alcohol and other services
- youth services
- justice and police services
- correctional services
- child protection services
- sexual assault services
- emergency and supported accommodation services.

When doing a **referral,** it is important to provide information about the client

2.7 Knowing yourself

Whether your role in sexual health is broad or narrow, you will need to know a bit about yourself, and have a good idea of your strengths and limitations.

Shame

The word 'shame' often comes up with sexual health issues in Aboriginal and Torres Strait Islander communities. Shame can mean embarrassment from talking about sensitive issues or from being singled out.

> **Interviewer:** ... 'What about talking with family about things like [sexual health]?'
>
> **Participants:** 'Ah, shame ... my mum talks with us about it ... gross, nah ... I didn't even talk to mum when I went to get the pill, I took my auntie and told her to never tell mum...'
>
> **Participants in a young women's group**

People can also feel shame, or embarrassment, about not knowing something.

> 'Yeah, we shame about this sex stuff. But we shame 'cos we don't know what to tell our kids about it, too.' **Aboriginal parent in a mothers' group**

Shame can be a big barrier to young people getting access to the information and services they need. You may need strategies to help young people overcome shame, such as making services youth friendly.

To start with, you should get to know the things about sexual health that embarrass you, or that you are uncomfortable with, and find training or support to become more comfortable with those things and with sexual health in general (see *Background and supporting material*, Section 5.2 for a list of training providers).

Sexual health knowledge

No matter what your role, you need to know the facts about sex, reproduction and relationships. It takes training and practice to be able to talk comfortably — even about the basics. Good training is very important. If you can't attend training, there are some excellent websites that have basic, factual information to get you started (see *Background and supporting material*, Section 3.4).

Values and attitudes

You need to know not just the basic facts, but also your own values about sex, sexuality and relationships. If you are deeply shocked by things like underage sex, prostitution or homosexuality, you may find yourself being judgemental of the young people who look to you for guidance and advice about these issues. It is important that you get training to help you understand yourself better and learn strategies to be accepting and nonjudgemental of people who are different from you.

Sometimes, if we don't have information about certain issues, we cannot understand them. Make sure that you try to understand the reasons for your clients' behaviour. You may not agree with the reasons, but understanding them will help you to respond professionally and be able to help your clients.

Examples of things you may find confronting:

- clients being affected by drugs or alcohol
- very young clients disclosing (telling about) sexual behaviour
- clients disclosing sexual abuse
- dealing with unwanted pregnancies.

Identify what makes you uncomfortable and develop coping techniques. For example, if the behaviour is unacceptable you could develop standard scripts (what to say) and practise these. It is important that your clients receive the services they need. If you cannot provide a particular service, make sure you refer the clients to someone who can.

2.8 Maintaining a professional role

If you work in a small community, you may find it difficult hearing confidential and sensitive information about neighbours and community members. You need to maintain a professional role so that community members are confident that their private business will be kept confidential. (See *Boundaries and working in a community that knows you* in Chapter 4 for more on this topic.)

Risky behaviour

People love talking about sex, pregnancy, alcohol and drug use when it is happening to someone else. On the other hand, people's sexual behaviour and concerns they have about their own health are very personal and sensitive. People may be taking risks — such as who they have sex with, whether they have safe sex, whether they give consent, and whether they think about pregnancy or infections. Their concerns and fears may be different from yours. Disclosing risk-taking behaviour is not easy for anyone.

Client and health worker

You may know your clients outside the clinic, and may know their family and friends; you may even be related. These people may see you in the clinic and disclose confidential matters about their health and circumstances. Whatever their expectations of your role, you must maintain confidentiality.

Community influences

You may feel pressured to talk about your clients to others, or to give advice to your client that they do not want. There can also be groups in the community with differing positions, and they may try to pressure you in different directions.

The organisation

You may find that your organisation responds in different ways to the sexual and reproductive health issues of young people; this may affect how you can perform your professional role.

Professional and personal support

Sometimes, there may be a lack of professional and personal support available at work and outside of work. This may affect your work performance and wellbeing.

How do workers handle these issues and the very sensitive consequences that may result? Being prepared is useful, but it is not possible to prepare for every situation. It is valuable to develop a system of self-support and professional support where you can discuss and plan these issues as they arise or before they happen.

2.9 Self-care

Self-care starts with the belief that looking after yourself is vital to your personal and professional wellbeing.

It is important that you look after yourself because you:

- are a valuable and worthwhile person
- are a valuable and worthwhile professional
- can't do everything
- are not indispensable (absolutely necessary)
- are part of a wider system, community and society
- will be more effective in your work and home life if you are not tired, stressed, nervous, worried or scared.

If the organisation or the system is not providing you with the support you need, you will have to look to other places, people or methods.

Ways of looking after yourself include:

- setting limits for work and play (e.g. do not engage in leisure activities at work, and do not work during leisure time)
- taking your allocated breaks (e.g. lunch and annual leave)
- using your friends, family and colleagues to support you and vice versa (e.g. talk about issues and concerns without breaching confidentiality).

You should seek help about:

- what you don't know — you are not expected to be an expert in everything
- how things are done
- your context — find out whether your experiences and your clients are similar to other workers in your field
- your irregular behaviour — alcohol, drugs and food become a problem if used as an escape; self-medicating with pharmaceuticals (pills) is also not a good way to care for yourself
- any ongoing feelings you may have of anxiety (nervousness), anger, depression and hopelessness, or of being trapped or overwhelmed.

A problem shared is a problem halved

With such demanding and sometimes stressful work, you will, from time to time, experience problems that affect your health and wellbeing. Although you work in the health sector, don't be tempted to diagnose or treat yourself. The saying that 'the lawyer who represents himself or herself has a fool for a client' also applies to health professionals.

In thinking about the need for professional and personal support, remember:

- different issues require different approaches
- everyone has different capacities, strengths and weaknesses
- you need to identify early when you have reached the limit of your clinical or counselling skills or your personal resources, because the longer you wait, the harder it may become to deal with the issue

- to consider whether there are personal issues — with colleagues, clinical supervisors or managers
- you are not available all the time, so develop a polite and acceptable way to be unavailable, and get managerial support
- you need to understand the consequences of being unavailable (e.g. clients may have to seek help elsewhere) and always available (e.g. you might become physically and mentally exhausted), and decide how you will deal with the consequences of both actions
- you can share with your supervisor or manager any worries about managing work, because such worries can be easily sorted out
- professional support is available (e.g. counsellor, GP or professional association) and if you are concerned about confidentiality or privacy, discuss this with your health-care provider.

For people working in rural and remote areas, the Council of Remote Area Nurses of Australia (CRANA) offers a confidential 24-hour phone support service (1800 805 391). This service is for all health professionals, including Aboriginal and Torres Strait Islander health workers and allied health workers in rural and remote settings. You do not have to be a member of CRANA to use the service.

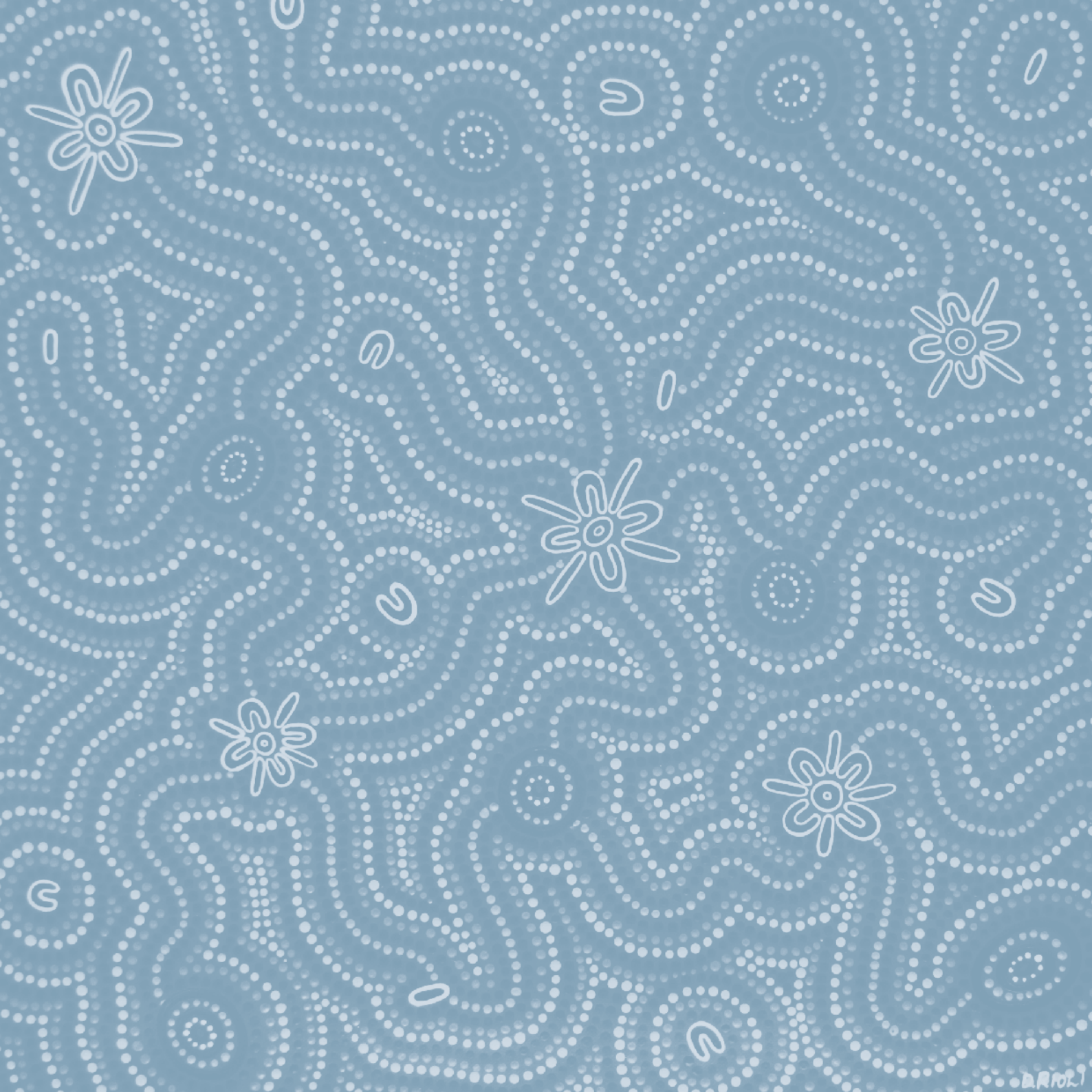
'A young dad I was working with ended up going on a rampage after his ex-missus took that baby to another town and wouldn't let him see her. It really ripped him apart; he said he felt like a failure again after all we had done to build him up. He come good for a while, then, without warning mate, he suicided. He was covering up just how much pain he was in. Man, it really broke my heart. Now his family want payback from her family and it's all on. And that's just one kid. There are at least a dozen of them I work with who go through this all the time. It's really getting to me, you know?' **Youth worker, SA**

2.10 References and suggested readings

Larkins SL, Page RP, Panaretto KS, Scott R, Mitchell MR, Alberts V, et al. Attitudes and behaviours of young Indigenous people in Townsville concerning relationships, sex and contraception: the 'U Mob Yarn Up' project. Med J Aus. 2007;186(10):513–518.

3

EDUCATING ABOUT SEXUAL HEALTH



3.1 Introduction

Let's revisit the goals of sexual health work; these are:

- for young people to have the **skills and knowledge** to enjoy **positive and healthy** sexual relationships so that they can **protect** themselves from harmful relationships, STIs, and unwanted pregnancy
- for young people to have **access to clinical treatment** if they are at risk of an STI or need other help with their physical or emotional health.

Working towards these goals takes a lot of education — formal and informal. The first half of this chapter is about formal education — lessons, workshops, programs, and so on. The second half is about informal education, which often happens through casual conversations and yarning.

Young people get their sexual and reproductive health information from many sources including parents, relatives, friends, television, DVDs, magazines, religious groups, the internet, school and special workshops. Along with the information come a lot of values, attitudes and behaviours that young people also need to make sense of.

Research with young Aboriginal and Torres Strait Islander people in Townsville found that some families gave their children good sexual health information, whereas other families did not discuss sexual health issues. As in the non-Indigenous population, many families find it hard to talk with their kids about sex and staying safe, and they hope that school will give their children the information they need to build happy and healthy sexual lives.

Young people get their sexual and reproductive health information from many sources

A lot of young people get their sexual health information from peers — and it is often wrong!

You play an important role in making sure that young Aboriginal and Torres Strait Islander people receive accurate and factual information about sexual and reproductive health. Below is some information about different ways of educating young people on this subject.

3.2 Educating groups

School-based sexual health education

In Chapter 2, we introduced the idea of a local team or network who can share sexual health roles. A local team could include workers from many sectors, including health, education, youth and welfare.

School teachers are important members of your local sexual health team. Most schools give their students some basic education about male and female physiology and the mechanics of sex and conception, usually when children are in years 6 or 7. For many Aboriginal and Torres Strait Islander kids, this is their main source of early information about sex. Unfortunately, many students miss out on this education because they are not at school on that day or they are just 'turned off' by the subject. Sometimes in high school, additional classes are given on contraception, pregnancy, alcohol and other drugs and sex. These are often taught in years 8, 9 or 10. Again, many Aboriginal and Torres Strait Islander teenagers may miss out on these lessons (see later section on special workshops).

If you work in the health or education sectors, you may be invited to deliver or assist with classroom sexual health education. Most states and territories have curriculum material for school-based education; these include lesson plans, DVDs, pictures and fun activities. Nongovernment schools, including church schools, also have these materials. If a school invites you to work with young people in the classroom, talk to the teacher first to find out the content of the lesson, the lesson plan and the materials that will be used. If you and the teacher are going to deliver the lesson together, work out what part you will each play (see *Background and supporting material*, Section 5.3 for examples of school-based curriculum materials).

Education about clinical services

Many Aboriginal and Torres Strait Islander young people are sexually active by the age of 15. Therefore, if you are developing lessons for teenagers, it is important to remember the second goal of sexual health work:

- for young people to have **access to clinical treatment** if they are at risk of an STI or need other help with their physical or emotional health.

You may be able to include information about clinical services in school-based sexual health lessons. For example, you can tell young people:

- where and when to go for a sexual health check-up (e.g. local youth-friendly GP services, Aboriginal health services, community health, special sexual health services and hospital emergency services)
- how easy it is to get an STI test — by self-obtained swabs or urine sample (e.g. in some states a form can be downloaded from the internet and taken to a local pathology laboratory with the urine sample)
- what day and time a youth-friendly or gender-appropriate worker is available at the clinic or health service
- how to ask for an STI test (e.g. explain that they can simply say 'I think I may need to have an STI test'; you can print a card for young people to take to the clinic so they don't have to speak their concerns out loud).

'I'd like to be tested for an STI. I think I may be at risk.'

Special workshops in schools and other settings

You may be asked to deliver workshops on particular topics (e.g. contraception and condom use or pregnancy) to groups of young people in schools, youth centres or correctional services. If you haven't had training on this topic, seek advice from an expert. If there is no expert available, get familiar with the content area through reliable websites or other resources.

Don't work in isolation. Think about who in your local sexual health network could help you out with the planning and delivery of the workshop (e.g. a youth worker, teacher, Aboriginal and Torres Strait Islander education worker or nurse). It is always worth having someone with you in the room who knows that group of young people and works with them regularly. Spend time with your support person beforehand explaining your aims for the session and what content you will cover; this prepares the other person and reduces their discomfort with the content. (See *Background and supporting materia*l, Section 4.1 for information on organising a workshop.)

Creating safety in workshops

It is important for people doing sexual health work to create a safe environment where the limits are clear. Here are some ground rules that will help. These are the same rules that you should set and get agreement on when working with individuals (see Section 3.3 on page 34). Each time you meet with a group of young people, be sure to establish these rules with them.

The **physical environment** is an important part of creating safety.

- *Be nonjudgemental*. 'In this workshop we are not going to judge each other for the things we say. We all need to feel OK about asking questions or giving opinions.'
- *Be confidential*. ' In this workshop, we are going to respect privacy and confidentiality. What we say and hear stays in this room.'
- *Have the right to 'pass'*. 'If you don't want to answer a question or make a comment at any point, you can just say "pass". You will not be forced to participate.'
- *Have limits to confidentiality.* ' If somebody tells me something that makes me think she or he is in danger, I might have to tell other people to make sure she or he is kept safe.'

The physical environment is an important part of creating safety. Try to arrange chairs in a circle or informal layout.

Be aware of what is happening outside the room or venue where your session is. If a group of boys are playing football outside the room where a

group of girls are having an education session, the girls will probably be uncomfortable, and likewise for sessions with boys. If your education session is in a room with a lot of windows, the people passing by and looking in the window may make the room feel unsafe.

> 'When you have a big age range — say 10 years old to 16, it's too big to really engage with the group. But then if you jump in the car with some of the older girls and a few resources and go for a drive, it's amazing the questions that will come out while they are looking through the flipcharts or whatever. They'll happily ask questions in that environment because it's private. I do a lot of education work in the car.' **Female Aboriginal sexual health worker, WA**

Creating cultural safety

As well as creating personal safety, you need to create an environment that respects local Aboriginal and Torres Strait Islander culture. Gender issues are important here. Sometimes the topic of your workshop or talk will clearly be for males or females only, but at other times it may be unclear whether men and women should be separated. In these situations it is best to say something like, 'We're going to be talking about safe sex and condoms. How do you feel if everyone stays together in one group for this part?' Often young people are willing to learn about sex and sexuality issues in mixed gender groups.

The same goes for having male presenters talk to females and female presenters talk to males. This can vary from community to community. Often the cultural issue can be more about age than gender; for example, men may be comfortable with an older woman presenter, especially if she is non-Indigenous.

> **This story is from a very experienced, older, female non-Indigenous sexual health educator who spent a year in the Kimberley region of WA.**
>
> 'My job was to do sexual health workshops with young people. In each community I would always start by getting permission from the women. I would meet with a group of women and explain the kinds of things I would be talking about to the young people and the women would give it the OK. In many communities, the women would say "We need you to talk to us as well." And then after I did a workshop with the women, they would say to me "You need to talk to the men, too." I would always check and say "Is that OK? I am a woman. Is it OK for me to talk to the men?" Usually they would say "You're an old girl. You're OK." I gave many workshops to men. Sometimes the men invited me to return to give another workshop. In one place, 30 men showed up. Occasionally no men came. It varied from community to community.'

Many sexual health workers find it easier to separate older people and younger people in sexual health education. Older people are more likely than younger people to find discussions about sexuality confronting or inappropriate, and it is important not to alienate or shame Elders within the community.

Creating cultural safety in clinical care also requires sensitivity to gender, age and other issues. Generally, older men will want to see a male practitioner, whereas younger men may not feel it is such an issue. Older and younger women will have their own preferences too. Don't assume you know what is going to be right in any situation. Always ask your client or patient if he or she is comfortable and also check the person's body language.

Developing skills in communication and relationships

Knowing the facts about biology, reproduction and how to use a condom to prevent STIs and pregnancy are very important to help young people learn to be in control of their sexuality, relationships and sexual health. But young people also want and need to learn about healthy relationships, negotiating consent, handling peer pressure and the potential for violence in relationships. Learning is more meaningful for young people when it combines information with discussion and activities that help to build skills in communication and relationships.

Young teenagers are usually just beginning to develop their communication and relationship skills. Unfortunately, many 'mature adults' also struggle with communicating clearly and respectfully and developing positive, healthy relationships! So it is not surprising that a lot of sexual health education is limited to 'the facts'. If you don't feel confident, you may not want to open up areas of discussion where you could be out of your depth. Once again, training can be helpful in developing your skills.

Getting into discussions or practising role-plays can be powerful ways to learn about things like relationships, sexuality (including same-sex relationships) and sexual assault. But it normally takes much more than a one-off workshop or lesson to get beyond the facts and into the more complex issues. Extra sessions are worth the effort because these activities are the ways that are most likely to give young people the skills, knowledge and confidence that they need for their sexual health (see *Background and supporting material*, Section 6.3 for websites with reliable sexual health information for young people).

You may also find that school-based lesson plans, DVDs and so on are useful for designing special one-off sessions for groups outside of schools.

Special workshops can also include information about clinical services (see earlier section on education about clinical services).

Sexual health and relationships programs

There are many excellent, interactive sexual and reproductive health programs that can run from a few hours to weekly sessions over several months. These programs have structured sessions, and include discussions and skill-building in areas

Well-designed programs build information and skills over time

such as communication, negotiation, consent, jealousy and peer pressure. Well-designed programs build information and skills over time, and give young people lots of opportunities to discuss, work through the issues and practise the skills, and to participate in lots of fun activities. However, to run programs like these, you need to have some training yourself.

Some of these sexual and reproductive health programs are designed specifically for Aboriginal and Torres Strait Islander young people; examples are *Mooditj* in Western Australia and SHine's *FRESH* course in South Australia. These programs can be delivered by Indigenous and non-Indigenous workers from the health, youth, education, or welfare sectors. Both organisations will provide you with training so you can deliver these programs in your local community.

However, not all Aboriginal and Torres Strait Islander young people will learn in a workshop situation, especially if there is not enough time or opportunity to build trust. Also, the most vulnerable and 'hard to reach' young people may avoid such workshops.

Those who are most at risk

Aboriginal and Torres Strait Islander young people who are most at risk of STIs and poor sexual health are those who are marginalised through unemployment, poor emotional support, transience (moving around a lot), homelessness or dependence on alcohol or other drugs.

Young homeless people are particularly at risk because they are more likely to have been victims of child sexual abuse and other forms of sexual exploitation, such as exchanging sex for shelter, food, drugs or transport. In turn, young people who have been sexually abused are at risk of having multiple partners and unprotected sex, and of engaging in prostitution.

Unfortunately, the groups at highest risk are often those least likely to attend workshops for education or a clinic for a sexual health check-up. Thus, they miss out on both sexual health education *and* clinical care. For these people, relationships with their peers are even more important because they look to their friends to provide the love and support missing in the rest of their lives. These people need someone to give them good advice and referral (see *Background and supporting material*, Section 4.4 for information on peer education).

'The most effective ways to promote behaviour change are by building strong, trusting relationships with clients, normalising discussions around a broad range of sexual health issues and incorporating skills practice.'

3.3 Working with individuals: a framework for discussing sexual health — the PLISSIT model[5]

Learning about sexual health often occurs through casual conversations and interactions. The following PLISSIT model framework can be used by workers when dealing with sexual health issues in one-on-one conversations or with small groups of young people (some of this information will also be useful when working with larger groups).

The framework allows for the possibility that you may hold back from talking about sexual health issues with young people because you don't have in-depth knowledge of the subject. The framework also recognises that, if you are too pushy about raising sexual health matters, you may frighten off your clients. Young people need to feel safe, and you must take the time to build trust with them.

The framework has four stages:

Stage 1 — Permission giving

Stage 2 — Limited information

Stage 3 — Specific suggestions

Stage 4 — Intensive therapy.

Many of you will only go through the first two stages of this framework. After that, it may be appropriate or necessary for you to refer your client to someone with more expertise, for example, a sexual health clinic, counselling service or welfare agency.

Learning about sexual health occurs through **casual conversations** and **interactions**

Stage 1: Giving permission to talk about sexual health and relationship issues

The permission-giving stage is necessary to get over the shame barrier; it is probably the most important stage in the PLISSIT model. Young people need signals that it is OK to talk about sex and relationships, otherwise they will assume the subject is taboo, off limits and just too shameful. Even if your job role has 'sexual health' in the title, young people may be wary about what they can discuss with you.

So how can you let young people who may be at risk of STIs, HIV, unplanned pregnancy or sexual assault know that you are open to talking with them about these issues? You can start with the physical environment.

5 This section has been adapted from Janssen M and Davis J. The youth worker's role in young people's sexual health; a practice framework. Youth Studies Australia. 2009;28:4. Used with permission of the authors.

Making your organisation or office sex-positive

If a young person has concerns they want to discuss, such as sex, sexuality, body image, contraception or relationships, the person may feel too shy or shame to start a conversation. To overcome this, your work environment needs to send the message that 'It's OK to talk about sexual health and relationship issues'. One way of doing this is by having sex-positive posters and leaflets on display. These can include leaflets about safe sex, pregnancy and sexual health services, and images of healthy relationships.

Making the environment sex-friendly like this gives the message that you think sex is a normal part of life and are willing to answer questions about it. Another way to provide a sex-positive service is to have bowls of condoms (or a mixed bowl of condoms and lollies) in a place where young people can take them quietly and confidentially.

Creating safety

It is very important that you have rules that will create a safe environment where the limits are clear. These are the same rules that you should give, and get agreement about, at the start of workshops on sexual health issues (first mentioned on page 30).

- *Be nonjudgemental.* 'I will not judge you. You can trust me with your concerns about sex and relationships.'

Being nonjudgemental means just that: knowing what your values are and being able to put them aside. At the same time, it is OK to let young people know that some behaviours, such as violence and abuse, are not acceptable.

- *Be confidential.* 'I respect your privacy. As far as possible, I will keep what you say to myself.'

Studies of sexual health in Aboriginal and Torres Strait Islander communities have found that community members worry that their private business will get out, and people will talk and gossip about them. Young people want reassurance that their private business will stay private. If you work in a clinical setting or sexual health service, young people may avoid you and your service because they don't want others to think they are having a sexual health problem. They need to feel safe that their private business will stay private. You can practise reassurances such as 'I never talk about my work outside of work' or 'This place is very confidential and safe — your private business will stay private'.

Organisations also need to make arrangements so that information does not go astray. For example, pathology results and health records need to be kept secure so that medical notes can't be seen by general staff and other people who are passing by a fax machine or a desk. To reassure community members, an organisation can put a sign on their wall that says 'Your private health business will be kept confidential'.

- *Have the right to 'pass'.* 'If you don't want to answer a question or make a comment at any point, you can just say "pass". You will not be forced to participate.'
- *Have limits to confidentiality.* 'If the things you tell me make me think you are in danger, I might have to tell other people to make sure you are kept safe.'

Workers in Aboriginal and Torres Strait Islander sexual health must be clear about their limits of confidentiality. If you believe the client may reveal that she or he has been abused or is at risk of abuse, you need to tell the person that there are some things you are obliged (required) to pass on. It is not necessary to read out the rule book, but the young person has the right to know that there are some things you are required by law to tell to other authorities, particularly child protection matters (see Chapter 6 for more information on this).

Opening up the conversation

Here are some strategies you can use to let young Aboriginal and Torres Strait Islander people know that you can be approached to discuss sensitive issues. After delivering a workshop or information session, you can say:

- 'If anyone would like more information about sexual health or relationship issues, we can talk together after the workshop or you can come and see me later.'
- 'You know how we were talking about contraception, if you want some more information, I have pictures that show it really well.'
- 'A lot of kids wonder about how to say "no" to sex if they don't want to have it. If you are concerned about this, come and talk to me about it.'

Other permission-giving strategies are listed in Box A.

Box A: Permission-giving strategies

Questions or lines of discussion

1. Make general statements such as, 'A lot of young people have questions or worries about sex and sexual health. We have info and resources here that young people have found useful. Would you like to see them?'
2. To start a conversation, you can say, 'It's confusing with all these different messages about sex — in movies, on television, from religious groups, parents and friends. How do you make sense of it all?'
3. Refer to popular culture — for example, show fashion magazines and body images and say 'Gee, one week she's too skinny and the next week she's too fat! It's hard to know what to be these days, isn't it?'
4. Take advantage of 'Dolly Doctor' articles and 'sealed sections' — for example, say, 'Did you see what it says in here about (chlamydia, teen pregnancy, same-sex relationships). What do you think about that?'
5. Include discussion about the internet, given its place in young people's lives. 'Have any of your friends had funny or bad experiences in chat rooms? What do you think about that? What would you do?'

Permission-giving is the most important stage in this framework. It lets people get comfortable with the idea of talking about sensitive topics. If they are not comfortable, they won't be receptive (open) to the help you can give them.

Stage 2: Giving limited information

You can be an important source of information for young people. They can be confused by conflicting information or myths about sex and relationships because they are getting information from different places, including their peers, television, the internet, magazines, their parents and other relatives, and the church. So what they may want is clarification on one particular point.

Your role may be to help them sort out some basic facts. Imagine that a homeless 13 year old asks you 'Is it true that girls can't get pregnant the first time they have sex?' Depending on the situation, it is probably better to say 'No, it's not true. Pregnancies can happen that way.' You don't need to give an explanation of the mechanics of conception and pregnancy or get out the Magnel Kit[6]. But don't let your short answer shut the conversation down. Check to see whether she has the information she wants and invite her to seek more information. For example, say 'Would you like to know about what you can do to prevent pregnancy?' or 'Is there something else you've been wondering about?' or 'Are you concerned that you might be pregnant?'

Other limited-information strategies are given in Box B.

Box B: Limited-information strategies

Once you have become familiar with detailed sexual health information and youth-friendly resources, including websites and games related to sexual health, you can begin to engage more confidently with young people. Here are some possible activities:

1. Invite a young person or a small group to give their opinion about a recommended youth sexual health education website, play a sexual health game, or use stories or role-playing (see *Background and supporting material*, Section 4.5 for references to games, stories and role-playing).
2. Incorporate into your service a visit to a youth-friendly sexual health or community health clinic, or arrange for clinic staff to visit the young people in the community. This can help break down the barriers between clinical services and young people.
3. Use the strategy of modelling enthusiastic information-seeking behaviour; for example, say 'I don't know the answer to that. Let's see if we can find out.' Another strategy is to let the young person be the expert, for example, 'Can you help me find this website? I think it is called "Sex Fu Challenge" or something like that…"

6 A Magnel Kit is a set of magnetic panels showing male and female reproductive organs, how pregnancy happens, and the growth of the embryo, along with contraceptive methods.

A good way of giving factual information to individuals or small groups is to use quality internet sites. You can sit down with one or two young people and show them reliable sites with good information. It works best if you do this over a few sessions. You can then follow up with a discussion by saying 'What sort of information did you find useful on that website?'

Research has shown that the first question that a young person asks is not always the one that is most important to them. Sometimes the first question is a test to see how you will respond. If you respond positively, you open up the possibility for more discussion.

The limited-information stage allows you to develop your knowledge, skills and confidence as a sexual health educator. By opening up conversations, answering simple questions, researching websites, attending training and creating a sex-positive environment, you will show you are competent and approachable; then you may be able to move on to the next stage — specific suggestion.

Stage 3: Specific suggestion

The specific-suggestion stage of the PLISSIT model involves discussing issues of sex, sexuality and relationships on a deeper level. It is the next step on from providing basic factual information on matters such as risky behaviour, safe sex or STIs. The specific-suggestion stage usually develops over a period of time after trust and a sense of safety have been developed with a young person. It builds on the limited-information stage of the model, and progresses as you develop more experience, knowledge and skill in responding to these issues.

Other specific-suggestion strategies are given in Box C.

Box C: Specific suggestion strategies

This stage will probably only be reached with young people after you have developed a more trusting relationship with them. This trust can happen through short but intense contact such as helping them through a crisis. More often, it occurs over time.

In clinical work, specific suggestion may mean giving detailed sexual health advice (e.g. about contraception or STI testing). If your role is mainly support and education, the specific suggestion stage may be more about deeper exploration of a relationship or sexuality issues. At this stage, you are encouraging the young person to reflect on his or her behaviour in order to make wise choices. Some questions could be:

1. 'How will that affect you and your partner?'
2. 'What is that going to be like for you, knowing this?'
3. 'What if you got infected with an STI? — how would you react?'

Training will help you to develop self-awareness about potential barriers

Not all of you will feel comfortable and confident enough to progress to this stage with all clients. Usually, it would take a good amount of training and experience to have the knowledge and skills, as well as the comfort and confidence, to do so. The section on 'Knowing yourself' in Chapter 2 mentioned issues that may make you feel uncomfortable and out of your depth. These include:

- very young clients who disclose sexual behaviour
- clients who disclose sexual abuse
- clients with unwanted pregnancies
- clients who inject drugs.

Training will help you to develop self-awareness about potential barriers to understanding and working with a young person with challenging issues. For example, your values, beliefs, personal experience or lack of knowledge may create barriers to you talking in depth and giving specific suggestions about some issues. Self-awareness will help you to be prepared to either overcome the barriers or work around them.

If there are issues you know you can't easily discuss, refer the young person on to another worker. Through talking to your colleagues you will know if they are more confident or knowledgeable to discuss certain matters that are beyond your capacity. Don't leave the young person feeling judged and shame about what they have told you. Say something like 'I am not confident to talk to you about this but I can take you to Jane who has a lot more experience than me. How do you feel about talking to that person?'

Stage 4: Intensive therapy (referral to experts)

This is the most advanced stage of the PLISSIT model; it involves deep exploration of, and counselling on, psychological issues or past trauma. **Most of you will not have the many years of training and experience required to be an expert counsellor in this area.** If this is the case, you need to refer your client to a specialist such as a sexual health or sexual assault counsellor, or a psychologist. You need to know about the services that are appropriate and available, and how to access them, so that you can provide the best possible access and transition for young people to these services (see the section on referral in Chapter 2).

It is important that you are aware of the limits to your skills so you do not get into issues you can't handle well, and which may leave the young person more confused and vulnerable.

The PLISSIT model shows how you can assess your and your client's readiness to engage with sexual health issues, and move to the next stage when you and the client are ready.

Review stage

It is good to get into the habit of checking back with the young person and keeping the conversation open by asking:

- 'Does that answer your question?'
- 'Is there something else you wanted to know?'
- 'After we talked last week ... did you think of other things you wanted to ask about.'

This keeps the permission-giving stage going and reassures the young person that you haven't closed off the subject of sexual health.

The other part of the review stage relates to knowing yourself. These are some questions you can ask yourself to check on how you are developing in this aspect of your sexual health work:

- 'When did a young person last ask me a question about sex, sexuality or relationships?'
- 'When did a young person last disclose to me that she or he was in a same-sex relationship?'
- 'What questions make me feel embarrassed or uncomfortable?'
- 'Am I able to recognise my values?'

Everyone has areas of difficulty. It is human to have these. It is vital for you to acknowledge these issues and difficulties, and either seek training or develop strategies to help you manage them.

'Kids will make all kinds of value judgements about how things should be — "Dads should be around for their kids", for example. They throw values around very easily. One boy at [the detention centre] asked "When is a good age to be a parent?" Some of the young teenagers in that group are already parents. I don't want to put them down and make them feel like they are failures. So I put it back to them? "When do you think is a good age to be a parent?"

Sometimes when I learn a bit about their lives, I wonder how many of the young people in the group have known a healthy relationship. Do I want to make judgements about the relationships the young people are having, or say their parents' and family members' relationships are bad? They have the right to personal respect and dignity. But at the same time, it's our job. Balancing giving the information and not judging their reality is pretty difficult.

The most significant thing I learnt in my training was being aware of my values and the need to not push my values on other people.'
Aboriginal sexual health worker, WA

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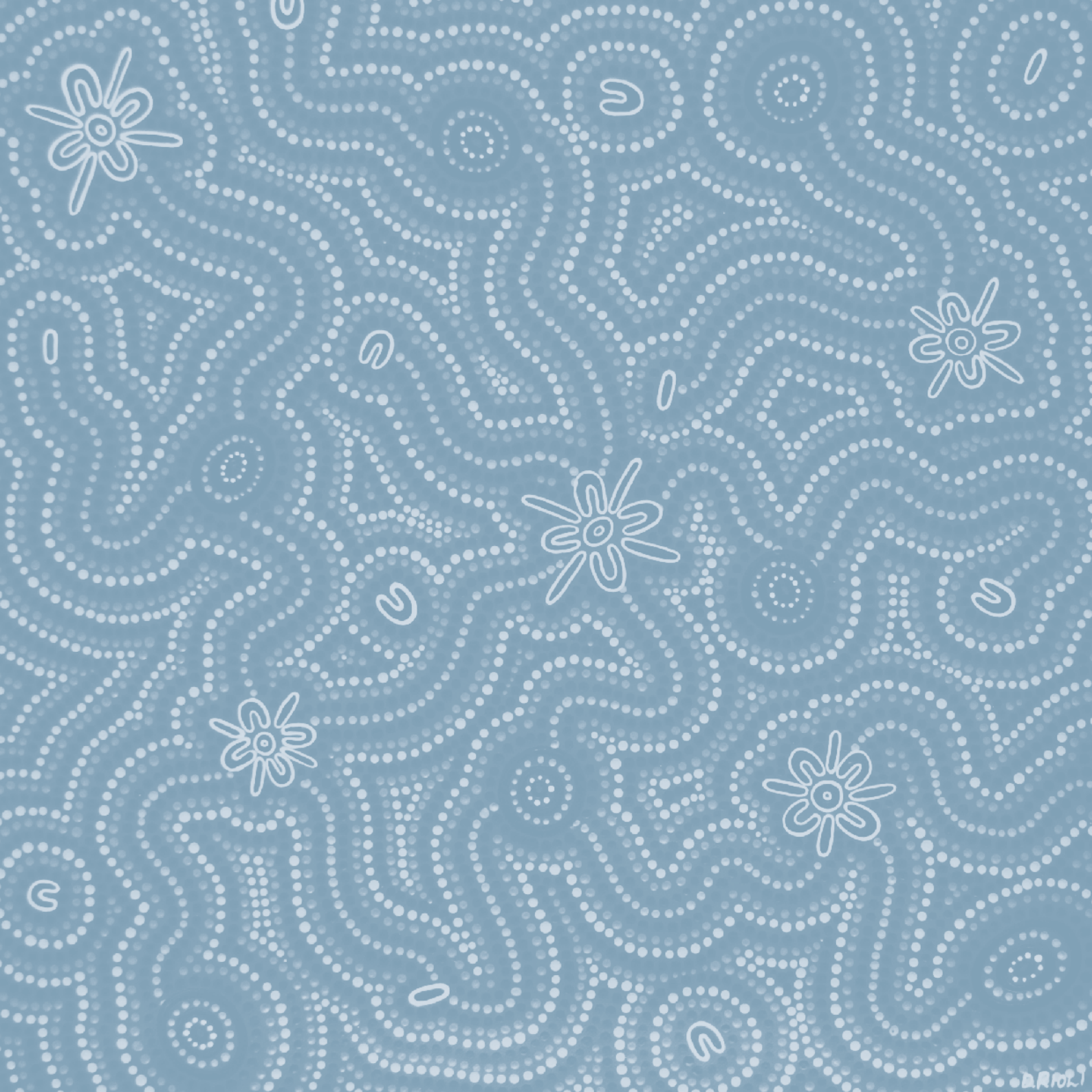
4

IMPROVING ACCESS TO SEXUAL HEALTH SERVICES



4.1 Introduction

Sex is a natural part of every human being, but sexual matters are often felt to be embarrassing and regarded negatively. This is particularly so in Aboriginal and Torres Strait Islander communities, where sexual matters are often felt to be 'shame'. (As noted in Chapter 2, shame can refer to things that are embarrassing or private, or that single out an individual for any reason.)

Young people are especially likely to be very sensitive or shame about sexual matters. This can create barriers to young people talking or learning about sexual health, and to taking action if they need help or advice. Making services private can help to reduce the shame barrier. In the clinical setting, one of the best ways to do that is to bring sexual health into general health business (primary health care).

It is not only young people who find sexual health matters difficult to talk about. GPs and other service providers also have a shame barrier that can stop them mentioning sexual health. For example, even though a GP may be aware that young Aboriginal and Torres Strait Islander people are at high risk of having an undiagnosed STI, they often don't ask young clients if they have been at risk and need an STI test. Fortunately, the Adult (or Youth) Health Check includes an STI test, so it is an easy way to overcome the shame barrier for all concerned.

Developing communication and trust with community members is essential, and can greatly improve the accessibility of services. Part of your job is to normalise discussions about sexual health so that health-care providers are less 'hung up' about sexual matters, and general services are more 'sex-positive'. However, there are specific cultural sensitivities that need to be respected, and these are discussed in the next section.

4.2 Cultural respect and sensitivity

All organisations should give their non-Indigenous staff training in cultural competence. Such training should include important facts about the history and culture of Aboriginal and Torres Strait Islander Australians. In addition, workers need to be aware that every Aboriginal and Torres Strait Islander community is different. Whatever a person's background, it is important to find out about the history of the local area and the concerns and ways of local people. It is not necessary to know everything about local languages, belief systems and cultural practices, but a worker needs to be willing to find out about the local people and their concerns, and how these affect people's access to health services. This includes knowing about the different family groups and the hopes, goals and challenges of the local young people. Listening to and being open to learning about local people are vital skills in cultural competence.

Communication

When talking about something that might be shame, communication needs to be very sensitive. Open, straightforward and honest communication

is usually the best way, but communication that is too direct or businesslike may frighten people away. If you ask a direct question, you may get a quick — and untrue — 'yes' or 'no' answer, just to get away from an embarrassing topic. Open-ended questions phrased in a positive way, such as 'Can you tell me about that?' are much less threatening.

Someone with a sexual health issue may ask to see you about some minor health problem — such as a sore foot — and cover up their real problem out of shame or embarrassment. The more important health issue may come out with some gentle open-ended questions. For example, 'Tell me about the footy weekend — I heard you young fellas got up to some fun ...' rather than 'Are you really here because you had unsafe sex during the footy weekend?'

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.
- Check to ensure that the person has understood what is being said; repeat information if needed.
- Acknowledge that certain issues may be embarrassing or difficult to talk about.
- Speak quietly if other people are around.
- Use nonthreatening body language and tones.
- Be patient.
- Do not make assumptions about sexuality or behaviour.
- Have a nonjudgemental 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.
- Use open-ended probing questions when obtaining a sexual history.
- Emphasise the confidentiality of the conversation, but 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.

Eye contact

For non-Indigenous people, making eye contact is polite and expected, but young Aboriginal and Torres Strait Islander clients may be reluctant to make eye contact. In some situations, making eye contact is seen as disrespectful by many Indigenous people; it can be seen as something that is done to dominate or tell someone off. If a young client is not making eye contact, it may not be a sign of rudeness or bad communication; it may simply be a sign of respect.

To make a service **culturally safe**, workers need to be respectful, approachable and trusted

Men's business and women's business

To make a service culturally safe, workers need to be respectful, approachable and trusted. For Aboriginal or Torres Strait Islander people this often means being able to see a worker of the same gender. Therefore, services should have both male and female workers available. Also, in sexual health education, having both a male and a female worker enables groups to be separated into boys and girls or men and women as necessary. In clinical services, whenever it is possible, offer an Aboriginal or Torres Strait Islander client the opportunity to see a worker of the same gender.

Unfortunately, not every service has both a male and a female worker to do sexual health education and clinical work. In this situation, how can we offer culturally safe, appropriate services?

This is where your local sexual health network is very important. In both education and clinical work try to find someone of the opposite gender in another service and get to know them, so that you can refer clients to each other, or work as a pair to deliver sexual health workshops.

In clinical work, or one-to-one discussions, you will need to quietly explain to the client that there is only one worker available and ask whether she or he would prefer to go to another service. Seeing a person of the same sex may be much more important for some clients than for others, so don't assume you can't offer a service to someone of the opposite gender; let the client decide. You will need to have your referral list of local agencies if the client chooses to go somewhere else.

If you are in a small, remote or isolated service, you may have a Royal Flying Doctor Service (RFDS) visit that regularly brings in a female doctor to see female patients, or a male doctor if there is no male doctor in the town or community.

In sexual health matters, one factor that will make your clients more comfortable with you, regardless of your gender, is your level of

comfort and sensitivity with sexual health. Good training and practice in talking with clients about sexual health will increase your level of comfort.

The location of services should take into account the need to separate men's business and women's business, as shown by the example below.

> 'People were hanging around, you know, but just weren't prepared to come over. So, afterwards I said to my colleague, "Right, let's find out what the problem is here because the women ... were interested when asked by the local Aboriginal health care worker..." The problem was that we were right next door to where all the men hang out — that was the only place to put the bus — and that was something that we hadn't thought of earlier.' **Worker involved with a mobile clinic offering women's sexual health services**

Indigenous and non-Indigenous workers

Some Aboriginal and Torres Strait Islander clients may be more comfortable talking about sexual health with a worker who is also an Aboriginal or Torres Strait Islander. Others may be willing — or even prefer — to see a non-Indigenous worker.

Sometimes, clients are concerned their private business will get out if the worker is someone from the community or the family. It is important to separate your personal roles from your professional roles, and to reassure clients that their private business will be kept confidential. See Section 4.5 below entitled *Boundaries and working in a community that knows you*.

Locals and 'outsiders'

If a client is reluctant to see you, don't take it personally. The problem may not be that they don't trust you; it may be that you are 'a local'. This is true for non-Indigenous people too. This can be more of an issue in small communities where everyone knows everyone. Aboriginal and Torres Strait Islander people may be happy to see local workers for most of their health matters, but choose to go to another town or community for their sexual health business.

Don't assume your client will — or will not — feel comfortable to see you about their sexual health; always ask first. Try to identify other workers in your local network to whom you can refer people if necessary. Referral to workers in other towns may be a good option. Assistance with transport can be a way of improving access to services as well as building trust.

> 'We offer them transport if they want to visit a sexual health centre, and if they don't want to be treated in their own town.' **Sexual health worker, NSW**

4.3 Identified sexual health workers

> 'If you're up the street seen talkin' to a work officer, he's getting you rehabilitated into the workforce. But if you're up the street talkin' to me, you've got an STI or something.' **Sexual health worker, NSW**

Unfortunately, many workers face the problem above. Not only are they managing the shame around sexuality, they also become associated with STIs. Too quickly they can be labelled as 'the pox worker'.

How can you overcome this?

To reduce stigma (negativity) and increase effectiveness, you can broaden your focus to include other duties. For example, you may take on the job title 'Youth health worker' and help out with other youth health programs such as drug and alcohol or mental health. Another option is to stick to sexual health, but change the title of your role to 'Lifestyle worker' or 'Women's health worker'.

Working holistically

Working holistically means taking a 'big-picture' view of health.

Working holistically can reduce the stigma attached to your role. If you are known to be involved in a number of different health issues, people won't know which job you are doing when you are seen talking to someone or visiting a group.

> 'I went with the child health nurse to see families. When I was visiting a young person about an STI issue, the mother would think I was following up on vaccinations.'
> **Sexual health worker, WA**

There are other benefits in taking a broader, more holistic approach, such as making sexual health more relevant to young people's daily lives. There is no doubt that many other issues impact on sexual health; these include:

- poverty
- cultural pride
- drug and alcohol use
- access to education and employment
- homelessness
- self-worth
- a sense of a positive future.

When you work more broadly, you recognise that sexual health is embedded in all the complex aspects of young people's lives — it is not a separate, stand-alone issue.

Working holistically can also mean thinking through issues from all sides. It is important to include all the relevant groups in sexual health programs. Below is an example of what can happen if you don't work holistically.

> A program for young Aboriginal women in a small, isolated community tried to address problems around sexual abuse. The young women went on a camp and received 'empowerment' training, such as how to say no to unwanted sex. When they returned to their community, in the words of the worker, 'they started to say no to sex and some of the girls got badly abused... They hadn't worked on the boys; they'd only worked on the girls.'
> **Aboriginal health worker**

4.4 Involving the community in your work

If you have the community behind you, sexual health work is a lot easier. Community involvement and ownership help to build self-determination and community control. The more a community is involved, the more people will access sexual health services.

Positive community involvement is also good for young people. Research shows that young Aboriginal and Torres Strait Islander people who feel connected to their families and have caring adults who are involved in their lives have a lower risk of poor sexual and reproductive health.

> 'You just need to work out how that community works and how to fit in with that community. To give it lots of time, not to think "I have a certain time limit", because pressure just won't work.' **Aboriginal sexual health worker, NSW**

> 'The backlash from rushing into something will take longer to repair than going slow at the start.' **Aboriginal sexual health worker, WA**

Where to begin

To get the community behind you, you need to build trust. As the above quote says, getting to know the community takes time. Start by mapping out the main groups and organisations in the community, and decide which of these groups work with young people. Here are some examples of the groups that may be on your list:

- youth centres
- clinics (e.g. Aboriginal and Torres Strait Islander services, youth clinics and GPs)
- community health
- schools
- sporting groups
- police–citizen youth clubs
- TAFE colleges
- community council offices
- men's and women's groups
- correctional facilities
- drug and alcohol rehabilitation services
- community policing agencies
- mental health workers
- community organisations.

Go and visit these agencies and ask about **their** concerns for young people. They may be concerned about many of the issues that affect sexual health, such as drug and alcohol use, low school attendance and poor employment opportunities. Find out if they have run sexual health programs before. What was the outcome? Have there been bad experiences in the community that you need to be aware of and to handle sensitively? Try to find common ground. By listening, you may find you have similar goals. Keep revisiting your goals to keep on track.

Most people can relate to concerns about not being able to have babies. So, explaining that one of your objectives is to reduce the risk of infertility caused by STIs can be a good place to start conversations in a non-threatening way.

Getting community support

It is important that you have the support of key people in the community to do sexual health work.

> 'Check you are going through the right channels for that community. The people you are talking to need to be the people who are respected by the community. Sometimes the easiest or most obvious person is not the right person to talk to.'
> **Aboriginal sexual health worker, WA**

Many workers first introduce themselves to a community women's or men's group, and receive support to work in the community that way. One program in the far north of Western Australia started with a session with the women's group. This led to the women asking the workers to do sexual health sessions in the school, which they did (weekly) for a term. A nurse and a sexual health worker ran a session with the women in the morning and then a school session with the young people in the afternoon. The content of both sessions was similar, and the women were comfortable that they were getting the same information as their children. This is a good example of working holistically.

Another way of building trust, knowledge and local capacity is to get a local mother or another Aboriginal or Torres Strait Islander worker from the school to attend some sexual health training with you. Credible sexual health education programs, such as Family Planning WA's *Nuts and bolts of sexual health*, are pitched at ordinary people with no background knowledge. There are also training programs in how to deliver quality sexual health programs that community people can attend (e.g. *Mooditj* training in Western Australia or SHine's *FRESH* training in South Australia). Providing some skills as well as knowledge to the adults of the community goes a long way towards building their sexual health capacity as well as building trust in your role in educating the young people.

Getting people to come along

Running information or education sessions in conjunction with a barbeque is a proven way to get people to show up.

> 'If we don't put a feed on we don't get anyone attending the programs. You've got to feed them: that's one of the laws of these promotion things, and I think it's fair. You've got to have incentives ... If you've got a feed it gives them something to talk about ... and it keeps the group together.'
> **Aboriginal health worker**

Hint: Hold the information session before the food comes out, or have displays for people to look at while they are queuing up for their tucker.

Working with **positive celebrations** can bring the community onside

Working with positive celebrations can bring the community onside.

In one remote town, the youth worker ran a semester-long sexual health program that involved the whole community, including the school. The program culminated in a community-wide event with local bands playing sexual health songs they had written, young people parading a huge 'condom snake' they had made, and a fashion show that was designed to build confidence and self-esteem in the girls.

4.5 Boundaries and working in a community that knows you

Working in a community where you are well known can be very positive for community involvement, but it can also raise challenges in the sensitive area of sexual health. It may be difficult to separate your work and personal life. You may feel as though your job goes for 24 hours a day, 7 days a week.

'Can you help me? I think I need the morning-after pill … I just had sex and don't want to get pregnant … Can you come to the clinic? I don't want to wait at the hospital and I don't want to wait until morning …' **Young person on the phone talking to the health worker at 10 pm**

It can be difficult to refuse requests like the one in the example above, and still maintain credibility and positive relationships within the community. However, in small towns where everyone knows everyone else, these types of interactions can get complicated. Therefore, it is important to try to keep a professional 'hat' on as well as maintaining your community roles.

Some tips for setting limits are to:

- spend time at the start of your job thinking about your role, goals and objectives
- work out what your limits are, and what requests are reasonable or unreasonable (e.g. you can state clearly that you are not available after work hours)
- discuss your role with the client at the very beginning of your work with that person
- explain to your client, family and friends that you have to keep work and home separate for your own wellbeing
- keep your family and personal life private and separate to your work — don't provide too much personal information about yourself or other workers

- review how you are going from time to time
- discuss any issues with your co-workers and your line manager
- if you feel unsupported, keep asking for support, supervision, feedback, training and mentoring — all workers need these things
- use your local sexual health network as a source of support — don't do it tough by working on your own.

Your professional 'hat'

A relaxed and informal approach is usually the best way to approach sexual health education and services. But do make sure you develop your professionalism — don't make the mistake of slipping too far into the informal role.

> 'No matter how hip or streety you appear to be, people don't want to see that, I think, in educational programs. They want to be told by someone they consider professional.'
> **Aboriginal sexual health worker, NSW**

To be effective, you need to be a credible, professional and trusted worker. Work on developing your professionalism and take pride in it. Training and support will help you build your confidence. Your professional hat will help with the two situations described below.

> **Situation 1**
> 'Why are you teaching my 12-year-old daughter about the pill? What are you accusing her of? Hey? Tell me! Are you calling her a slut?'
> **Health worker confronted by an angry parent in front of the supermarket on the weekend**

How would you respond? First off, keep your professional hat on and keep cool. You can say 'I can see you're worried. I'd like to talk to you about what all the children are learning about sexual health. Can we meet at my office in the week?'

> **Situation 2**
> 'You can't tell my daughter not to have children! I had her when I was a teenager, the government supports her having kids [baby money] and we all need the money!'
> **Comments from a meeting with parents of teenage mums about the problems of teen pregnancy**

How would you respond? Keep your cool and know your facts. You could say 'Let's look at the facts. If young women delay having a baby by one or two years, the health of the baby and the mother are better. What do you think is a good age to start having babies?'

If you have done the groundwork with key community leaders and Elders, you will have support to deal with incidents like these.

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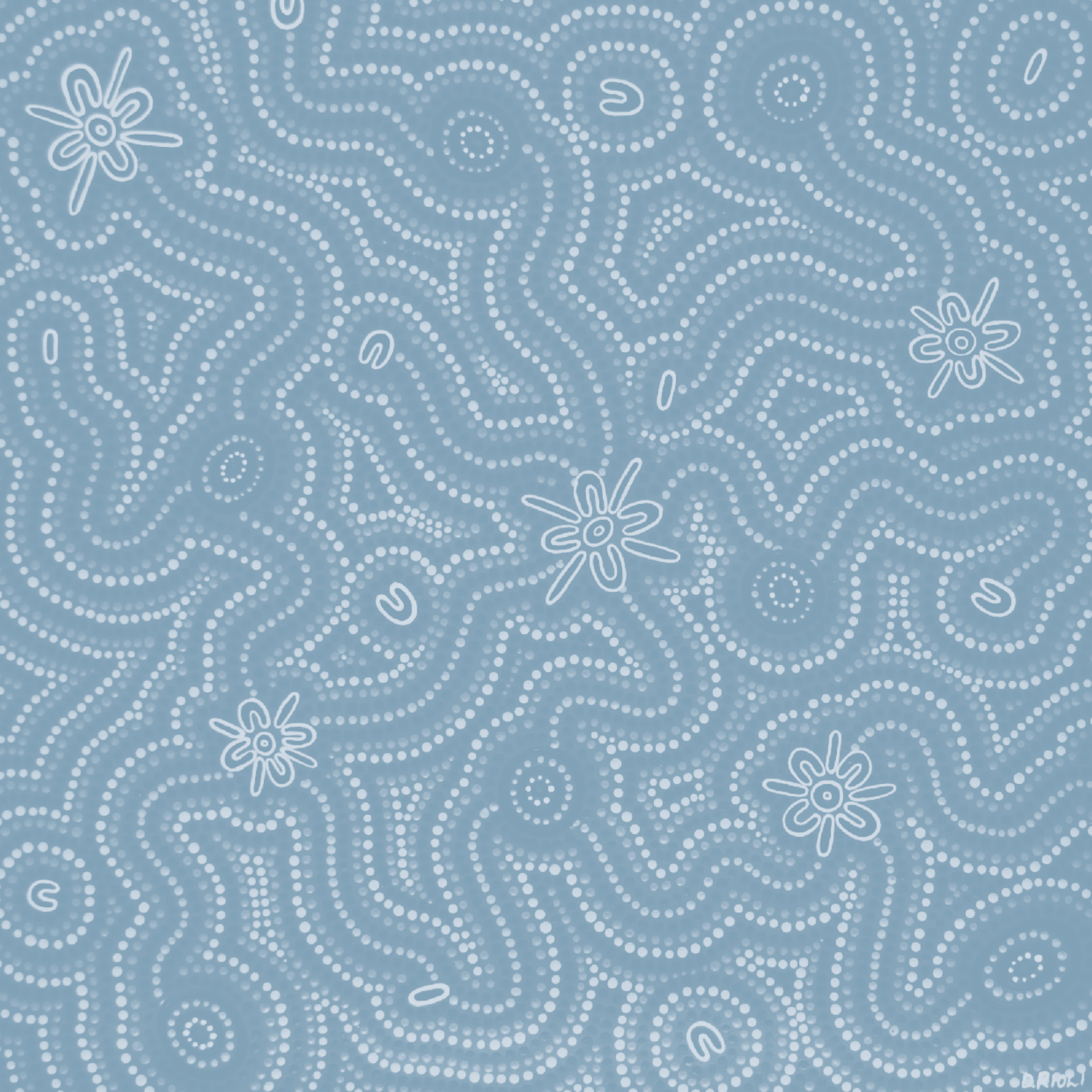
5

CLINICAL ASPECTS OF STIs



5.1 Introduction

Even if your work does not involve clinical aspects, it's important to know a bit about what is involved in testing and treating common STIs, so that you can educate young people about what to expect if they go to the clinic.

5.2 Who is at risk?

Anyone who has unprotected sex (sex without a condom) is potentially at risk of getting an STI. Many STIs do not have symptoms, so people can be carrying an infection and passing it on to others without knowing it.

All young people should be offered a screening test for STIs if they are sexually active. In a clinical setting, an easy way to do this is to say 'I offer all sexually active young people a test for chlamydia and gonorrhoea. It's a simple test — are you happy to give a urine sample?'

Keeping STI testing simple and non-embarrassing will help people — clinicians as well as young people — get over the shame barrier.

If the test comes back positive, the client will need to be treated. That is usually a very simple matter of taking some antibiotics. At this stage, a sexual history may need to be taken to find out whether risky behaviours have been involved and who else may be at risk of having been infected. A blood test may need to be taken if there is a risk of other infections also being present (e.g. syphilis or HIV). The table in *Background and supporting material*, Section 3.2 shows the different infections and how they are treated.

All young people should be offered a **screening test** for STIs if they are sexually active

5.3 What is a sexual history?

A sexual history is taken to assess risks and clinical responses for each individual client.

The history needs to be taken with sensitivity — these are very private issues. If the questions are not asked carefully a client can be shamed or take offence and may avoid any future contact with the health service.

You need training and practice to take a sexual history in a professional way that builds trust.

These are some of the questions that you might ask in taking a sexual history:

- 'Are you sexually active?'
- 'Do you currently have a regular partner?'
- 'When was the last time you had sex?'
- 'Have you ever had an STI? If yes, when?'

- 'In the past three months, did you use condoms? (always, sometimes, never)'
- 'Do you have sex with men, women or both?'
- 'Have you ever injected drugs?'

5.4 Contact tracing

Contact tracing is also known as partner notification. It is a process used to stop the spread of many different infections. In sexual health, contact tracing involves:

- finding contacts or sexual partners of a person who has been diagnosed with an infection
- informing those contacts or partners that they might have an STI, and offering testing and treatment to cure any infections and prevent them being passed on to other sexual partners.

You will see in the STI and BBV table in *Background and supporting material*, Section 3.2 that many infections require treatment, and sometimes follow up of contacts or sexual partners.

If a client is diagnosed with an infection that requires contact tracing, they will be asked to give the names and contact details of their sexual partners. Sometimes the client will choose to inform their partner or partners that they should go to the clinic for an STI test. Other clients prefer a health professional to get in touch with their sexual contacts and inform them that they may be at risk of an infection.

Contact tracing should be voluntary and the trust the client has in the health service and the practitioner is very important. The name and identity of the person who is first diagnosed with the infection (known as the 'index' case) must be kept confidential.

Contact tracing can be difficult for many reasons, as shown by the examples below.

'If I would go and look for a person and that lady wasn't there, a lot of times the aunty or the mum would say "What do you want to see her for?" and I could not say why ... [so I would say] "Oh, I just want to have a talk with her ... you let her know I came to see her and I'll come back, or if she wants to see me, to come to the offic".'
Aboriginal health worker, WA

'There was one particular woman we brought up for testing because she was a named contact, and when I took her back home she said "Oh drop me off at my Mum's house" because she was afraid her partner might see her in the work car and think "Oh what have you been doing up at the clinic?" And she'd be questioned afterwards.'
Aboriginal health worker, WA

'It's a bit hard with the contact tracing because if some of the guys have been a bit naughty and like, mixed up with skin groups [that they shouldn't mix with in a sexual way], that [could lead to] tribal punishment. So these guys have declined to say whether they have been with the people. So you miss out on getting names and contacts through that.'
Aboriginal health worker, WA

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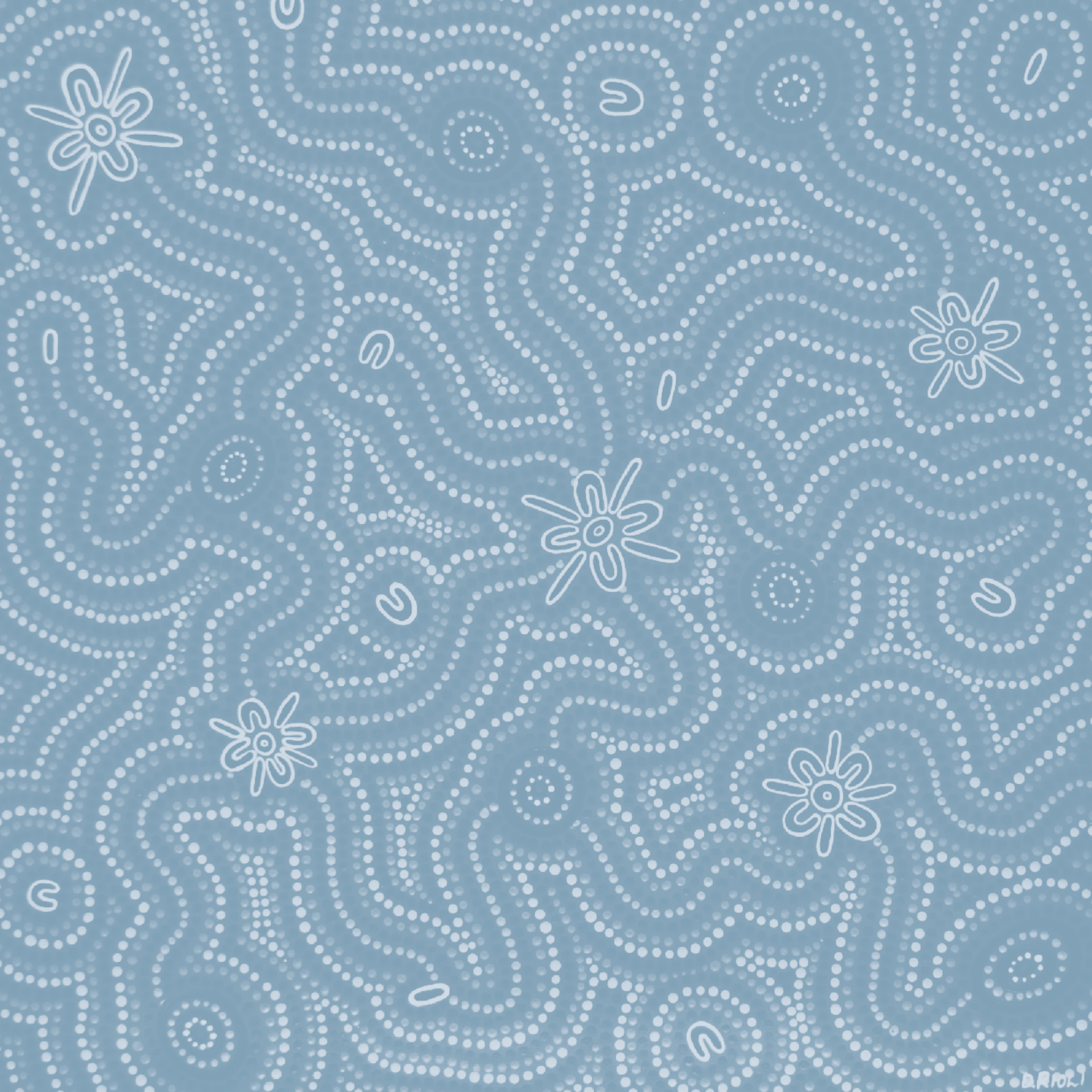
6

SPECIAL ISSUES IN SEXUAL HEALTH



6.1 Introduction

The definition of sexual health in Chapter 1 included this sentence:

> *Sexual health is also about a person's ability to enjoy and control sexual experiences and relationships — free from coercion (being forced), discrimination or violence.*

This chapter gives some information about sexual violence in Indigenous Australia. Dealing with sexual violence against children and adults is a specialised area of work requiring training and experience. Sexual health workers are not expected or required to be sexual assault counsellors. However, as educators of young people and reliable sources of information to communities and other professionals, you need to know about sexual violence and how to respond to it. If you are educating groups or individuals about healthy relationships and healthy sexuality, it is your professional responsibility to think through your values and attitudes about sexual violence.

'Last year as part of a program called "Good Lovin" I ran 17 sessions consecutively in 17 high schools with kids aged 13–15. Almost every group was only Aboriginal kids, a couple were mixed. In every session we asked the group the same set of questions. One of the questions was "Why do you think people have sex?" In almost every single session, one of the answers we got back from these kids was "Because they have been raped or abused". This same reason was also put forward as a reason why people DON'T have sex.' **Sexual health worker, WA**

Dealing with **sexual violence** against children and adults is a specialised area

The term 'family violence' is often used within the Aboriginal and Torres Strait Islander community to refer to all forms of violence between members of a kinship group or the immediate community. In the same way, abuse of Indigenous children, particularly sexual abuse, is often viewed as a community issue rather than being seen as an issue for the narrow family unit, as in non-Indigenous society.

The causes of family violence are often linked to the impact of past traumas, including the removal of Indigenous children from their families and the long history of dispossession and oppression. The current high level of disadvantage in Aboriginal and Torres Strait Islander communities also contributes to family violence.

This chapter covers two aspects of family violence: child sexual abuse and sexual assault. Both children and adults are victims of sexual assault. In children, sexual abuse and sexual assault refer to the same thing, so the terms may be used interchangeably.

6.2 Child sexual abuse

What is child sexual abuse?

Child sexual abuse is any form of sexual behaviour directed towards a child. Sexual abuse includes, but is not limited to:

- showing a child pornography or sexual acts
- taking visual images of a child for pornographic purposes
- masturbating near the child
- placing the child's hand on another person's genitals
- touching a child's genitals
- any form of penetration (oral, anal or vaginal) with a penis, finger or object of any sort.

Penetration does not have to occur for it to be sexual abuse.

Facts about child sexual abuse

It is important that you know the facts about child sexual abuse before you start working with young people in the area of sexual health. Some of the facts are that:

- child sexual abuse
  - is a criminal offence
  - is not a part of traditional Aboriginal or Torres Strait Islander culture
  - can happen in all types of families
  - can happen to children of all ages, from small babies to teenagers
- most child sex offenders are men
- girls are more likely to be a victim of sexual abuse than boys, but there is evidence of widespread sexual abuse of boys in some Aboriginal communities
- many perpetrators commit their first child sex offence when they are adolescents
- children are most often sexually abused by family and friends of family
- sexual abuse is never the child's fault.

Child sexual abuse in Aboriginal and Torres Strait Islander communities

An inquiry into child sexual abuse in Western Australia, New South Wales and the Northern Territory found that the sexual abuse of Aboriginal children was common, widespread and grossly under-reported.

It is likely that less than 30 per cent of all sexual assaults on children are reported; for Aboriginal and Torres Strait Islander children, the figure is even lower. Even though levels of reporting are low, there is no doubt that Aboriginal and Torres Strait Islander children are at greater risk than other children of being sexually abused.

It is important to remember that levels of abuse vary between communities, depending on community location and other factors such as alcohol and other drug use and the general level of violence in the community.

Many factors contribute to situations where children are abused. Some or all of the following can have an impact:

- poverty, unemployment, overcrowding or unstable housing
- racism, discrimination or poor education
- issues within the family, such as mental health, substance abuse, poor parenting skills, family or domestic violence, or easy access to pornography
- low birth weight, disability or other special needs of the child
- poor relationships within the family, large numbers of children, single parenthood or early parenthood
- previous experiences of abuse or neglect (of either parents or children).

The loss of clear social and economic roles and status for Aboriginal and Torres Strait Islander men can also be a factor in both child and adult sexual assault. This loss may lead to the men aggressively asserting themselves over women and children to make up for the loss of role and status.

Effects on individuals, families and communities

Child sexual abuse can have serious effects on children, adults, families and communities.

The consequences vary depending on the type and amount of abuse, the age of the child and many other factors. However, there is no doubt that chronic and multiple forms of abuse increase the risk of more damaging and severe consequences for young people and adults.

Some of the possible effects of sexual abuse on children and adult survivors are:

- trauma and psychological problems
- learning and developmental problems
- behavioural problems
- mental health problems
- eating disorders
- drug and alcohol abuse
- aggression, violence, and criminal activity
- teenage pregnancy
- homelessness
- suicidal behaviour
- revictimisation (i.e. abused children are more likely to be victims of abuse as adults)
- intergenerational transmission of abuse and neglect (i.e. victims of child abuse may themselves become child abusers as adults)
- high-risk sexual behaviour such as early onset of sexual behaviour and multiple partners.

Early identification and effective intervention can help overcome the initial effects and long-term consequences of child sexual abuse and promote the recovery of victims.

6.3 Sexual assault

In Aboriginal and Torres Strait Islander communities, sexual assault of adults is often called family violence, but it shouldn't be. Sexual assault refers to rape or any unwanted sexual activity that is forced on a person. Women are more often the victims of sexual assault, but men can also be raped or assaulted sexually in some other way.

Across Australia, Indigenous women are 12 times more likely than non-Indigenous women to be the victims of assault; women's partners or husbands are most often the perpetrators of this violence. The level of abuse varies greatly from region to region and community to community. In New South Wales, Indigenous women are more than twice as likely as non-Indigenous women to be victims of sexual assault. A 1996 report found that Aboriginal women in rural and remote Western Australia were 45 times more likely than non-Aboriginal women to be sexually assaulted by their spouse or partner.

As with child sexual abuse, adult sexual assault is under-reported in Aboriginal and Torres Strait Islander communities. One researcher estimated that almost 9 out of 10 cases of sexual assaults in Indigenous communities go unreported.

Unfortunately, child sexual abuse and sexual assault are often hidden.

6.4 Why are child sexual abuse and sexual assault hidden?

Shame may be an important reason why child sexual abuse and sexual assault stay hidden. Shame may trigger a whole range of emotions — embarrassment, disgrace, dishonour and humiliation. It can have a huge effect on decision-making and on health and wellbeing for young people, adults, community members and families.

Shame also reduces the likelihood of discussion and education about sexual assault. A young person who is being abused will have a lot of difficulty telling somebody about it if child sexual abuse is never talked about.

When child sexual abuse is not discussed among Aboriginal and Torres Strait Islander people, children who are being abused have no one to talk to, yet having someone to talk to is the first step needed for a child's protection.

Discussions about sexual abuse and assault can occur out in the public through television, radio, newspapers, education workshops or school awareness programs (including Protective Behaviours courses — specially designed programs for children that explain what sexual abuse is and what children can do if they are being abused). Discussions about these issues can also happen with community members, professionals and in families.

Besides shame, there are other reasons why people don't report or respond to sexual assault of adults and children. The table below lists some barriers to reporting child sexual abuse and assault.

Barriers to reporting child sexual abuse and sexual assault

Personal or family reasons	System or community reasons
Fear of payback from the perpetrator or relatives in small, closed communities.	Disturbed, abusive or dysfunctional behaviour can become 'normalised'. For example, violence may be seen as so common in some Indigenous communities that it is ignored.
Fear that the perpetrator will go to prison.	Workers can turn a blind eye to sexual assault in children and adults by saying it is 'cultural'. Excusing abuse in this way is wrong and a further abuse.
Fear of the police response.	Past inaction associated with reports of abuse means that people lose confidence that there is any point in reporting.
Lack of confidence in ability to talk to legal staff.	Authorities may be fearful of retaliation for action they may take.
Difficulty in accessing someone to report to and lack of secure shelter for the victim.	Indigenous workers may be shunned for actions taken against an offender.
Lack of trust of the 'white' system.	Stress and burnout of professionals who have too few resources and too much work.

It is important to try to overcome these barriers to protect the victims of sexual assault so that the cycle of abuse can be stopped.

6.5 Education about child sexual abuse and sexual assault

Sexual health workers usually provide some education about sexual assault in workshops or programs that teach about healthy relationships.

Experts in the area of Aboriginal child sexual abuse say that education about it must be presented in a way that is neither threatening nor alienating.

Sometimes, when you are educating about sexual abuse, children or young people will disclose that they have been abused. Both the examples below are clear cases of sexual assault that must be reported.

> 'This 14-year-old girl reported that her 22-year-old boyfriend forced her to have sex with him. She says it doesn't count as rape because she is in a relationship with him. What do I do? It doesn't sound right to me ...'
> **Health promotion worker, Northern Australia**

Saying nothing or pretending you didn't hear will leave the person feeling lost and abandoned

'This young boy, a petrol sniffer, told me that he had been 'used' by other men who regularly visit his house for sex. He has legal rights but I am concerned for my safety here if I mandatorily report. This is my home too. I know his family will come for me ...'
Health worker, urban health service

6.6 What if a young person discloses abuse or the worker suspects abuse has occurred?

If a young person discloses abuse, or a worker believes abuse may be occurring, the worker needs to follow the laws and protocols of the relevant agency and state or territory.

Sections 6.1 and 6.2 of *Background and supporting material* have information on the state and territory laws and protocols about reporting abuse. You should also learn your agency rules about this.

This is an area you should seek training about, so that you will know exactly what to do and who the experts are in your local area. **Do not offer counselling to someone who discloses sexual abuse or assault unless you are trained and authorised to do so.**

Research about child sexual abuse in Aboriginal and Torres Strait Islander communities has found that, 'The importance of having qualified professional people working with children and adult survivors of child sexual abuse, especially from when disclosure first occurs, was stressed over and over again ... Aboriginal people want professional help from competent people whom they can trust'.

At the same time, you need to know how to respond if a person discloses that they have been sexually abused or assaulted. Saying nothing or pretending you didn't hear will leave the person feeling lost and abandoned.

If a young person discloses abuse:

- remain calm, listen very carefully to what they are saying
- always tell them you believe them
- tell the child it is not her or his fault
- tell the child it is right for her or him to talk about it
- acknowledge that it is very hard talking about these things
- let the young person know you will try to keep her or him safe

- do not make promises you cannot keep
- do not confront parents or offenders
- seek advice from your nearest Aboriginal and Torres Strait Islander child welfare agency, health service, or state or territory child protection service
- help the child to make an emergency safety plan that involves people the child feels safe to talk to and a safe place for him or her to go to.

Make sure you know your agency's protocols about reporting and referral.

Such protocols may differ from place to place but must comply with all child protection legislation for your state or territory. Protocols should include guidance on:

- who makes the report
- who you report to – e.g. Department of Community Services (DoCS), police and the relevant contact details
- what must be reported
- when the report must be made
- how the report is to be made (i.e. written, by telephone)
- what support services are available in your area (i.e. for the child, for the family and for you), and what are the relevant contact details.

Dealing with child sexual assault can have a profound effect on you, so it is important to have strategies in place to minimise the impact on your health and wellbeing.

Talk with others. If possible, debrief with other workers who are directly involved with the care of the child (e.g. the treating doctor or health worker).

Find out what help your workplace has in place for workers in case this situation arises. This may include contact details for an external counsellor or an employee assistance program.

For people working in rural and remote areas, CRANA offers a confidential 24-hour phone support service (1800 805 391). This service is for all health professionals, including Aboriginal and Torres Strait Islander health workers and allied health workers in rural and remote settings. You do not have to be a member of CRANA to use the service.

6.7 References and suggested readings

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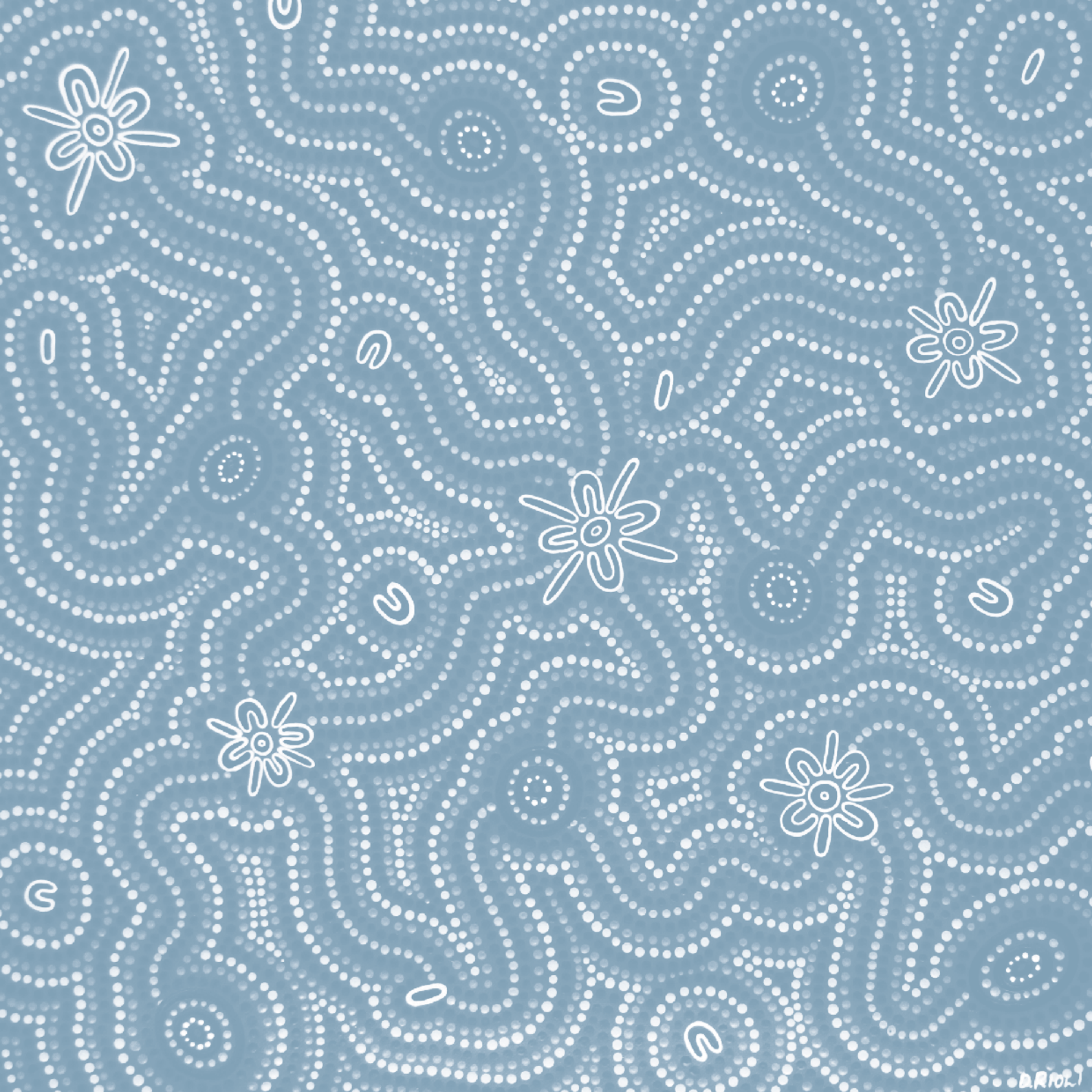
BACKGROUND AND SUPPORTING MATERIAL



1 Introduction

The information provided here supplements *Djiyadi: Can We Talk? – a resource manual for sexual health workers who work with Aboriginal and Torres Strait Islander youth*.

Section 2 acknowledges the many agencies and people who contributed to the development of the resource, and the remaining sections provide useful supporting materials.

Section 3, 'About sexual health and the role of sexual health workers', provides a variety of background information and materials.

Section 4, 'Tools and related resources', includes information about some activities you may be required to undertake in your role as a sexual health worker.

Section 5, 'Sexual health networks, organisations and training' provides details of networks and organisations, which will assist you in your work.

Section 6, 'Other useful websites', gives links to sites from which you can access other relevant information.

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* **In memoriam** Dr Penny Lowe, a valued Clinical Advisor and member of the professional education team at ASHM, passed away suddenly in late 2010. Penny's dedication to sexual health medicine and her passion for education will be remembered by all who knew her.

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Stakeholder consultation and focus testing

The following organisations were represented during stakeholder consultation and focus group discussions and testing:

Aboriginal Health Council of South Australia

Aboriginal Health Council of Western Australia

Clinic 34 Alice Springs NT

Family Planning Western Australia

Goldfields Public Health Unit WA

Kimberley Population Health Unit WA

Kirby Institute (then National Centre for HIV Epidemiology and Clinical Research) NSW

People Living with HIV organisations Qld and SA

Queensland Aboriginal and Islander Health Council Qld

Rumbalara Aboriginal Cooperative Ltd Vic

3 About sexual health and the role of sexual health workers

3.1 The sexual and reproductive health of Aboriginal and Torres Strait Islander peoples

In relation to reproductive health, compared with other Australians, Aboriginal and Torres Strait Islander people have:

- higher birth rates
- babies at younger ages
- more than four times the birth rate of babies born to teenagers
- more than twice the number of babies born of low birth weight
- a higher number of pre-term births
- higher numbers of mothers dying in childbirth (maternal mortality)
- higher rates of tobacco smoking during pregnancy
- higher rates of alcohol use during pregnancy (and higher rates of babies born with foetal alcohol spectrum disorder)
- lower rates of contraceptive use, especially among young people
- lower levels of antenatal and postnatal care.

And research findings show that, compared with other Australians, Aboriginal and Torres Strait Islander people have:

- more than eight times the rate of new cases of chlamydia
- more than 70 times the rate of new cases of gonorrhoea
- around eight times the rate of new cases of syphilis
- around four times the rate of new cases of hepatitis B
- around two-and-a-half times the rate of new cases of hepatitis C
- similar overall rates of HIV diagnosis
- a much higher proportion of STIs among Indigenous females
- a much younger age of first contracting STIs.

There are several reasons why STI rates are higher in the Aboriginal and Torres Strait Islander population, including:

- poor access to health services
- a lack of staff with specific training on how to sensitively deal with Aboriginal and Torres Strait Islander clients
- a younger population
- higher rates of substance use
- a population who move around more
- social and economic disadvantage
- a history of colonisation.

For Aboriginal and Torres Strait Islander young people – as for other young people – sexual activity at younger ages has been linked with:

- lower school attendance
- higher rates of tobacco smoking
- higher rates of marijuana use
- higher rates of alcohol use
- greater number of sexual partners
- greater likelihood of acquiring an STI
- teenage pregnancy.

3.2 STI and BBV table

Infection	Transmission	Clinical	Treatment
Chlamydia (*Chlamydia trachomatis*) (The most frequently notified STI)	Sexual*, genital, oropharyngeal and rectal	Asymptomatic, genital and anal discharge, dysuria, PID, infertility, chronic pelvic pain	Antibiotic oral (azithromycin) Treat contacts
Gonorrhoea (*Neisseria gonorrhoeae*)	Sexual*, genital, oropharyngeal and rectal	Asymptomatic, genital and anal discharge, dysuria, PID, infertility, chronic pelvic pain	Antibiotic oral or injection (need to check sensitivity to antibiotic – resistance is a problem) Treat contacts
Syphilis (*Treponema pallidum*)	Sexual^, genital, oropharyngeal and rectal, congenital	Primary chancre (ulcer) Secondary syphilis Early and late latent Tertiary syphilis (neurosyphilis, cardiovascular and gummas) Congenital syphilis	Antibiotic oral or injection (penicillin) Treat contacts
Trichomonas (*Trichomonas vaginalis*)	Sexual	Asymptomatic, dysuria, discharge, irritation	Antibiotic (metronidazole, tinidazole)
Genital herpes (HSV)	Sexual^, genital, oropharyngeal and rectal, close contact, congenital	Primary infection with local painful ulcers Recurrent episodes (virus re-activated)	No cure Antiviral (famciclovir, valciclovir) for primary event and to prevent recurrences

Infection	Transmission	Clinical	Treatment
Genital warts (HPV)	Sexual^, genital, oropharyngeal and rectal, close contact, congenital	External genital lumps, vaginal, cervical and rectal infections Genital pre-cancer and cancer	Cosmetic treatment (podophyllin, imiquimod) Screening for cervical cancer in women – Pap smear
Thrush (*Candida albicans)*	**Not sexually transmitted**, overgrowth of normal flora	Genital itch and discharge	Topical creams, pessaries (e.g. clotrimazole), oral fluconazole for chronic or recurrent episodes
Bacterial vaginosis Women only	**Not sexually transmitted**, overgrowth of normal vaginal flora	Asymptomatic, offensive vaginal discharge, adverse pregnancy outcomes	Antibiotic (metronidazole, tinidazole)
HIV	Transmission through infected body fluids: sexual, injecting drug use, MTCT	Primary: asymptomatic or flu-like symptoms Advanced HIV range of conditions related to depressed immune status – opportunistic infections and malignancies	Lifelong antiretroviral drugs – combination therapy provides very good response and quality of life. Prophylactic treatment in advanced disease for opportunistic conditions Follow up contacts
Hepatitis B virus	Transmission through infected body fluids: sexual, injecting drug use, MTCT, close contact	Infection of the liver which can progress to chronic hepatitis, cirrhosis, liver failure and liver cancer	Vaccine preventable Antiviral combination therapy
Hepatitis C virus	Transmission though blood to blood contact: primarily injecting drug use Low risk of sexual transmission MTCT is considered low risk	Infection of the liver which can progress to chronic hepatitis, cirrhosis, liver failure and liver cancer Other organs involved (kidneys)	Antiviral therapy that has a good success rate (curative). There is no vaccine available
Scabies and pubic lice	Close contact, sexual	Itch, skin lesions, observation of parasites	Topical treatments, treat contacts

* Also mother-to-child transmission (MTCT)
^ Also mother-to-child transmission and close contact with infectious lesions
PID: pelvic infection
MTCT: mother-to-child transmission
HSV: herpes simplex virus
HPV: human papillomavirus
HIV: Human immunodeficiency virus
STI: Sexually transmitted infection
BBV:Blood-borne virus

3.3 Aspects of sexual health work table

Use this table to clarify your role, identify relevant training, and consider who should/could be a part of your sexual health 'team' or network.

Role	Example	Is this part of my work role? (Yes/No)	Who in my local area could help in this work?	Do I need training or support to do this? (Yes/No)	Where could I get the training or support?
Education					
Providing information to groups in one-off sessions	Giving talks or workshops about safe sex in schools or youth centres; running sexual health sessions for men's groups or young mums				
Running structured programs that teach skills and information	A 10 week program for youth aged 11-14 that covers many aspects of growing up including relationships, sexuality and safe sex; a safe sex program for young women that includes negotiation and consent skills				
Being a source of good, reliable sexual health information in the community	Informal chats with family, friends, and colleagues; informal chats with youth				
Educating health and other professionals	Mentoring non-Indigenous staff about local cultural issues; explaining how to be culturally sensitive in sexual health; talking up the importance of doctors and nurses offering STI tests to young people; explaining how to communicate with different people such as youth, older men and women				

Role	Example	Is this part of my work role? (Yes/No)	Who in my local area could help in this work?	Do I need training or support to do this? (Yes/No)	Where could I get the training or support?
Running community events	World AIDS Day and National Condom Day; sexual health stalls at NAIDOC Week events or music festivals				
Running creative activities	For example, sexual health poster design art competitions to engage youth with the topic in a creative way				
Clinical					
Clinical work – in a health service or through outreach	Collecting urine samples or swabs				
Keeping records of client contacts and attendances	For example, a work diary or attendance sheet at an event				
Contact tracing	Following up the sexual contacts of a person who has been diagnosed with an infection, so their partner/s can be treated				
Bringing people to the clinic for a check-up	A young woman asks you for emergency contraception; a friend tells you they have pain when they urinate				
Providing health hardware					
Making sure that condoms are available in the community	Asking the youth service to put out a bowl of condoms on the front counter; getting a condom vending machine installed in the local servo				

Role	Example	Is this part of my work role? (Yes/No)	Who in my local area could help in this work?	Do I need training or support to do this? (Yes/No)	Where could I get the training or support?
Making sure that sterile injecting equipment is available in the community	Advocating for needle and syringe programs to prevent the spread of HIV, hepatitis C and other blood-borne viruses				
Making a health service more youth friendly and sexual health friendly	Putting up appropriate posters and having youth events at the service				
Liaison					
Building relationships with organisations that service Aboriginal and Torres Strait Islander youth and encouraging them to offer sexual health education to their clients	Schools; youth centres; prisons and juvenile justice centres; mental health services				
Building relationships with Aboriginal and Torres Strait Islander community members and organisations	Offer to give a talk to the Board members of local organisations; have a 'safe sex' sausage sizzle at your organisation so that locals get to know where you are and what you do.				
Referring clients to other services	Contraceptive services; sexual assault services; counselling services; welfare services;				
Advising other organisations and individuals about Aboriginal and Torres Strait Islander sexual health	Giving presentations, participating in reference groups				

3.4 Websites that provide factual sexual health information

National

Australasian Society for HIV Medicine (ASHM)
http://www.ashm.org.au

Australian Federation of AIDS Organisations (AFAO)
W www.afao.org.au

HealthInsite – sexual health
http://www.healthinsite.gov.au/topics/Sexual_Health

Hepatitis Australia
http://www.hepatitisaustralia.com/

Marie Stopes
http://www.mariestopes.org.au/our-services

Sexual Health & Family Planning Australia
http://www.shfpa.org.au/

Australian Capital Territory

Canberra Sexual Health Centre
http://health.act.gov.au/c/health?a=sp&did=10078309

Sexual Health and Family Planning ACT
http://www.shfpact.org.au/

New South Wales

Family Planning NSW
http://www.fpnsw.org.au/

NSW Department of Health – Sexual Health Plus
http://www.health.nsw.gov.au/publichealth/sexualhealth/

Sydney Sexual Health
http://www.sesiahs.health.nsw.gov.au/sydhosp/services/sshc.asp

Northern Territory

Family Planning Welfare Association of NT
http://www.fpwnt.com.au/

Northern Territory AIDS and Hepatitis Council
http://www.ntahc.org.au/

Northern Territory Department of Health
http://www.health.nt.gov.au/Centre_for_Disease_Control/Sexual_Health_and_Blood_Borne_Viruses/index.aspx

Queensland

Family Planning Queensland
http://www.fpq.com.au/

Queensland Association for Healthy Communities
http://www.qahc.org.au

University of Queensland – HIV & HCV education projects
http://www2.som.uq.edu.au/som/Research/HIVHCV/Pages/default.aspx

South Australia

SHine SA
http://www.shinesa.org.au/

Tasmania

Family Planning Tasmania
http://www.fpt.asn.au/

Sexual Health Service Tasmania
http://www.dhhs.tas.gov.au/sexualhealth/sexual_health_service_tasmania

Victoria

Family Planning Victoria
http://www.fpv.org.au/

HIV, Hepatitis & STI Education + Resource Centre
http://www.hivhepsti.info/index.php

Melbourne Sexual Health Centre (MSHC)
http://www.mshc.org.au

Western Australia

Family Planning WA
http://www.fpwa.org.au/

WA Sexual Health Network
http://www.washn.org.au/

Western Australian Department of Health – Sexual health and blood-borne viruses
http://www.public.health.wa.gov.au/1/53/2/sexual_health_and_bloodborne_viruses_public.pm

4 Tools and related resources

4.1 Meetings and workshops

As a sexual health worker you will be involved in meetings and workshops. This section aims to help you when organising and conducting effective meetings and workshops – just in case you have to take on this task. These notes are not very detailed; you may need to seek further information if you are required to organise a meeting or workshop.

Why have meetings?

Working in sexual health involves a lot of meetings but most of these will not be formal meetings. Meetings can be time consuming but they are important. Meetings enable you to get to know the community and its health needs better, and the community gets to know you better and have a say in the health program you are developing. Community meetings should include all those with a stake in its success. The meetings allow information and ideas to be shared, resources and participants to be identified and program goals and action plans to be developed and monitored.

Before calling a meeting, you should:

- be clear on the reason for the meeting and what you want to achieve
- take the time to tell community leaders and key stakeholders the purpose of the meeting and seek their participation.

Preparing for the meeting

Have an agenda. An agenda is a list of items to be dealt with at a meeting. An agenda keeps the meeting focused. The key is to make sure everyone approves the agenda before you start. Try to send the agenda out to all participants before the meeting so they know what will be discussed. At the meeting ask if anybody has items they want added (providing there is time available). A basic agenda should include:

- purpose of the meeting
- date and location of the meeting
- the start time and finish time of the meeting
- the items to be discussed.

Please note: reports or information that meeting participants need to consider before the meeting should be sent out with the agenda before the meeting.

(An agenda template is provided on page 92)

Choose a suitable venue. The choice of venue for the meeting is important. In some Aboriginal and Torres Strait Islander communities it may be important to use a neutral venue, that is, a place not associated with any particular group within the community. The meeting space should be comfortable and set up to allow everybody the opportunity to be seen and heard.

Running the meeting

Starting on time. Try to start the meeting on time because this is a courtesy to those who get there at the nominated time and it sets the tone from the start that your group means business. But you also need to be attuned to a community's sense of time. Above all else you want community members to feel their attendance is welcome.

Making introductions. If appropriate, acknowledge the traditional owners of the land on which the meeting is being held. Introduce people, including speakers and community leaders and any new people, at the start of the meeting. In a small meeting it may also be useful to ask people to tell the group a little about themselves (providing people are comfortable speaking in public).

Chairing the meeting. The chairperson should:

- ask somebody else to take the minutes so there is a written record of the meeting; the minutes would include a brief account of decisions, a list of those who attend, and the 'apologies'
- try to keep people to time so you cover all agenda items and finish the meeting on time. However, you need to be flexible and sometimes allow participants extra time so they feel comfortable in the meeting
- ensure everybody has an opportunity to talk and encourage the shy ones so they feel involved
- summarise and confirm key decisions
- check to make sure the minute taker records any action items including who is responsible for carrying them out and when
- set a date and time for the next meeting.

Following up after the meeting. It is important to understand that a meeting is the middle part of a process involving preparation and follow-up. Others who have a stake in your program, but who were not at the meeting, need to be kept informed. So let them know about the outcomes of the meeting. Also, keep in touch with those participants who took responsibility for certain tasks. You can then provide support if necessary, to make sure the actions are carried out.

Organising and running a workshop

You may have attended workshops in the past and it is useful to think about what made it a good experience and what made it a not-so-good experience. This will help you to plan for a great workshop!

The following five checklists outline some of the practical issues in running workshops. They can be used for planning which will increase the chances that the workshop will be successful.

Before the workshop

- Who do you want to attend the workshop? Brainstorm with other members of your team or colleagues in other organisations about who to invite.
- Decide on subject matter.

Example agenda

Date: 12 August 2011

Time: 10 am – 12 pm

Location: Community Centre, 100 Station Street, Mount Isa

Agenda

Meeting purpose: Organisation and conduct of sexual health workshop

Attendees/Introductions

Apologies

1. **Business arising from the previous meeting 2 February 2011**

   No business arising

2. **New business**

   2.1 Workshop location (Sandra)

   Where should the workshop be held? See attached report of possible locations, which lists the facilities, benefits and possible problems of each location.

   2.2 Participants (Ann)

   Who needs to be involved? How do we get them involved?

   2.3 Workshop program (Jim)

   Review of (1) goals and objectives; and (2) draft program. Do we need someone external to assist in running the workshop program?

   2.4 Budget (Darryn)

   Review of costs for hire, catering and materials (see attached report).

3. **Other business**

4. **Next meeting**

- How long is the workshop – a half day, 2 days? This will depend on the purpose and the availability of participants and presenters.
- Set dates, and start and finish times.
- Write a plan for what will happen. Do you have enough money to run the workshop? If not, then think about applying for funds.
- Select a venue that is suitable. Is it accessible – close to public transport? Is parking available? Does it have disabled access or any other special requirements?
- Organise the resources that will be required, e.g. computer equipment.
- What about catering? Do you need to provide lunch, morning or afternoon tea?
- Who will run the workshop? Is it you, a local person, or will it be someone outside the community? Negotiate costs for facilitators or speakers.
- Invite someone to open the workshop and arrange for an Elder to conduct a Welcome to Country if participants come from outside the community. Negotiate costs.
- Advertise the workshop. Discuss whether you will send out flyers, personal invitations, emails or formal letters. Develop flyers or posters, arrange media interviews or think of other ways to spread news about the workshop. Ensure you keep a record of who the invitations were directed to and when they were sent then follow up 1 to 2 weeks before the workshop with a reminder by phone or email to the people you sent the invitations to.
- If you want to attract participants from outside the community, make transport and accommodation arrangements and secure discounts for group bookings where possible. It might be more economical to run the workshop at the same venue as the accommodation.
- Set a closing date for people to register for the workshop so that catering can be organised. Keep a record of who registered.
- Organise the seating arrangements for the workshop according to the activities that you want people to do (e.g. for an activity-focused workshop, use tables of five or six people).

During the workshop

- As participants arrive, give them a name tag and ask them to complete a contact details sheet.
- Include a Welcome to Country or other opening ceremony.
- Talk about housekeeping (e.g. meal times, where the toilets are).
- Establish ground rules with participants, such as not talking over others, not swearing, and confidentiality.
- Ask what participants are hoping to achieve from the workshop.

- Make sure that you have good timekeeping that keeps to the workshop program.
- Value and acknowledge the contribution of participants.
- Avoid lecturing styles in presentation. (Many people have negative memories of their school days and old style learning methods are likely to make people uncomfortable.)
- At the end of the workshop ask if the participants' needs and outcomes have been addressed.
- Invite feedback from participants; use feedback sheets or verbal feedback if literacy is an issue (e.g. 'What one/two/three things did you learn from this workshop?').
- Get participants to discuss next steps (e.g. do they want more workshops?).
- Thank participants for attending.

After the workshop

- Review and collate feedback/evaluation forms.
- Write up and circulate a workshop report, including how much you spent on the workshop.
- Send letters of thanks to organisers, guest speakers, and Elders for their participation.
- Send the workshop report to key stakeholders.
- Consider the feedback and recommendations from participants to develop future workshops and actions.

Workshop equipment and materials checklist

This is a guide to what you may need for your workshop.

Pre workshop packages
Workshop agenda
Feedback sheets
Service contact sheets
Photo consent forms
Art work conditions of use form
Certificate of attendance
Information and activity sheets
Overhead/data projector and spare globe
Audio or films on CD/DVD
CD/DVD player
Whiteboard and markers
Blu tack, drawing pins
Art materials
Gift for the welcome person
Keys to venue
Access to electronic equipment
Password to the computer
Computer and mouse
Digital camera/batteries
Mobile phone/phone access
Screen for presentations
Extension cords/power board
Tape to cover power cords (safety)
Butcher paper
Notebooks and pens
Name tags
Boxes of tissues
Venue heating/cooling

Catering

- Organise caterers and arrange time for delivery of food.
- Give refreshments on arrival if people have had to travel long distances.
- Arrange to meet special diet needs.
- Organise equipment and facilities for tea and coffee.
- Record phone number of catering company.

4.2 Lesson planning

As with many other aspects of sexual health work, lessons about sexual health are best delivered by people with appropriate training.

In your role as a sexual health worker, however, you may be required to deliver a lesson about some aspect of sexual health. If so, it is important that you plan your lesson well. Your plan will need to take account of the needs and nature of the people receiving the 'lesson', the topic, and your own knowledge and abilities. It is beyond the scope of this resource to deal with this aspect in any detail, but the following headings will provide some guidance in helping you prepare for a lesson on a sexual health topic[7].

Lesson outcome: *What do I want the young people to be able to do, know, or think at the end of this lesson?*

Resources: *What will I need to have on hand for this lesson?*

Lesson outline:

Introduction: *How best to motivate and explain the importance of this lesson?* (This should be about 5 minutes with links to previous learning or experiences)

Learning activity and strategy: *What will support the young people to learn the ideas I'm trying to teach, and to reach the outcomes I'm aiming for? What will participants be doing? What will I be doing?'*

Concluding strategy: *How can I capture the main learning points of the lesson?*

Evaluation/feedback: *What will be the evaluation task relating to my lesson outcome?*

Special considerations or contingency plans: *Consider participants with special needs*

Self-reflection: *Anticipated self-questioning*

4.3 Evaluating sexual health programs

Evaluation means finding answers to the question 'Did the event (or program) get results?' Evaluation is important because it allows you to check the progress of your programs, who has benefitted and what should be done differently next time. Evaluation does not have to be complicated or take a lot of time.

7 The template has been adapted from Community Partnership Tool Box: Edith Cowan University

Why do an evaluation?

Evaluation provides you with the evidence of what has worked in your program and what hasn't. From this evidence you can make decisions about what to do in the future. You will have to make choices about how you do the evaluation and how much you evaluate.

A starting point is to make clear the purpose (main reason) for your program. By the end of the program you should strive to answer the following questions:

- has the program reached the right people? If not, why not?
- was it run as planned? If not, why not?
- did it achieve its purpose? If not, why not?

Different types of evaluation

The type of evaluation you do will depend on the questions you want to ask. You must also be prepared to adapt your evaluation to your audience as some methods will not be appropriate for some groups.

The different types of evaluation are:

Qualitative evaluation

Qualitative evaluation involves gathering people's thoughts and feelings about an activity or program. You can ask questions that enable people to tell you, in their own words, whether they liked an activity or program and whether they thought it useful.

Quantitative evaluation

Quantitative evaluation involves gathering information that can be counted. For example, you could count how many people attended an event, how many condoms were distributed, or how many people asked for an STI test.

Process evaluation

Process evaluation focuses on how the activity or program is being run. For example, in an evaluation of an STI program for teenagers, you might ask yourself: Did the right people attend the program? Were they from the age groups and backgrounds that we were targeting? Did the venue work out OK?

Impact evaluation

Impact evaluation is used to measure what your activity or program is achieving in the short term. For example, at the end of a workshop, you could ask young people to name how STIs are passed on and how to protect themselves, or what are some of the ways to know if your relationship is healthy.

Outcome evaluation

Outcome evaluation is measuring what you have achieved over a longer period of time. For example, you could measure the reduction of STI notifications in a community. Outcome evaluations are typically measured by professional evaluators.

The following is a simple step-by-step guide on how you can build evaluation into your program plan.

A guide to evaluation

1: Plan the program – what do you want to achieve, who do you want to involve, what will you do, and how will you do it? What do you want the people to know about (e.g. to know how HIV is spread) or be able to do (e.g. how to correctly use a condom) at the end of your program?

2: Plan an evaluation – use your objectives and goals and decide how you will measure whether you have achieved them or not. Identify key questions, identify cultural sensitivities, identify good processes and allocate necessary resources.

3: Design the evaluation – decide on the methods you will use to collect the information you want, such as: counting who attended a sexual health program; giving out a short questionnaire before the program and afterwards to measure if people's knowledge and attitudes have changed; asking what people thought of the program; and, after perhaps a month, getting the young people together to discuss their thoughts about safe sex and healthy relationships.

4: Collect and record your information – do this systematically to get a true picture of what your program achieved.

5: Analyse your information – see if the program achieved what you intended, and identify the lessons learnt.

6: Provide feedback on your findings – let the people involved in the program know about what was achieved. This could be a community presentation, a short written report, or series of meetings with the people involved to tell them about what you found.

Do not expect your program to run or achieve its goals exactly as it was intended. All programs are a learning experience for you and those involved. Monitoring your results throughout the program will help you keep track of progress, identify when important changes occur and make it easier at the end of the program to summarise what was achieved. Answering the following questions may help you keep your evaluation on track while the program is running:

- What do the early results mean in terms of what you are trying to achieve?
- Should you be changing the way you are doing things?
- How do you keep the positive changes you are achieving with your program?
- Are you doing things in the best possible way?
- Are you talking to the right people about the progress of your activity or program?

When you have finished your program, you will need to think about the following:

- How did the program go, did you make a difference?
- How can you share the information about what has been achieved?
- What is the next step?

Evaluation sheet

You may want to give participants an evaluation sheet. An example of an evaluation sheet follows:

Sexual health event [enter details]: Please let us know what you think
Event title: Date:
How would you rate the event? ☐ Excellent ☐ Very good ☐ Good ☐ Poor ☐ Very poor ☐ Undecided
Do you have any comments about the event venue, facilities, seating, etc.
Did you learn anything new or important about safe sex? ☐ Yes ☐ No ☐ Undecided If you answered 'yes' what did you learn?
How did you hear about this event? ☐ Poster ☐ Newspaper ☐ Indigenous radio ☐ Mail ☐ Email ☐ Friend ☐ Other:
Do you think you need to make changes to your lifestyle? ☐ Yes ☐ No ☐ Undecided If you do plan to make changes, what will they be?
Do you have any other comments to help us to do it better next time?

Practical evaluation tips

- Keep it simple – think about what you need to measure; focus on a few key features so the evaluation does not become too difficult.
- Make it relevant – think about the parts of the program you choose to measure and ask if they address your purpose.
- Think about evaluation from the beginning – remember to build in evaluation from the start of your program so you can monitor progress.

- Look at how similar programs have been evaluated – can you learn from what others have done?
- Promote your findings – everyone likes a good news story. Local media are often interested in community programs. Newsletters are good ways of promoting your program to the community. Think about making a presentation to the community.

4.4 Peer education

Youth peer education programs educate and train motivated young people about sexual health to become peer educators. This allows them to communicate these messages to their peers. Peer educators are people of similar ages, backgrounds, and interests. Peer education can be used for a variety of age groups and populations for various goals. Peer education has been widely used internationally to change behaviour and give information about sexual and reproductive health for young people.

You will not be expected – without special training – to set up peer education programs but it is important that you have some idea of the value of such programs in sexual health work among Aboriginal and Torres Strait Islander young people. This section summarises the advantages and disadvantages of peer education and outlines program considerations. It also provides you with information about sources that you may want to refer to.

Advantages

- Peer educators can access hard-to-reach groups if they are themselves members of hard-to-reach groups.
- Adolescent development theory tells us that peer groups are highly influential, and young people are more likely to accept information from peers rather than adults.
- Peer educators themselves experience positive benefits by increasing knowledge and leadership skills for their own professional development.
- Peer education links young people to other community services.

Disadvantages

- Organising peer education programs is difficult because adolescent peer educators often leave the program as they get older and constant recruitment and retraining is needed.
- Program evaluation can be difficult because some programs are done together with other activities or have limited budgets for monitoring and evaluation.
- Programs that lack a clear structure for providing information can result in misinformation and unprofessional advice.
- When not appropriately targeted, peer educators become channels of outreach to the larger community rather than just their peers which reduces the program's impact.

Program considerations

The following are recommendations to improve peer education:

Training

Provide high quality training for peer educators that includes building self-confidence and skills and has clear program objectives to keep peer educators motivated and focused.

Structure

Base programs on a topic that is relevant to the peer groups. In the training, assist young people to target messages and meet the outcomes of the organisation supporting the peer education program.

Retention

Peer educators need supervision, support and debriefing. Information – such as accessing services, distributing condoms and overcoming myths – has to be delivered in ways that link the peer educator's personal values and beliefs with those of the organisation. Using creative approaches and career development opportunities are important to retain peer educators for long periods of time.

Monitoring and evaluation

Peer educators may need to be trained or supported to do data collection, basic data analysis, and dissemination. Encourage partnerships with other agencies to work with peer educators to share the success of their stories.

Youth involvement

Include youth participation in designing, implementing, monitoring and evaluating programs.

Include both young men and women

Encourage young women and young men from regional areas to become peer educators.

Involving parents and adults

Parents can be recruited as peer educators to undertake home-visits to talk about parent–child communication, STIs, gender-based violence, condom demonstrations and referrals for clinical cases to do with adolescent sexual and reproductive health. Parent peer educators become educators to other parents who have no access to sexual or reproductive health information. The parent peer educators could also act as intermediaries between families, community leaders and youth centres, becoming advocates that link the community to decision makers.

Safe meeting places

As is the case for other aspects related to sexual health, you will need to think carefully about where to run a peer education program. It is crucial that the meeting place is 'safe' for Aboriginal and Torres Strait Islander young people.

Information about peer education programs

The following sources provide general information about peer education programs for young people. Some are for areas other than sexual health

and some not specifically for Aboriginal and Torres Strait Islander young people. However, you should find them useful if you want to think more about peer education programs.

Bentley M (2008) Evaluation of the peer education component of the *Young Nungas yarning together* program. Adelaide: South Australian Community Research Unit, Flinders University [Accessible at: http://www.adac.org.au/resFILE/res147.pdf]

Burnet Institute (n.d.) The value of peer education (Fact sheet). Melbourne: Burnet Institute [Accessible at: http://www.burnet.edu.au/freestyler/gui/files//The Value of Peer Education.pdf]

McDonald J, Roche AM, Durbridge M, Skinner N (2003) *Peer education: from evidence to practice, an alcohol and other drugs primer.* Adelaide: National Centre for Education and Training on Addiction [Accessible at: http://www.nceta.flinders.edu.au/pdf/peer-education/entire-monograph.pdf]

Mikhailovich K, Arabena K (2005) Evaluating an Indigenous sexual health peer education project. *Health Promotion Journal of Australia* 2005;16:189-193

Prosser S, Batson L (2008) *Youth sexual health project, peer education program: session plans*. Geelong: Headspace, Barwon [Accessible at: http://www.headspace.org.au/media/39531/youthsexualhealthprojectpeereducationprogram_education%20page.pdf]

4.5 Games, stories, and role-playing

In educating young people about sexual health, you may want to do more than just talk – games, stories and role-playing can help you get your 'message' across.

The brief introductions provided here aim to give you an idea of their place in sexual health work.

Games[8]

Games attract and hold attention and provide learning from experience. By teaching through games, you encourage people to participate and self-regulate (self-control). Games can overcome the greatest barrier to sexual health education: silence. Sexual health experts suggest that games are fun and important as an education tool because they:

- increase learning and decrease anxiety
- increase group togetherness and get people talking
- help youth learn from each other
- take players' minds off their troubles and teach social skills
- teach skills and offer unplanned counselling opportunities
- offer chances to show knowledge and lighten things up.

Running successful sexual and reproductive health games

Get everyone involved – and comfortable. Keep an eye out for the players who are not participating and gently try to get them involved. However, always allow them the opportunity to pass or not participate. You may want to follow up quiet players later in private.

8 The material about games has been adapted from *PATH: Games for adolescent reproductive health: an international handbook.* To access this resource and a wide selection of game ideas, go to http://www.path.org/files/gamesbook.pdf

Keep score! This can build momentum for many groups. Scores may be kept for one game or added up over many games and weeks.

Pace the game. When players get too excited, they may rush through the content. Slow them down. On the other hand, if a game starts to drag or attention is waning you can encourage players to pick up the pace or you may want to modify the rules.

Keep the competition fun. Encourage a light atmosphere during competitive games. Establish rules of conduct as a group. Encourage and model positive ways to handle winning and losing. Leave the refereeing to game participants as much as possible, referring them back to their own rules.

Play up the cooperative nature of games. Many elements of game play offer chances to practise social skills and allow for differences. Aim for a combination of chance and skill. Adding an element of chance to skills-based games makes it more fun. This allows young people to practise skills with a bit less worry and makes for less pressure about winning and losing.

Encourage problem solving. Include chances for players to decide if an answer works for them. This encourages creative thinking and discussion. Since so much of sexual health behaviour is linked to complex individual and social behaviour, values, and choices, this topic is ripe with learning opportunities.

Set up a 'parking lot' list. Complicated, important health or sexuality issues arise, but sometimes there is not enough time to explore them. This can be addressed by having the group write issues in the 'parking lot' (a large piece of paper prominently posted). Be sure to discuss them later.

Offer prizes. A stash of inexpensive fun prizes adds to the game atmosphere and suspense.

Use the test of success. Because active participation is one of the most valuable attributes of games for education, a simple measure of success is player involvement. Are the players doing most of the talking? Are most of the players contributing?

Stay creative! Take the games out to schools, other programs and the community. Create family fun nights, hold fundraisers and try games for community outreach. Ask your players to take the games home to play with their families. Make up new games. The possibilities are endless!

Stories

Sharing and creating stories about sexual health are also good ways to get messages across to young people. For example, young people can develop characters, identify their issues and write their own conclusions about what happens. Good stories introduce characters, have themes that are explored (e.g. contraceptive choices, crisis, peer pressure) and describe ways young people can cope or not cope in that situation. It is good for the young people attending a program to identify ways to help the characters in their story and places where the characters can go for support.

Example of a story

Lilla and Gary are 18 years old and in the final year of high school. They live in a country town and got together on a school sexual health camp. At age 16 they enjoyed each other's company and hung out a lot. Lilla came from a big family and wanted a lot of children. She wanted to start young like her dad and mum. She wondered when she and Gary could start their family. She was only at school filling in time until she could have a baby. Gary was a great catch, smart, good at sports and he would be a good dad. He was approached by the coach who suggested Gary would be eligible for a sports scholarship to a University but it meant leaving the town and moving to the city. Gary was ambitious, he wanted to go to University and have a good career. While he loved Lilla, he was not ready to start a family. He felt pressured to have a family and to stay with his friends. Gary talked to his family and got their support. He went to Lilla very excited about his opportunity. When he told her, Lilla was devastated – Gary wanted to leave her.
Group discussion activity: What should Gary and Lilla do?

Turning stories into visual aids

Stories can be useful in their own right, but may have greater impact if they are presented visually. This can be in the form of comic strips, cartoons, DVDs/videos, and the like.

Comic strips and cartoons[9]**.** Turning stories into comic strips or cartoons is a powerful way to engage young people who have not had a lot of education. You can either engage a cartoonist or get the young people to sketch out the story. Ask them to think about clothing, the background, location, types of trees and houses in the background as well as the characters and expressions they might use.

DVDs and videos[10]**.** You can also use these stories to develop scripts for use in making DVDs or videos. For assistance with script writing, see websites such as http://www.filmscriptwriting.com/. You can engage young people in script writing and acting, even without acting experience.

Using stories in workshops for young people or service providers

You can use stories in workshops with young people or service providers. This is best done in small groups where people get a chance to have a discussion about their story. People need butcher paper to write down the group's ideas.

9 Condoman – a comic book that promotes condom use among Aboriginal and Torres Strait Islander people – is one example of how comics can be used to promote sexual health messages http://www.qahc.org.au/condoman#comic

10 Examples of interactive DVDs that have been produced to promote sexual health awareness among young Aboriginal and Torres Strait Islander people include Risky business http://www.visualobsession.com.au/services/interactive-multimedia), Put it on http://www.hitnet.com.au/kiosk/, and Kaiyai girl: an interactive film http://www.hitnet.com.au/kiosk/

Exercise

- What are the issues for people in the story?
- Are the people in the story supported?
- Who are the characters going to hear information from?
- How can they best be helped?
- Who can help them in your community?
- What services are available to address these issues?

After this exercise, the groups can present the information back to the main group to have a larger discussion.

To inform adults in the community. Stories can also be used to inform service providers, parents, and Elders about issues going on in their communities. This is a safe way to bring some of the experiences of young people in the community to the forefront of people's minds, without blaming anyone, or singling out individuals in that community.

For peer education training. You can use stories with peer educators to discuss these and other issues, to identify what information they would provide young people in these circumstances, and to role-play what they would do in these situations.

Role-playing[11]

A role-play is an activity in which learners re-create a real life social situation. This method is useful when learning skills in a workshop.

11 This section has been adapted from the Australian Nursing Federation HIV/AIDS Train the Trainer Program, written by VH Read. 2002-2003

Role-playing can be done in five ways:

1. Two or more people role-play a situation in front of the other learners, who act as observers.
2. Each member of the group may be given a role to act out.
3. Learners divide into pairs, with one person acting as the client and one as the helper.
4. Role reversal: learners in pairs act as the client or helper and then they switch roles to experience both roles.
5. The group divides into threes and switch roles as client, helper, and observer.

The advantages of role-playing:

- Learners are able to experience various roles.
- Learners are active participants in their learning.
- The workshop facilitator can evaluate the learner's understanding of the topic.
- Skills are learnt in problem solving and observation.

In preparing for a role-play:

- Explain clearly to the group what is going to happen and why you are doing it this way.
- Ask for volunteers: some people are fearful of role-plays. Work out which of the five ways of doing role-plays will work with this group.
- Make it clear that perfect acting is not necessary; it's OK if people dry up or get the giggles!

- Everyone needs to be very clear about who they are representing. Facilitators may provide information cards that outline the character and present the problem, or they can describe this information verbally to each participant.
- People in role-plays should not use their own names. Also avoid giving any of the characters the names of people in the group.
- Most people know about role-plays, but if they do not, you may need to show them how to do it.

When conducting a role-play:

- Keep it as brief as possible (around 5 minutes).
- If it is not working, stop and start again. The same people can be used or others selected.
- Stress the process of what is going on (how) rather than the content (what).
- People can get very emotional in role-plays, so make sure you carefully monitor and provide support and processes for taking people out of role.

After the role-play:

- Thank participants.
- Debrief: ask participants what it was like to be in the role.
- Invite participants to talk about how they found the experience and what they learned from it; encourage participants to be supportive of each other.
- Direct feedback from observers to the experience and what they learned from it, not the acting talents of the role-players!

4.6 Glossary

Abstinence: Sexual abstinence is a decision to avoid certain sexual activities or behaviours. Different people can have different definitions of sexual abstinence. For some, it may mean no sexual contact. For others, it may mean no penetration (oral, anal, vaginal) or only lower-risk behaviours, such as safer sex where no body fluids are exchanged between partners. People of all ages, genders, and sexual orientations can choose to be abstinent at any time in their lives.

Abstinence-only education (e.g. Abstinence-only; Abstinence-only-until-marriage): These programs emphasise abstinence from all sexual behaviours and do not include information about contraception or disease prevention methods. Abstinence-only-until-marriage education emphasises abstinence from all sexual behaviours outside of marriage. It should be noted that abstinence is often taught as one option for safer sex as part of comprehensive sexuality education programs.

Bisexual: An individual who is sexually and emotionally attracted to men and women. Bisexual people need not have had a sexual experience to identify as bisexual.

Child sexual assault: The involvement of a child in a sexual activity in which the child is used as a sexual object and where there is unequal power in the relationship between the child and the abuser (see s4 of the *Family Law Act 1975*).

Contact tracing: The process used to help stop the spread of many different infections. In sexual health, it involves finding and treating contacts, or sexual partners, of a person who has been diagnosed with an infection.

Gay: A man who is sexually and emotionally attracted to other men. It can also refer to a woman who is sexually and emotionally attracted to other women.

Gender: The economic, social, and cultural attributes associated with being male or female in a particular point in time. It may also refer to a person's biological, social, or legal status as male or female.

Gender equality: Equal representation of women and men. Gender equality does not imply that women and men are the same, but that they have equal value and should be accorded equal treatment.

Gender roles: The characteristics and behaviours that different cultures attribute to the sexes. What it means to be a 'real man' in any culture requires male sex plus what our various cultures define as masculine characteristics and behaviours; likewise, a 'real woman' needs female sex and feminine characteristics.

Harm minimisation: Policies or strategies designed to reduce the harmful consequences associated with recreational drug use and other high-risk activities.

Health hardware: In the context of sexual health, things that people need to use to maintain healthy sexual practices (e.g. condoms).

Heterosexual: An individual who is sexually and emotionally attracted to a person of the opposite sex. Heterosexual people need not have had a sexual experience to identify as heterosexual.

Homosexual: An individual who is sexually and emotionally attracted to a person of the same sex. Homosexual people need not have had a sexual experience to identify as homosexual.

Lesbian: A woman who is sexually and emotionally attracted to other women.

Questioning: A person who is in the process of identifying their sexual identity.

Scope of practice: Defines the range of roles, functions and responsibilities, and decision-making capacity which the professional performs in the context of their practice.

Sex: The biological characteristics that define humans as female or male. These sets of biological characteristics are not mutually exclusive as there are individuals who possess both, but these characteristics tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean 'sexual activity'. See also *Gender*.

Sexual health: Is a state of physical, emotional, mental, and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health encompasses sexual development and reproductive health, as well as the ability to develop and maintain meaningful relationships; appreciate one's own body; interact with both genders in respectful

and appropriate ways; and express affection, love, and intimacy in ways consistent with one's own values. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination, or violence.

Sexual health services: The methods, techniques, and services that contribute to sexual health and wellbeing through preventing and solving sexual health problems. All people have a right to information, education, and health care services that promote, maintain, and restore sexual health.

Sexual history: Information about a person's sexual functioning that can be used to assess the person's risk for an STI or BBV. Examples of the type of information that might be collected include sexual orientation, number of sexual partners, and use of condoms. Information would also normally be sought about risk factors for blood-borne viruses (e.g. injecting drug use, tattooing, and piercing).

Sexual intercourse: Penetrative sexual behaviours, including oral sex, anal sex, and penile-vaginal sex.

Sexual orientation: The gender of another person to which a person finds themselves emotionally and sexually attracted. The common terms for the variety of sexual orientations are homosexual, gay, lesbian, bisexual, transgender, questioning and heterosexual.

Sexuality: Sexuality is an intrinsic part of being human throughout a person's entire life. It encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.

Sexuality education: An age-appropriate, culturally sensitive and comprehensive approach to education about sexuality that includes programs providing scientifically accurate, realistic, nonjudgemental information.

Transsexual: A transsexual is a person who identifies as a member of the opposite gender. People who are transsexual often want to surgically or hormonally alter their bodies to match their identity.

Transgender: A broad term generally used to include any person who feels his or her assigned sex does not completely or adequately reflect his or her internal gender identity. This includes the group of all people who are inclined to cross gender lines, including transsexuals, cross-dressers and other gender non-conforming individuals. Some people also use the word transgender to mean the same as transsexual, but transgender people may or may not take steps to live as a different gender (e.g. Sistagirls).

5 Sexual health networks, organisations and training

5.1 State and territory sexual health networks

New South Wales

NSW Aboriginal STI, HIV and Hepatitis Workers Network
http://www.ashhwntoolbox.org.au

Queensland

Deadly Sex Congress
http://www.qaihc.com.au

Western Australia

WA Sexual Health Network
http://www.washn.org.au/

5.2 Institutions/organisations providing sexual health training

Australia Capital Territory

Sexual Health & Family Planning, ACT (SHFPACT)
Accredited training for teachers, nurses, youth workers (workshops, courses, and certificates)
http://www.shfpact.org.au/index.php?option=com_content&view=article&id=199&Itemid=132

New South Wales

Albion Street Centre
Education and training for health care workers
http://www.sesiahs.health.nsw.gov.au/albionstcentre/education/index.asp

University of Sydney
Graduate Program of Sexual Health
http://www.healthinfonet.ecu.edu.au/key-resources/courses-training?fid=77

Aboriginal Health College
Diploma in Community Services – Case Management (with a focus on Aboriginal sexual health)
http://www.healthinfonet.ecu.edu.au/key-resources/courses-training?fid=224

Northern Territory

Family Planning Welfare Association of Northern Territory (FPWNT)
Training courses and education such as Certificate in Sexual and Reproductive Health for Nurses and other courses for health workers including Aboriginal health workers
http://www.fpwnt.com.au/pages/Training-Courses-and-Education.html

Northern Territory AIDS and Hepatitis Council (NTAHC)
Sex worker outreach program – peer based education
http://www.ntahc.org.au/index.php?page=Sex-Worker-Outreach

Queensland

Family Planning Queensland (FPQ)
Certificate in Sexual and Reproductive Health
http://www.healthinfonet.ecu.edu.au/key-resources/courses-training?fid=336

University of Queensland
Education Course in Sexual Health & HIV for Health Care Workers that work with Aboriginal & Torres Strait Islanders Communities
http://www.healthinfonet.ecu.edu.au/key-resources/courses-training?fid=293

Mental Health & HIV Seminar
HIV & Wellness Workshop, Griffith University Graduate Certificate in Sexual Health
http://www.healthinfonet.ecu.edu.au/key-resources/courses-training?fid=64

South Australia

SHine SA
Certificate in Sexual Health
http://www.shinesa.org.au/go/workforce-development/nurses-and-midwives/nurse-and-midwife-courses/certificate-in-sexual-health

FRESH course
http://www.healthinfonet.ecu.edu.au/key-resources/courses-training?fid=352

Workers in Aboriginal And Torres Strait Islander Communities
Individually negotiated presentations on women's and men's education
http://www.shinesa.org.au/go/workforce-development/atsi-workers

Yarning on sexual health program
http://www.healthinfonet.ecu.edu.au/key-resources/programs-projects?pid=1051

Tasmania

Family Planning Tasmania (FPT)
Workshops and short courses
http://www.fpt.asn.au/professional-training/course-outlines

Victoria

Family Planning Victoria (FPV)
Certificate and non-certificate courses for doctors, nurses, allied health professionals, and teachers
http://www.fpv.org.au/education-training/

Victorian Government Department of Education and Early Childhood Development
Professional learning for teachers and staff
http://www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality/proflearn.htm

Western Australia

Family Planning Western Australia (FPWA)
Nuts and Bolts of Sexual Health
http://www.healthinfonet.ecu.edu.au/key-resources/courses-training?fid=68

Mooditj Leader Training
http://www.healthinfonet.ecu.edu.au/key-resources/courses-training?fid=67

Certificate in Sexual and Reproductive Health
http://www.fpwa.org.au/educationtraining/nurses/nursescourse/

5.3 School-based curriculum material on sexual and reproductive health

National

Australian National Council for AIDS, Hepatitis C and Related Diseases – Talking Sexual Health: National Framework for Education and STI HIV/AIDS and Blood-borne Viruses in Secondary Schools
http://www.latrobe.edu.au/arcshs/downloads/arcshs-research-publications/TSHframework.pdf

New South Wales

NSW Government – Teaching sexual health
http://www.curriculumsupport.education.nsw.gov.au/sexual_health/index.htm

Queensland

FPQ - Bodies and Relationships Education Essentials
http://www.fpq.com.au/publications/teachingAids/BARE.php

Queensland Government – Information for educators
http://www.health.qld.gov.au/sexhealth/school_resources.asp

South Australia

Media smart body image course
http://sparky.socsci.flinders.edu.au/researchonline/projects/5

Tasmania

Family Planning Tasmania (FPT) – Education services for students + training
http://www.fpt.asn.au/education/secondary-students

Victoria

Victorian Government – Sexuality education resources
http://www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality/ltresources.htm

http://www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality/aboutreferences.htm

Western Australia

Western Australian Government – Growing and Developing Healthy Relationships
http://www.public.health.wa.gov.au/2/233/2/schoolbased_sexual_health_education.pm

6 Other useful websites

6.1 Reporting child sexual abuse

Australian Capital Territory

Age of consent

Resource sheet: Age of consent laws
http://www.aifs.gov.au/nch/pubs/sheets/rs16/rs16.html

Crimes Act 1900
http://www.austlii.edu.au/au/legis/act/consol_act/ca190082/

Child protection

Resource sheet: Australian child protection legislation
http://www.aifs.gov.au/nch/pubs/sheets/rs14/rs14.html

Children and Young People Act 2008
http://www.austlii.edu.au/au/legis/act/consol_act/caypa2008242/

Mandatory reporting

Resource sheet: Mandatory reporting of child abuse
http://www.aifs.gov.au/nch/pubs/sheets/rs3/rs3.html

Children and Young People Act 2008
http://www.austlii.edu.au/au/legis/act/consol_act/caypa2008242/

Keeping children and young people safe. Reporting child abuse: A shared community responsibility
http://www.dhcs.act.gov.au/__data/assets/pdf_file/0017/5660/keeping_childweb.pdf

New South Wales

Age of consent

Resource sheet: Age of consent laws
http://www.aifs.gov.au/nch/pubs/sheets/rs16/rs16.html

Crimes Act 1900
http://www.austlii.edu.au/au/legis/nsw/consol_act/ca190082/?stem=0&synonyms=0&query=Crimes%20Act%201900

Child protection

Resource sheet: Australian child protection legislation
http://www.aifs.gov.au/nch/pubs/sheets/rs14/rs14.html

Child protection roles and responsibilities – Interagency
http://www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_104.pdf

Children and Young Persons (Care and Protection) Act 1998
http://www.austlii.edu.au/au/legis/nsw/num_act/caypapa1998n157469.pdf

Mandatory reporting

Resource sheet: Mandatory reporting of child abuse and neglect
http://www.aifs.gov.au/nch/pubs/sheets/rs3/rs3.html

NSW online mandatory reporter guide
http://sdm.community.nsw.gov.au/mrg/app/summary.page

Children and Young Persons (Care and Protection) Act 1998
http://www.austlii.edu.au/au/legis/nsw/num_act/caypapa1998n157469.pdf

Northern Territory

Age of consent

Resource sheet: Age of consent laws
http://www.aifs.gov.au/nch/pubs/sheets/rs16/rs16.html

Criminal Code Act 1983
http://www.austlii.edu.au/au/legis/nt/consol_act/cca115/

Child protection

Resource sheet: Australian child protection legislation
http://www.aifs.gov.au/nch/pubs/sheets/rs14/rs14.html

Care and Protection of Children Act 2007
http://www.austlii.edu.au/au/legis/nt/num_act/capoca20073702007315/

Mandatory reporting

Resource sheet: Mandatory reporting of child abuse and neglect
http://www.aifs.gov.au/nch/pubs/sheets/rs3/rs3.html

Care and Protection of Children Act 2007
http://www.austlii.edu.au/au/legis/nt/num_act/capoca20073702007315/

Queensland

Age of consent

Resource sheet: Age of consent laws
http://www.aifs.gov.au/nch/pubs/sheets/rs16/rs16.pdf

Criminal Code Act 1899
http://www.austlii.edu.au/au/legis/qld/consol_act/cca1899115/

Child protection

Resource sheet: Australian child protection legislation
http://www.aifs.gov.au/nch/pubs/sheets/rs14/rs14.html

Child Protection Act 1999
http://www.austlii.edu.au/au/legis/qld/consol_act/cpa1999177/

Mandatory reporting

Resource sheet: Mandatory reporting of child abuse and neglect
http://www.aifs.gov.au/nch/pubs/sheets/rs3/rs3.html

Information
http://www.health.qld.gov.au/childsafety/default.asp

Child Protection Act 1999
http://www.austlii.edu.au/au/legis/qld/consol_act/cpa1999177/

Public Health Act 2005
*http://www.austlii.edu.au/au/legis/qld/*consol_act/pha2005126/

South Australia

Age of consent

Resource sheet: Age of consent laws
http://www.aifs.gov.au/nch/pubs/sheets/rs16/rs16.html

Criminal Law Consolidation Act 1935
http://www.austlii.edu.au/au/legis/sa/consol_act/clca1935262/

Child protection

Resource sheet: Australian child protection legislation
http://www.aifs.gov.au/nch/pubs/sheets/rs14/rs14.html

Key points of the *Children's Protection Act 1993* from the Department for Families and Communities
http://www.dfc.sa.gov.au/pub/tabid/485/itemid/1427/default.aspx

Children's Protection Act 1993
http://www.austlii.edu.au/au/legis/sa/consol_act/cpa1993229/

Mandatory reporting

Resource sheet: Mandatory reporting of child abuse and neglect
http://www.aifs.gov.au/nch/pubs/sheets/rs3/rs3.html

Guidelines for reporting child abuse and neglect
http://www.dfc.sa.gov.au/pub/tabId/968/itemId/285/Training-for-mandated-notifiers--reporting-child.aspx

Mandatory notification: A practical guide for organisations
http://www.dfc.sa.gov.au/pub/tabId/968/itemId/285/Training-for-mandated-notifiers--reporting-child.aspx

Children's Protection Act 1993
http://www.austlii.edu.au/au/legis/sa/consol_act/cpa1993229/

Tasmania

Age of consent

Resource sheet: Age of consent laws
http://www.aifs.gov.au/nch/pubs/sheets/rs16/rs16.html

Criminal Code Act 1924
http://www.austlii.edu.au/au/legis/tas/consol_act/cca1924115/

Child protection

Resource sheet: Australian child protection legislation
http://www.aifs.gov.au/nch/pubs/sheets/rs14/rs14.html

Child, Young Persons and their Families Act 1997
http://www.austlii.edu.au/au/legis/tas/num_act/cypatfa19972801997445/

Mandatory reporting

Resource sheet: Mandatory reporting of child abuse and neglect
http://www.aifs.gov.au/nch/pubs/sheets/rs3/rs3.html

Information sheet
http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0020/63047/FINAL_-OTS_Mandatory_Reporters_Fact_Sheet.pdf

Child, Young Persons and their Families Act 1997
http://www.austlii.edu.au/au/legis/tas/num_act/cypatfa19972801997445/

Victoria

Age of consent

Resource sheet: Age of consent laws
http://www.aifs.gov.au/nch/pubs/sheets/rs16/rs16.html

Information sheet: Minors, privacy laws, and consent
http://www.health.vic.gov.au/hsc/infosheets/minors.pdf

Crimes Act 1958
http://www.austlii.edu.au/au/legis/vic/consol_act/ca195882/

Child protection

Resource sheet: Australian child protection legislation
http://www.aifs.gov.au/nch/pubs/sheets/rs14/rs14.html

Children, Youth and Families Act 2005
http://www.austlii.edu.au/au/legis/vic/consol_act/cyafa2005252/

Mandatory reporting

Resource sheet: Mandatory reporting of child abuse and neglect
http://www.aifs.gov.au/nch/pubs/sheets/rs3/rs3.html

Children, Youth and Families Act 2005
http://www.austlii.edu.au/au/legis/vic/consol_act/cyafa2005252/

Western Australia

Age of consent

Resource sheet: Age of consent laws
http://www.aifs.gov.au/nch/pubs/sheets/rs16/rs16.html

Criminal Code Act Compilation Act 1913
http://www.austlii.edu.au/au/legis/wa/consol_act/ccaca1913252/

Child protection

Resource sheet: Australian child protection legislation
http://www.aifs.gov.au/nch/pubs/sheets/rs14/rs14.html

Guidelines for protecting children 2009
http://www.health.wa.gov.au/CircularsNew/circular.cfm?Circ_ID=12541

Operational directive: Interagency management of children under 14 who are diagnosed with a sexually transmitted infection
http://www.health.wa.gov.au/CircularsNew/circular.cfm?Circ_ID=12745

Children and Community Services Act 2004
http://www.austlii.edu.au/au/legis/wa/consol_act/cacsa2004318/

Mandatory reporting

Resource sheet: Mandatory reporting of child abuse and neglect
http://www.aifs.gov.au/nch/pubs/sheets/rs3/rs3.html

Operational directive: Mandatory reporting of sexual abuse of children under 18 years
http://www.health.wa.gov.au/CircularsNew/circular.cfm?Circ_ID=12477

Children and Community Services Amendment (Reporting Sexual Abuse of Children) Act 2008
http://www.austlii.com/au/legis/wa/num_act/cacsasaoca2008260200876o/s9.html

Child Care Services Regulations 2007
http://www.austlii.edu.au/au/legis/wa/consol_reg/ccsr2007276/

Western Australian Family Court Act 1997
http://www.austlii.edu.au/au/legis/wa/consol_act/fca1997153/

6.2 Legal and human rights aspects of sexual health

National

Australian Human Rights Commission Act 1986

http://www.hreoc.gov.au/about/legislation/index.html#ahrc

http://www.austlii.edu.au/au/legis/cth/consol_act/ahrca1986373/

Age Discrimination Act 2004

http://www.hreoc.gov.au/about/legislation/index.html

http://www.austlii.edu.au/au/legis/cth/consol_act/ada2004174/

Disability Discrimination Act 1992

http://www.hreoc.gov.au/about/legislation/index.html

http://www.austlii.edu.au/au/legis/cth/consol_act/dda1992264/

Racial Discrimination Act 1975

http://www.hreoc.gov.au/about/legislation/index.html

http://www.austlii.edu.au/au/legis/cth/consol_act/rda1975202/

Sex Discrimination Act 1984

http://www.hreoc.gov.au/about/legislation/index.html

http://www.austlii.edu.au/au/legis/cth/consol_act/sda1984209/

Australian Capital Territory

Notifiable diseases

Diseases to notify
http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=516989015&sid

Privacy

Privacy Act 1988
http://www.comlaw.gov.au/Series/C2004A03712

Health Records (Privacy and Access) Act 1997
http://www.legislation.act.gov.au/a/1997-125/default.asp

Human Rights Act 2004
http://www.austlii.edu.au/au/legis/act/consol_act/hra2004148/

New South Wales

Notifiable diseases

List of notifiable diseases
http://www.health.nsw.gov.au/publichealth/Infectious/notification.asp

Privacy

Information on privacy, confidentiality, consent, view Privacy Manual (version 2)
http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_593.pdf

Privacy and Personal Information Protection Act 1998
http://www.austlii.edu.au/au/legis/nsw/consol_act/papipa1998464/

Health Records and Information Privacy Act 2002
http://www.austlii.edu.au/au/legis/nsw/consol_act/hraipa2002370/index.html

http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_184.pdf

Northern Territory

Notifiable diseases

Information
http://www.health.nt.gov.au/Centre_for_Disease_Control/Notifiable_Diseases/index.aspx

List of notifiable conditions to be reported in the NT
http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/20/49.pdf&siteID=1&str_title=Notifiable conditions to be reported in the NT.pdf

Privacy

Northern Territory Information Act 2002
http://www.austlii.edu.au/au/legis/nt/consol_act/ia144/

Queensland

Notifiable diseases

List of pathological, clinical, and provisional diagnosis notifiable conditions
http://www.health.qld.gov.au/ph/documents/cdb/notif_conditions_list.pdf

Privacy

Information
http://www.health.qld.gov.au/privacy/default.asp

Information Privacy Act 2009
http://www.austlii.edu.au/au/legis/qld/consol_act/ipa2009231/

Health Services Act 1991
http://www.austlii.edu.au/au/legis/qld/consol_act/hsa1991161/

South Australia

Notifiable diseases

List of notifiable diseases in South Australia
http://www.dh.sa.gov.au/pehs/PDF-files/o811-notifiable-disease-list.pdf

Information on reporting process
http://www.dh.sa.gov.au/pehs/topics/topic-notifying-disease.htm

Public and Environmental Health Act 1987
http://www.austlii.edu.au/au/legis/sa/consol_act/paeha1987291/

Privacy

Information privacy principles
http://www.premcab.sa.gov.au/pdf/circulars/Privacy.pdf

Code of fair information practice
http://www.publications.health.sa.gov.au/ainfo/1/

Tasmania

Notifiable diseases

Information on notifiable diseases
http://www.dhhs.tas.gov.au/peh/infectious_diseases_communicable_diseases

Privacy

Personal Information and Protection Act 2004
http://www.austlii.edu.au/au/legis/tas/consol_act/pipa2004361/

Victoria

Notifiable diseases

Notifiable cases of infectious diseases within Victoria
http://www.health.vic.gov.au/ideas/notifying/whatto

Privacy

Privacy information
http://www.health.vic.gov.au/privacy.htm#download

Information Privacy Act 2000
http://www.austlii.edu.au/au/legis/vic/consol_act/ipa2000231/index.html

Health Records Act 2001
http://www.austlii.edu.au/au/legis/vic/consol_act/hra2001144/index.html

Western Australia

Notifiable diseases

List of notifiable communicable diseases
http://www.public.health.wa.gov.au/3/284/3/notifiable_comm.pm

Privacy

Operational circular: Patient confidentiality and divulging patient information to third parties
http://www.health.wa.gov.au/CircularsNew/pdfs/12052.pdf

WA open disclosure policy: Communication and disclosure requirements for health professionals working in Western Australia
http://www.health.wa.gov.au/CircularsNew/attachments/395.pdf

6.3 Websites appropriate for young people

National

Hep C and me
http://www.hspace.org.au/

Tune in not out
http://www.tuneinnotout.com/topics/sexuality

Reach out
http://au.reachout.com/

Get clued up (chlamydia info)
http://www.getcluedup.com.au/default.aspx

Love: the good, the bad and the ugly
http://lovegoodbadugly.com/

Like it is
http://www.likeitis.org.au/

Somazone
http://www.somazone.com.au/

The hormone factory
http://www.thehormonefactory.com/index.cfm?flashOK=1

Australian Capital Territory

Sexual Health & Family Planning, ACT (SHFPACT) – young people
http://www.shfpact.org.au/index.php?option=com_content&view=article&id=33&Itemid=72

New South Wales

Family Planning NSW South Wales (FPNSW) – Under 25s
http://www.fpnsw.org.au/index_under25s.html

Northern Territory

Safe sex no regrets
http://www.safesexnoregrets.nt.gov.au/

Queensland

Family Planning Queensland (FPQ) – Youth project
http://www.fpq.com.au/youthproject/index.html

Queensland Government – I stay safe
http://www.health.qld.gov.au/istaysafe/

South Australia

Children, Youth and Women's Health Services
http://www.cyh.com/SubDefault.aspx?p=160

SHine SA – young people
http://www.shinesa.org.au/go/working-with-communities/young-people

Tasmania

Working it out
http://www.workingitout.org.au/index.html

Family Planning Tasmania (FPT) – Rash decisions
http://www.fpt.asn.au/youth/

Victoria

University of Melbourne – Your sex health
http://www.yoursexhealth.org/flash/index.html

Western Australia

Freedom centre
http://www.freedom.org.au/

WA Government – Get the facts
http://www.getthefacts.health.wa.gov.au/

6.4 HIV and Hepatitis Community Organisations

Australian Federation of AIDS Organisations (AFAO)
T 0295579399
W www.afao.org.au

Anwernekenhe Aboriginal and Torres Strait Islander HIV/AIDS Alliance (ANA)
T 02 9557 9399
W www.ana.org.au/

Hepatitis Australia
T 1300 437 222 (1300HEP ABC)
W www.hepatitisaustralia.com

National Association of People Living with HIV/AIDS (NAPWA)
T 02 8568 0300 and 1800 259 666
W www.napwa.org.au

6.5 NACCHO and affiliates

National

National Aboriginal Community Controlled Health Organisation (NACCHO)
T 02 6248 0644
W www.nacho.org.au

ACT

Winnunga Nimmityjah Aboriginal Health Service
T 02 6284 6222
W www.winnunga.org.au

NSW

NSW Aboriginal Health & Medical Research Council (AH&MRC)
T 02 9212 4777
W www.ahmrc.org.au

Northern Territory

Aboriginal Medical Services Alliance Northern Territory (AMSANT)
T 08 8944 6666
W www.amsant.org.au

Queensland

Queensland Aboriginal and Islander Health Council (QAIHC)
T 07 3328 8500
W www.qaihc.com.au

South Australia

Aboriginal Health Council of SA Inc.
T 08 8132 6700
W www.ahcsa.org.au

Tasmania

Tasmanian Aboriginal Health Service (TAHS)
T 03 6234 0700
W http://www.tacinc.com.au/

Victoria

Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
T 03 94193350
W www.vaccho.org.au

Western Australia

Aboriginal Health Council of Western Australia (AHCWA)
T 08 9227 1631
W www.ahcwa.org

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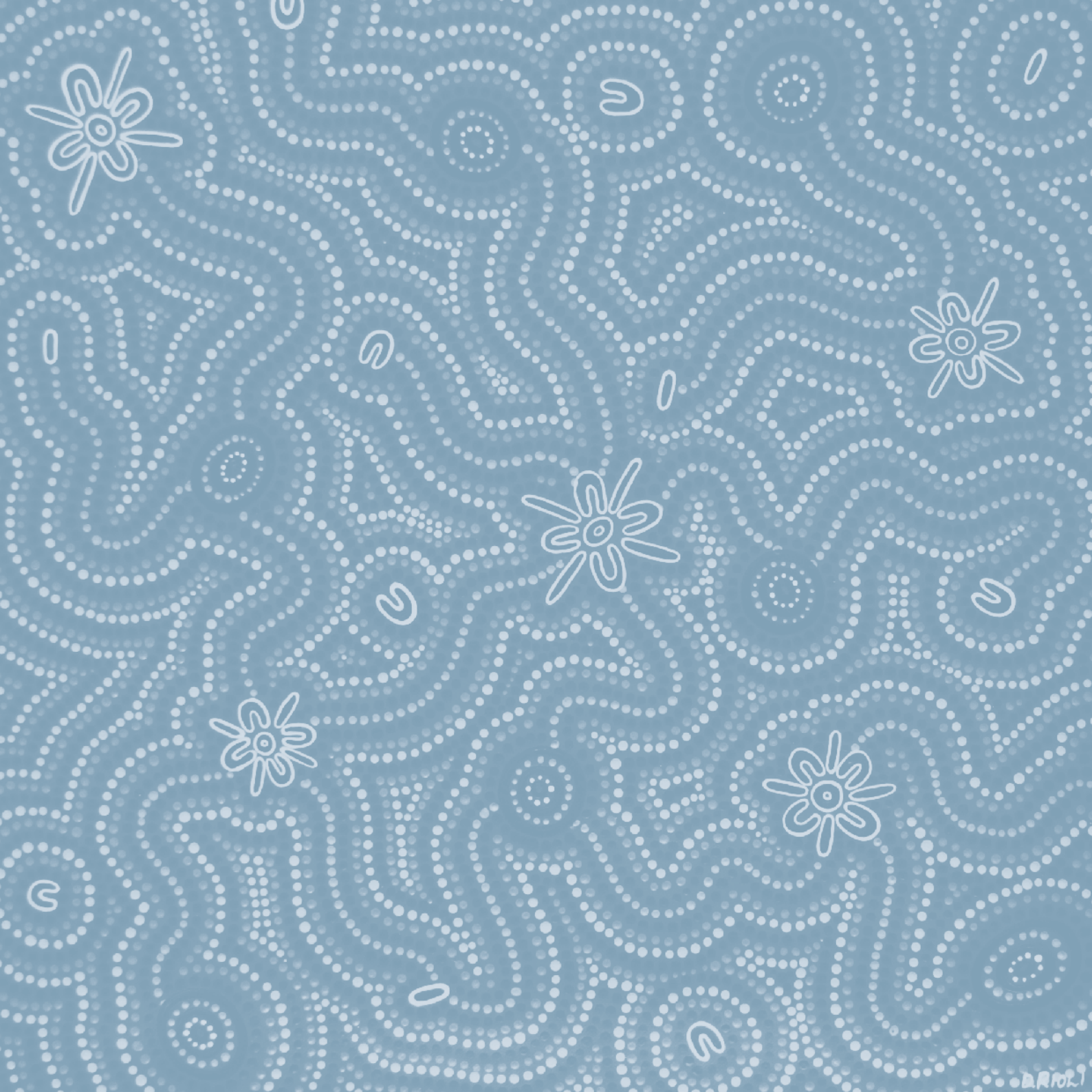

Abbreviations and acronyms

AFAO	Australian Federation of AIDS Organisations
AHCSA	Aboriginal Health Council of South Australia
AHCWA	Aboriginal Health Council of Western Australia
AH&MRC	Aboriginal Health & Medical Research Council
AIDS	acquired immune deficiency syndrome
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ANA	Anwernekenhe Aboriginal and Torres Strait Islander HIV/AIDS Alliance
ASHM	Australasian Society for HIV Medicine
BBV	blood-borne virus
CRANA	Council of Remote Area Nurses of Australia
DoHA	Australian Government Department of Health and Ageing
FPNSW	Family Planning NSW (New South Wales)
FPQ	Family Planning Queensland
FPT	Family Planning Tasmania
FPV	Family Planning Victoria
FPWA	Family Planning Association of WA (now Family Planning Western Australia)
FPWNT	Family Planning Welfare Association of (Northern Territory)
HIV	human immunodeficiency virus
HPV	human papillomavirus
HSV	herpes simplex virus
MHSC	Melbourne Sexual Health Centre
NACCHO	National Aboriginal Community Controlled Health Organisation
NAPWA	National Association of People Living with HIV/AIDS
NCHECR	National Centre for HIV Epidemiology and Clinical Research (now the Kirby Institute)
NTAHC	Northern Territory AIDS and Hepatitis Council
QAIHC	Queensland Aboriginal and Islander Health Council
QAHC	Queensland Association for Healthy Communities
SH&FPA	Sexual Health and Family Planning Australia
SHFPACT	Sexual Health and Family Planning ACT (Australian Capital Territory)
SNAICC	Secretariat of National Aboriginal and Islander Child Care
STI	sexually transmissible infection
TAHS	Tasmanian Aboriginal Health Service
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
WHO	World Health Organization

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Supporting the HIV, Viral Hepatitis and Sexual Health Workforce

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