Sexual Health for New South Wales Aboriginal People: A literature Review

by

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Submitted as part of course requirements for Honours Degree
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Supervisor's Signature
DECLARATION

I Anna Haining hereby certify that this Honours' thesis, Sexual Health for New South Wales Aboriginal People: A Literature Review, being lodged herewith for examination is my original work, unless otherwise acknowledged.

I certify that it has not been submitted, in part or whole, for a higher degree in any other university and/or institution.

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ACKNOWLEDGEMENTS

Firstly, I would like to acknowledge with deepest respect the original owners of the great Eora nation in which most of this thesis was written, thank-you.

This document primarily focuses on the sexual health status of NSW Aboriginal people. There is no intent to disrespect our brothers and sisters who are Torres Strait Islanders, but I believe that I am not in a position to comment or make assumptions about the status of Torres Strait Islanders Sexual health, as I am not from their community.

I would like to thank Anton Clifford and Freidoon Khavarpour for their directions and for not giving up on me, thank you to Central Sydney Area Sexual Health Service for their words of encouragement and to David Aanundsen and Miranda Shaw for their never ending support and guidance.

A warm thank you to Heather Worth who just kept moving me along so I could see the light at the end of this journey and also for her valuable support. And most of all I would like to say thank you to my family for the abundance of pride they have shown me throughout this thesis. Finally, many thanks to Racy Duroux who has given me the permission to use her art work to cover this Honours Thesis.

I have been given many rewards in doing this thesis. My skills in participating in a literature research, has improved immensely. I have a greater understanding of the planning, development and implementation of sexual health services for Aboriginal people. I believe that I have more to contribute to the sexual health concerns in local Aboriginal communities.
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BACKGROUND

During the past 16 years I have worked in the area of needle and syringe programs 'harm minimisation' and sexual health strategies, targeting different populations of injecting drug users in the Canterbury and Redfern area. My expertise in the field was delivering safe sex education and safe using practices to people who were at risk of HIV or sexually transmitted infections due to their using or sexual choices. Because of the nature of their using, it was not appropriate to provide extensive safe sex and safe using education, as contact with clients was usually less than 5 minutes. In this situation, each worker had to develop short and precise safe sex messages to this population while they were virtually walking out the door.

Sexual health for me is such an important part of peoples lives no matter who they are or what they do, but, there is also a down side in this area of health as many individuals have, in the past experienced many barriers and stigmatization that has influenced them in accessing sexual health services. These barriers and stigmatization from health professionals include inappropriate comments and cultural ignorance towards Aboriginal people.

During the first year of my employment as a sexual health worker, women from the local communities contacted me to discuss their concerns about the limited education that families have on sexual health. The women expressed the need and importance of having Aboriginal men and women’s sexual health clinics in the area that would provide clinical, education and support to community, as there was a growing concern of young girls falling pregnant and dropping out of school. In addition, the women spoke about their past (usually, not very good) experiences in attending health clinics, and identified what they saw as the main barriers which disabled them from attending sexual health clinics. These were:

- Lack of transport to Sexual Health Services
- Little cultural acceptance of Sexual Health Services
- Aboriginal Workers in the service.
• Lack of availability of culturally appropriate resources, such as men and women’s
business being separated and,
• The community’s lack of awareness of sexually transmitted infections.

Three important themes emerged from these talks:
• the need for Indigenous Sexual Health clinics, male and female, in a Primary Health
setting that take into account the diversity of Aboriginal/Torres Strait Islander’s culture;
and protocols
• the need for an increase of Aboriginal/Torres Strait Islander Health Workers in Primary
Health Care settings.
• Holistic Health for Aboriginal and Torres Strait Islander People

Central Sydney Area Sexual Health Service has now taken positive steps towards establishing
culturally effective and efficient sexual health clinics for Aboriginal men and women. Funding
has been approved and these clinics will commence in 2004. Thus, the choice of this topic for
my literature review is a timely one. Undertaking this literature review will provide information
that identifies the scope of Aboriginal sexual health issues and, in a broader sense, identifies
those issues of main concern - all of which may help inform the establishment of culturally
appropriate sexual health programs/projects in CSAHS. Identifying key concerns and
recommendations that relate to Aboriginal sexual health will provide an appropriate framework
for the formulation of a set of principles that may guide the sexual health planning, development
and implementation of sexual health projects/programs in the Central Sydney Area Health
Service.

In addition, Central Sydney Sexual Health Services in partnership with the Aboriginal Health
Service, Redfern are currently developing an Aboriginal Sexual Health Strategy for future men
and women’s sexual health clinics in this area.

In summary, this chapter provides an overview of the future direction of the Central Sydney Area
Sexual Health Services’ and how the findings of this thesis will help to provide a more support
pathway to the establishing of Aboriginal men and women's sexual health clinics in the local communities.
INTRODUCTION

In May 1995, The Australian National Council on Aids and Related Diseases (ANCARD) was invited to convene a sexual health forum, to highlight the sexual health status of Aboriginal and Torres Strait Islander people in Australia (National Indigenous Australians Sexual Health Strategy 1996-97). By the end of the discussions, it was evident to the forum members that the existing health strategies did not focus on sexual health when identifying specific clinical care and cultural needs of Aboriginal and Torres Strait Islander people (NIASHS).

The forum concluded that a working party should be formulated and that their task would be to research the sexual health status of Aboriginal and Torres Strait Islander people (National Indigenous Australians' Sexual Health Strategy, 1997). To this end, the forum also recommended that the working party be named ‘The Indigenous Australians Sexual Health Working Party’, and that ANCARD’s role would be to endorse and support the group. Membership mainly consisted of representation from Aboriginal and Torres Strait Islander communities and Community Controlled Organizations that had expertise in sexual health, education, clinical and policy development.

The purpose of this working party was to conduct an extensive national consultation process with Aboriginal and Torres Strait Islander people, conduct a literature review, and collect the necessary data that addressed the sexual health status of Aboriginal and Torres Strait Islander people (NIASHS 1996-1997). The process of the consultations was based on the holistic view of sexual health for Aboriginal people, which encompass the well-being of the individual, the social, emotional and cultural well-being of the whole community. This is a whole-of-life view, which includes the cyclical concept of life-death-life (NAIHO, 1982). However, during the consultation process, the working party experienced difficulties in discussing sexual health with community members, because (as it is acknowledged in the Indigenous community) sexual health is a very private and intimate part of peoples' lives.
In my experience as a Sexual Health Worker, I have witnessed a considerable amount of stigmatisation and negative stereotyping of sexual health, sexuality and sexual identity for some community members by Aboriginal and non-Aboriginal health professionals. Such a barrier in communication can have a devastating effect on the individual when accessing health services. These concerns are also highlighted in The National Aboriginal Health Strategy, which identifies concerns of under-diagnosed and reported sexually transmitted infections (STIs) for Aboriginal and Torres Strait Islander people (National Aboriginal Health Strategy, 2000).

Aboriginal community controlled health services were the first point of contact for any approach to HIV/AIDS and STIs for Aboriginal and Torres Strait Islander people (NAHS 2000) long before the development of the National Indigenous Australians Sexual Health Strategy. However, the National Indigenous Australians’ Sexual Health Strategy is central to increasing sexual health and well-being amongst Indigenous Australian's. These strategies can be achieved through access to Aboriginal Community Controlled Health Services, primary health care services, sexual health services, with the aim of working towards promoting and enhancing the sexual health of all Indigenous Australian's. (The National Indigenous Australian’s Sexual Health Strategy 1996-97).


1. The purpose of this Honours Thesis is to explore the literature on the topic of sexual health and its status among Indigenous communities in order to answer the following research questions:

2. What are the key issues that underlie the sexual health of NSW Aboriginal people and,
3. What are the key factors that determine this status? what are the key recommendations and guidelines relating to the planning, development and implementation of sexual health programs/projects for NSW Aboriginal people?

To summarise: the issue of sexual health and its origins within the Aboriginal context shows that access to relevant and culturally appropriate health services is one of the problems facing Aboriginal men and women today. There is also the need to increase Aboriginal health workers with the necessary skills and know how is paramount for the development of these services.
METHODOLOGY

A literature review is an investigation, collation and analysis of information that has been written about a particular topic. It is a definitive account of the state of knowledge and the central issues in a selected area. It indicates how prior research on the topic has been carried out; the key issues in the area; and how these have been applied and elaborated.

A literature review is not only an accurate and consistent compilation of bibliographic material and a summary of key ideas but it "weigh[s] up the contribution that particular ideas, positions or approaches have made to the topic" (Hart 2002: 9), that is, it demonstrates a critical awareness of the most valuable literature. A good literature will allow a researcher to:

- Substantiate and verify the claims being made in the thesis
- Evaluate different written accounts
- Offer a more scholarly account
- Prove their expertise within the research field.

What is Methodology.

Before deciding the best way to collect information for the research proposal, the initial question that needs to be asked is 'what do I need to know and why?' then, once this has been achieved the next step is to investigate 'what is the best way to collect the information, and what shall I do with it?' (Bell, 1999). Methods are usually chosen that will provide the data that is required to produce a complete piece of research. Once the best method has been decided for the research purpose, then data collecting instruments will be designed to complete the research (Bell, 1999).

There are a variety of different methods in research, but I have chosen to briefly outline qualitative and quantitative methods.

There are many different forms of qualitative research such as ethnography, case study, action research and evaluation, which often combine and overlap. They are the principal methods employed by anthropologists to study the social contexts and the meanings that people give to their lives, customs and behaviours: the ‘how’ and ‘why’ research questions. There are many
different schools of thought and perspectives which identify with qualitative research in different way such as; ethno methodology, empiricism, phenomenology, Marxism, symbolic interactions, feminism and structuralism (Kirk and Miller, 1986). Qualitative methods have much to offer those studying health and health care settings, and they are increasingly being used in health services research.

Quantitative research is designed to answer numerical questions on a large scale: who, how many, in what proportions and so on. Quantitative research is more statistically reliable than qualitative research and more easily generalisable over a population. However, a critique of this more positivist method is that if the social situation is too complex for numerical description and while quantified evidence can be very powerful it can also hide a great deal about people, especially their understandings of their own lives.

The purpose of a literature review is to critical look at existing research (both qualitative and quantitative, policy, program or investigator-driven) that is central to the work that is being carried out. It is a tool for both evaluation and discovery of relationships between different works that has already been carried out in the field you are researching and furthermore, how the literature relates to your own work.

**Conducting Literature Review**

In a literature review, it is important to read with a purpose, and to summarise the work you have already researched. Decisions have to be made about which of information which is important to your research (so you can emphasize it), and which is less important and can be covered briefly or left out of the review. Major concepts, conclusions, theories, arguments etc. that underlie the work must be teased out, and similarities and differences within closely related work must be identified. This can be difficult at the commencement of the literature review, but the more literature that is read it should be come easier to identify (Kirk and Miller, 1986).

During the course of the literature review, it is a good thing to keep central certain questions that will stop you from going off track. These can be in the format of the following: What do we already know in the immediate area concerned? "What are the characteristics of the key concepts or the main factors or variables? What are the relationships between these key concepts, factors
or variables? What are the existing theories? Where are the inconsistencies or other shortcomings in our knowledge and understanding? What views need to be (further) tested? What evidence is lacking, inconclusive, contradictory or too limited? Why study (further) the research problem? What contribution can the present study be expected to make? What research designs or methods seem unsatisfactory? “ (Barbour 1999)

Methods of doing a Literature Review

There are a number of methods that you can use to carry out a literature review, these are:

1. **Searching information sources.** For this thesis secondary sources such as bibliographies, indexes and abstracts were found through web-searches, library catalogues, sexual health libraries and the local AMS. Colleagues also provided relevant information. As well, primary sources research findings, books, articles, and reports, policy documents were also gathered from the same sources.

2. **Classification of the material.** “Rather than taking a routine attitude to classification we are adopting a technical attitude” (Hart, 2002) - to appraise the ways in which the topic has been organised. This can be achieved through sorting and organising the ideas, through identifying the categories, and by limiting the information so that it is manageable. For this thesis, each time I reviewed a piece of literature, I would take note of the author and topic and file it according what was being stated in the abstract of the document, a section for agreeing with the topic and a section for disagreeing with the topic.

3. **A number of search key words** were used in carrying out this literature review to locate literature and resources on the web, including, ‘Aboriginal’, ‘Indigenous’, ‘Sexual Health’, ‘research’, ‘gender’, ‘sexuality’, ‘Sexually Transmitted Infections’, ‘cross-cultural’, ‘HIV/AIDS’, ‘public health’ ‘gay men’, ‘lesbian’ ‘transgender’. A manual search of Bibliographic information was limited. Identification of common themes in the literature according to the questions being asked in the thesis. This can include the recognition of links between what has been done to show the thinking that has influenced what has been produced. An example of this was when I initially searched for Aboriginal sexual health and no articles were found, but then I used the

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word Indigenous and on of the first documents that came up was the National Indigenous Australians Sexual Health Strategy. What I realised was that sexual health was not a key word that produced information, but other word like Aboriginal or Indigenous health produced a quantity of data so I then could start comparing information for the review.

4. These articles were then categorized according to their content and relation to the thesis. Many of the articles are included in more than one topic area as there is a lot of information crossover as I had experienced difficulties with locating information on New South Wales Aboriginal Sexual Health. Before I could focus on the questions for my literature review I had to do more of a national search of literature, in doing it this way I found more literature which provided key information on Aboriginal people Australia wide, but it also revealed the gaps in research studies and literature for Aboriginal people in certain areas such as NSW.

Process

The bulk of the literature was gathered from a collection of articles and resources with the help of the Central Sydney Sexual Health Promotion Team and Heather Worth from the National Centre in HIV Social Research Department. An extensive web search was done, which produced a further body of literature, which previously was difficult to find through accessing the library.

Managing the information

This requires a systematic and meticulous approach to citations and references. Although I did not use Endnote for this thesis, all references were written down at the time first I found them. All the articles were photocopied and filed in alphabetical order. I also took precautionary measures to ensure no loss of data by keeping copies of work on a diskette stored separately.

Advantages and Disadvantages of a Literature Review

A thesis that comprises solely a literature review has a number of advantages and disadvantages. The major advantage is that it provides a variety and depth of written accounts of the topic. It is also manageable by a student on a tight timeframe (Bell, 1999). It is cost-effective, in that empirical is expensive both in human resources and field costs. In terms of sensitive or culturally appropriate research, a literature review avoids the lengthy and difficult (although necessary)
process of approval (Bell, 1999). During the course of this literature review it became apparent that literature on sexual health for Aboriginal people was extremely limited even though I saw this as being a disadvantage during the course of the literature review, I also saw it as being and advantage as it has provided me with future ideas for further study in the area of sexual health for Aboriginal people.

The disadvantages include: the literature about marginalised groups is very limited in scope; often not written by that group; the possibility of misinterpretation; the literature is often repetitious because little new data is available (Bell, 1999). Another disadvantage is that no new empirical (qualitative or quantitative) information is being collected, analysed and published. For information on sexual health for Aboriginal people, one of the major finding of being disadvantaged was the fact that statistical data on health issues have been collected, but at this point there is no published information only from the National HIV and Hepatitis C Surveillance Report. I found it difficult to obtain literature on projects and programs that Aboriginal people are currently running. There was very little literature available on the success stories of health programs for Aboriginal people.
INDIGENOUS HEALTH IN THE CONTEXT OF COLONISATION AND DISPOSITION

There has been much debate about how long Aboriginal people have lived in Australia (Flood 1983), but evidence does point to at least 50,000 years or over (Radcliffe-Brown, 1930). The Official Year Book of the Commonwealth of Australia (1930) noted that the population for Aboriginal people was approximately 300,000 in 1788. Yet, Butlin (1983) believed that the number is more likely to be five times that amount, for the Aboriginal populations in Victoria and New South Wales in 1788 combined, was around 250,000. White and Mulvaney (1987) also estimates that pre-colonisation (1788) there was close to three quarter's of a million Aboriginal people living in Australia.

Due to the inadequate recording mechanisms that define the status of Indigenous Australians, the Australian Bureau of Statistics estimate the current population of Indigenous people to be around 418,800 to 476,900, this is 2% of the total population. Unfortunately, this does not provide a true picture of the Indigenous population, past and present, as colonisation was the first step that the Europeans took to make Aboriginal people invisible.

Before the arrival of Europeans, Aboriginal Australians were a strong and healthy race. Men and women were as equally productive in the community as each other, the women were mainly gatherers of plants and small animals and the men were hunters of larger animals. Social organization was predominately based on small kinship groups, which is the link to the social and spiritual passage to their land (Saggers & Gray 1991). This also includes the traditional social and spiritual ways which were instilled in Aboriginal people from childhood even though they are a diverse group of people they all shared a common theme with spiritual beliefs and sense of belonging (Saggers & Gray 1991).

Now, in little over 216 years, there has been a disastrous change in Aboriginal Health. The legacy of dispossession of their country has had a continuing effect and impact on the economic, spiritual and cultural life of Aboriginal People. These factors continue to contribute to a reduced quality of life today (Australia Health, 2002).
The process of colonization started before Captain Cook raised the English Flag and the process continued as Cook declared Australia as "terra nullius" (meaning empty, uninhabited). He then claimed that the Australian continent was now Crown land and any resistance from Aboriginal people, (Grassby, &Hill, 1988) was deemed as acts of rebellion. This approach set the stage for all future interactions between the invaders and the Aboriginal Nations (Stanner, 1977).

The loss of land for Aboriginal people was not about ownership it was far more intrinsic than that. Land is the connection between people and everything that is living. Aboriginal spirituality binds together people, land and the mythic beings who control life, fertility and nature of the people (Saggers & Gray 1991; pp: 34), and living by Dreamtime (Law) ways ensures the continuity of people and nature and the continuance of Aboriginal people (Saggers & Gray 1991).

When it came to treating the sick and injured in their community, Aboriginal people used their extensive knowledge about plants and animals as part of the healing process. Traditional Aboriginal doctors (healers), were selected by other elders from the same community, or by inheritance (on the fathers side) or through experiencing a spiritual awakening. These healers looked after the spiritual, emotional and physical well-being of the individual so the health of the community or group could prosper. This could be achieved through being a healer or sorcerer (Saggers & Gray, 1991).

Various Aboriginal doctors had both healing and sorcerer's powers at their disposal, while in other regions such as the East Kimberley these roles were separated. In other Aboriginal communities, an individual might be a healer in one situation and a sorcerer in another. Some Aboriginal healers claim that they have the power to recover lost souls and cure the individual of what ever was ailing them (Saggers & Gray, 1991).

The missionaries that arrived during colonisation believed that traditional healing methods by Aboriginal people were witchcraft, and an anathema to the Christian values they brought with them and which subsequently dominated this country. The Missionaries arrived in Australia with
the view to save lost souls, and to accomplish this they had to wear down the existing spiritual belief systems and culture (Reid, 1983). This was done in the way of making traditional healing practices illegal, which resulted in the prosecution of community Elders and Healers. Aboriginal people were forced to become more secretive with traditional ways, or they stopped practicing their beliefs in fear of consequences. This destroyed traditional effective methods that prevented illnesses and injuries amongst Aboriginal people, and replaced it with ineffective health practices.

Aboriginal people like the Europeans, have always become accustomed to other groups sharing their environment (Eckermann, et al, 1995). Multiculturalism for the Aboriginal Nations is not a new experience, as Aboriginal communities for over 40,000 years have lived and shared with a diverse (although, like-minded) Aboriginal population through 230 different languages, marriage and a reciprocal way of life.

With the invasion in 1788 by the Europeans, Aboriginal society experienced a devastating culture shock, as Aboriginal people had to adapt to a group of people who had such a different perspective on life, economy and social structure. The Europeans, however, did not have to adapt or accept any of the ways of traditional Aboriginal Australians’; they, simply, took control (Eckermann, et al 1995).

Colonial Diseases

By 1789 diseases such as malaria, dysentery, scurvy, mumps and typhus fever affected many Aboriginal communities (Butlin 1983). From 1790 the smallpox epidemic claimed over 20% of the Aboriginal population, the exact number was impossible to determine (Butlin, 1983). In the 19th century the major causes of death for Aboriginal and Torres Strait Islander children were whooping cough, measles, and small pox. These diseases had a high mortality on the population in England and Wales, but for Aboriginal people it was disastrous. These diseases impacted on everyone in the community, commencing with the children to the elderly, sadly they all became ill at the same time. It was not uncommon for these diseases to wipe out complete families and whole communities (Butlin, 1985).
Butlin (1983) argues that before the arrival of Europeans there was no evidence that venereal diseases existed in Aboriginal communities. Yet, from 1791 venereal diseases became an epidemic in a number of Aboriginal communities. Reece (1974) contends that widespread venereal disease and leprosy in Aboriginal communities as early as the 1840's, all of which was spread by the European colonists.

Social impact of colonization
During the invasion, relations deteriorated to an 'open war on Aboriginal people' (Butler, Cameron, and Percival, 1995) throughout the different states and Territory. In the New South Wales the colonisers had an insatiable appetite for ownership of land, so with the support of the Acting Governor Paterson (NSW), instructed the settlers to destroy as many Aboriginal people as they saw fit to achieve their land they wanted. This action was deemed to be a warning to all 'Aboriginal tribes' not to retaliate or their bodies would be hung from gallows for all to see (Butler, Cameron, and Percival 1995).

Another primary source of conflict was when Aboriginal women against their will, were taken by the colonizers for sexual relations. These acts resulted in attacks from the Aboriginal men in protest of the barbaric treatment that was inflicted on them and their community by the Europeans. Historically, no records were kept of the number of Aboriginal people killed during these confrontations (Bowd, 1991).

From 1788 to 1960's many Aboriginal families continued to suffer as a direct result of colonisation. With the break down of Aboriginal social organisations, beliefs systems, and the hunter-gatherer economy, Aboriginal people started to feel the loss. With the killings of their men and the impact of diseases on the community, the demographic structure of Aboriginal society began to fracture. When the Europeans began to take Aboriginal women for domestic help and sexual services, the traditional marriage arrangements were broken (Saggers & Gray 1991) which added more grief and loss to their community.
These actions by the Europeans affected all Aboriginal communities throughout Australia but for Aboriginal people of New South Wales and Victoria, in 1858 the 'assimilation policy process' was in full swing (Tatz; 1999). Meanwhile, the 'protection policy was implemented in each State between 1840 and 1843, the introduction of the policy meant appointment of the Protectors of Aboriginal people whose responsibility was to enforce the legislation. The legislation was characteristic of social Darwinism which holds that 'the unfit test don't survive' (Saggers & Gray 1991; p: 59). Thus Aboriginal people, especially those who were not of mixed blood, were seen to be destined not to survive in the face of white civilisation (Tatz; 1999).

In 1936 the 'Aboriginal Welfare - Initial Conference of Commonwealth and State Aboriginal Authorities' was held in Canberra. The aim of this conference was to bring together Chief Protectors and Boards controlling Aboriginal affairs in the different States and the Northern Territories, to discuss Aboriginal issues that were impacting on the 'white community' (Aboriginal Welfare - Initial Conference of Commonwealth and State Aboriginal Authorities, 1936).

The key issues that the Aboriginal Welfare Protectors discussed at this conference were; 'the future of the race of Aboriginal people, legislation, education, employment, welfare benefits, infectious diseases and drug and alcohol use. During the conference, Pettitt who was the NSW Protector of Aboriginal people commented that, "in a few years there would be far less full blood (sic) Aboriginal people left in New South Wales, which inferred that the problem of the Aboriginal population would soon be eradicated" (Aboriginal Welfare 1937).

Pettitt also informed the conference that with the assimilation policy in place in all the States, and with the 'adoption' (removal) of Aboriginal children to 'white families', 98% of the Australian population would eventually be of British heritage (Aboriginal Welfare, 1936). The intention of the assimilation policy was not to provide a platform for equality for Aboriginal people but rather functioned with the singular intention to eventually remove Aboriginal people altogether.
Another concern raised at the conference was the evidence provided from all States and Territory that Aboriginal women were infected with gonorrhea. Their concern was not in the fact that Aboriginal women were infected, the concern was that it could have an impact on the white community (Aboriginal Welfare, 1936).

In those years, Aboriginal people were thought of solely as ‘flora and fauna’, and documentation that identified health concerns for Aboriginal people was very scarce. It is worth noticing that the key issues that were outlined in the 1936 conference papers are the same issues that are impacting on Aboriginal and Torres Strait Islander people today.

Tatz (1999) argues that the actions of the Europeans were ‘genocide’ of Aboriginal people. He believes it was the intention of the colonisers to eradicate Aboriginal people by introducing diseases, such as smallpox, typhoid, tuberculosis, diphtheria, whooping cough, influenza, pneumonia, measles and sexually transmitted infections. If this was not the intention, why were there not health policies in place to provide the care and support that was needed for Aboriginal people to overcome these diseases?

This also support the theory of Eckermann, et al (1995) which describes the three basic principles underlying the European invasion in Australia, they are:

- "basic ethnocentrism (attributing superior qualities to their own culture group) and xenophobia (a morbid fear of foreigners);
- scientific/intellectual climate of the times - discussion of nature of humanness and concepts of racial hierarchy in which northern Europeans occupied the number one position;
- the Protestant ethic and industrialization - changing values in Europe-wealth seen as an indicator of God’s grace. Increasing industrialization also meant more resources were needed" (p: 52).

These principles became the vehicle for the continued mistreatment on Aboriginal people resulting in a history of oppression, exclusion from mainstream economic opportunity and
poverty are just some of the influencing factors that impact on Aboriginal health, past and present (Saggers & Grey 1991).

From 1788 to 1960's, the process of categorizing Aboriginal identity commenced (Eckermann, et al 1995). This is when Aboriginal people were told who they were and legislation was devised that took away their identity, liberty, family and country and replaced them with restrictions, assaults, discrimination and death. When all these actions against Aboriginal people are brought together the coming of the Europeans certainly changed and continued to change the picture of Aboriginal health to the poorest in Australia (Waterford, 1982).

The Current Health Situation
Certainly the health of Aboriginal people has suffered, and continues to suffer as a direct result of colonisation. As one considers' the progress that has been made in the past 20 years for non-Indigenous Australian's health, the statistics are damning for Aboriginal people. Aboriginal people's life expectancy is 20 years less than that of non-Indigenous Australian's, infant mortality is four times higher than non-Indigenous people, imprisonment and suicide rates five times higher than non-Indigenous Australian's (Australia Health, 2002). Continuing poor health for Aboriginal people can be directly linked to poverty, inadequate housing, sanitation and poor water supply, which have severely impacted Aboriginal communities. The incidences of lifestyle diseases for Aboriginal people have been on the increase such as kidney disease, which is more prevalent among Aboriginal people compared to non-Indigenous people, as death rates for kidney failure are eight times greater than for non-Indigenous people.

It is also noted that Indigenous Australian’s receive lower incomes compared to the non-Indigenous population and also have higher rate of unemployment and lower education (ABS 1998 a). Indigenous Australians do suffer with a greater disadvantage across a range of socioeconomic factors that do impact on health compared to non-Indigenous population. Other disadvantages such as smoking, alcohol and drug misuse can also influence Aboriginal health (Australia’s Health, 2002).
Aboriginal communities experience higher death rates for all cancers, (40% higher than non-Indigenous Australians, ABS 2001; AIHW 2001). The death rate for lung cancer is much higher with Indigenous Australians, yet for melanoma and prostate cancer it is relatively low compared to the non-Indigenous population (ABS 2001; NSWAHS,1999).

Cardiovascular disease is high in the Indigenous Australian's population, with a standardised mortality ratio (SMR) more than twice that of the rest of the population. In spite of the low risk ratio, the impact of these diseases on the health of Indigenous Australians is high due to their prevalence. The incidence of diabetes is also quite high compared to non-Indigenous communities.

High rates of teenage pregnancies in some Aboriginal communities have become a large concern. A study was undertaken by the Department of Obstetrics and Gynaecology, Adelaide University, that compared pregnancy characteristics and outcomes between Aboriginal and non-Aboriginal teenagers in South Australia between 1995-1999 (Westenberg, et al, 2000). There were 449 Aboriginal and 4,625 non-Aboriginal teenagers who gave birth between those years, indicating that Aboriginal teenage pregnancy rate is twice as high as non-Aboriginal teenagers and that Aboriginal teenage girls are more likely to be single. They have a lower level of termination compared to non-Aboriginal teenagers and a higher level of neonatal deaths compared to non-Aboriginal teenagers. The conclusion of this study was that there is a high concern for Aboriginal teenagers in South Australia and the recommendations outlined that there is a greater need for education, nutrition, and breast feeding education for this group of teenagers (Westenberg et al,2000).

Comparisons of Aboriginal and non-Aboriginal health profiles need to take into consideration the different demographic structure of the two populations in particular the younger age profile of the Aboriginal population. The most common characterization of the differences in health profile between Aboriginal people and others is that while Aboriginal child health is comparable to that of the Third World (with respiratory, infectious and parasitic diseases rife). Aboriginal adults
suffer, in addition, all of the diseases of so-called civilized living (such as diabetes and hypertension) (Saggers & Gray 1991).

As Sandra Eades (2000) describes, Indigenous Australians' health is a cause for national shame, and argues that since 1788 Indigenous Australians have been excluded from Australian society. Eades (2000) also believes that there must be a commitment from all Australians to work towards social and educational equity and economic prosperity for Indigenous Australians, as Eades argues that this is the only way that significant improvements in health for Indigenous Australians can be achieved.

Colonisation and dispossession are not just single actions, for Aboriginal people they have had enduring and continuous substantial negative effects on Aboriginal people. While the colonial rule that governed this country by the Europeans was in the alleged “best interests” of Aboriginal communities (Cunneen, 2001), it was carried out using punishment and imprisonment against Aboriginal people.

The high levels of Indigenous imprisonment have long been a concern in Australia, and the levels keep increasing. In 1998, NSW Criminal Court Statistics identified that Aboriginal people are more likely than non-Aboriginal people to be re-offenders for the same crime and from 2001 there was a total of 1182 Indigenous people in NSW prisons, 1076 males and 106 women, this has increased by 363 people since 1995 (Keliher, 2001). Currently, prison population for Aboriginal men in NSW constitutes 18% of the total male population and women constitute 31% of the total female population. Overall, the picture that is consistently presented is that Aboriginal people are more likely to be sentenced at the heavier end of the spectrum, penalties of imprisonment and community service orders compared to non-Indigenous people (Matthews, 2001).

In summary, the social impact of colonization and the magnitude of these actions have imprisoned Aboriginal people for 216 years. These inequalities that Aboriginal people suffered and the loss and grief from broken families and the ultimate acts of genocide against Aboriginal
In the 1980’s and 1990’s studies indicated that 46.9% of Aboriginal school children in rural and urban areas from the Northern Territory have serological markers of HBV infection, and 26% of rural Aboriginal populations are hepatitis B surface antigen positive (indicating that some of the transmission of hepatitis infection occurred at an early age).

Nations, have left their mark on the health and well being of Aboriginal people for years to come. The new diseases Europeans brought with them helped to breakdown the health system that Aboriginal people maintained for many hundreds of generations (Saggers & Gray 1991). With the failure of past health systems for Aboriginal people, the new health systems that have evolved over time have also to a larger degree been ineffective (NATSIHS, 2000).

**Underlying key issues in sexual health of NSW Aboriginal people.**

When reviewing the epidemiological data that addresses the rates of sexually transmitted infections in Aboriginal communities, the theme that arises throughout the literature is that Aboriginal people are more likely to present late for diagnosis and treatment to health services. With sexual health concerns, this can result in sexually transmitted infections becoming endemic in Aboriginal communities (NATSIHS, 2000).

Assessing the key issues in sexual health for NSW Aboriginal people, one needs to keep in mind that the level of disease or ill-health in any marginalised community is usually difficult to identify because most illness are not presented to health services until the individual becomes very sick (NIASHS 1996-97 to 2003-04). In discussing sexual health issues for Aboriginal people, it is important to view health as being holistic, this will provide a more accurate picture on sexual health issues for Aboriginal people. Dividing health into discrete categories (a western perspective on health), means that other aspects of health are not your business as a health worker. This does not work for Aboriginal people as health takes a ‘whole of life’ and a ‘whole person’ perspective, as there are many lifestyle behaviours that affect health, sexual health and well being.

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It is now recommended that all Aboriginal and Torres Strait Islander children under the age of 18 years are hepatitis B vaccinated. Vaccinations for Hepatitis B only became available in most states in 1987, but for the Northern Territory it was in 1988 and South Australia in 1996 (Roche \textit{et al.} 2001: 201). Many Sexual Health services in New South Wales provide free hepatitis B vaccinations to Aboriginal and Torres Strait Islander people (Central Sydney Area Sexual Health Service Strategic Plan, 2003).

There were 420 newly diagnosed Hepatitis B infections for Aboriginal and Torres Strait Islander people for the year 2001 (Fisher & Huffam 2003). The management of Hepatitis B infection in remote communities is a continuous concern for health providers. As most individuals who have been diagnosed with the HBV virus at birth or in early childhood, ninety percent will develop chronic hepatitis B infection, which can have a devastating impact on the health of Aboriginal and Torres Strait Islander communities from remote areas.

Fisher, Huffame (2003) also identified that management for chronic Hepatitis B for Aboriginal people is a continuous concern for health care providers in remote areas, as there are no guidelines that facilitate follow up actions, continuous care and investigation of HBV infection (Fisher and Huffame, 2003).

From 1991-1995 the death rates (chronic liver disease and cirrhosis- both side effects of hepatitis) were four times and 5.5 times higher for Aboriginal men and women respectively compared to the rates of all other Australian population (Fisher and Huffame, 2003).

Hepatitis B prevalence in the adult population of Aboriginal and Torres Strait Islander people makes the issue of liver transplant even more pertinent. McCaughan and Torzillo addressed the fact that none of the issues related to transplants can be addressed in isolation until the basic requirements for improving Aboriginal Health are in order (McCaughan, and Torzillo 2000). The authors believe that Aboriginal and Torres Strait Islander people do not experience different problems than non-Indigenous people after a liver transplant, but there is a concern with issues
around primary health care and follow up for Indigenous people, especially in the area of access (McCaughan and Torzillo 2000).

From the first known case of HIV in Australia, which was diagnosed in 1982 (McDonald and Kaldor, 2003) there is now an estimation of 12,730 people living with HIV/AIDS in Australia up to the year 2001. Due to the sensitivity of this type data, population identity such as Aboriginal or non-Aboriginal was not recorded for some time (National Centre in HIV Epidemiology and Clinical Research, 2001). The most frequently reported route of transmission of HIV in the Indigenous people, as with the non-Indigenous population has been male homosexual contact (McDonald and Kaldor, 2003).

At present there is a growing concern in Australia over a documented rise in HIV infections among gay men. The HIV surveillance figures show 821 new diagnosis of HIV infection up to the 31st December 2002. This is an increase of 71 new HIV infections from 2001-2002. This is an indication that there is a national increase of eight percent for the 2002. New South Wales had a 15% increase, Queensland 20% and Victoria in which there was a 7% increase in the gay community (National Centre in HIV Epidemiology and Clinical Research, 2001).

With surveillance systems improving over the years, this has enabled health authorities to monitor the progress of HIV/AIDS in Aboriginal communities, keeping in mind that access to health services for Aboriginal people is very poor (National HIV/AIDS Strategy 1999). Also, the reliability of Aboriginal identity in reporting to any health service has been very mixed, and the collecting of health information is thwart with difficulties. There has been a slight improvement in this area but there is certainly a capacity for improvement (HIV/AIDS, HCV & STI Annual Report, 2002).

HIV in Aboriginal communities compared to non-Indigenous communities have to date not been high, but it does place them in a position of being at risk of HIV, since all the risk factors associated with the current high rates of sexually transmitted infections and poor access to effective health services (NIASHS, 1997) are prevalent.
There are noted differences between Aboriginal and non-Aboriginal people who have been diagnosed and exposed to HIV over the ten year period from 1992-2001 (The National Centre in HIV Epidemiology and Clinical Research 2002) in the area of:

- A higher proportion of heterosexual cases;
- Higher proportion has occurred in women;
- A higher proportion of cases attributed to injecting drug use;
- A younger age at diagnosis. AIDS incidence has declined more slowly.

Other vulnerabilities that may influence the increase of HIV and Hepatitis C in Aboriginal communities can be attributed to the over representation of Aboriginal people together with the high rates of injecting drug use within the prison system (NIASHS 1997). This information draws our attention to the status of the Hepatitis C virus in Australia, as Hepatitis C is now a major health problem due to the high levels of exposure to the virus, which stands currently at 20,926 people nationally (The National Centre in HIV Epidemiology and Clinical Research 2002). However, one difficulty is that ethnicity data is lacking in most new diagnosis with HCV except for the research that has been undertaken in needle syringe programs (HIV/AIDS, hepatitis C & Sexually Transmissible Infections in Australia Annual Surveillance Report, 2002).

In 1995 to 1998 participants involved in surveys, which were undertaken by Australian Needle Syringe Program reported that the prevalence of HCV for Aboriginal injectors was 56%, which was quite similar to the 51% prevalence in non-Aboriginal injectors (McDonald, et al, 2000). The results of the surveys found that 5.4% of injecting drug users identified as Indigenous, more than twice the 2.1% of people who identify as Indigenous in the general population (McDonald, et al, 2000). Furthermore, this figure could be higher due to Aboriginal injecting drug users could be less likely to attend needle syringe programs or take part in surveys. Aboriginals under 25 years of age who inject drugs are 38% compared to 23% non-Aboriginal people under the age of 25 years (HIV/AIDS, hepatitis C & Sexually Transmissible Infections in Australia Annual Surveillance Report, 2002).
The history of the Hepatitis C virus thus far, is that over a short period of time this virus has become an epidemic in the injecting drug users population. This is a major concern for health, as injecting drug users have a history of imprisonment, Aboriginal people are over represented in prisons which is a real risk for transmission of the virus to Aboriginal and non-Aboriginal populations. It should also be noted that sharing injecting equipment is not the only route of transmission for this virus, there are many different modes of transmission such as tattooing, piercing, razor blades, toothbrushes, if shared, are also high risk activities (Crofts, et al, 1996a).

Provided is a brief overview of the bigger picture of hepatitis C, Australia wide:

- For the first time in five years the annual number of diagnoses of hepatitis C infection declined in 2001, to 16,734 cases.
- The number of diagnoses of newly acquired hepatitis C infection continued to increase from 154 in 1997 to 587 in 2001. This could be due to a more improved monitoring system.

Hepatitis C transmission continued to occur predominantly among people with a recent history of injecting drug use.

- 157,000 people are estimated to be living with hepatitis C infection in Australia in 2001, this includes:
  - 124,000 with chronic hepatitis C infection, and stage 0/1 liver disease
  - 27,000 with stage 2/3 liver disease and
  - 6,500 living with hepatitis C related cirrhosis.
- A further 53,000 had hepatitis C antibodies but were not chronically infected.
- Around 1,650 people were prescribed treatments for hepatitis C infection in 2001.

Unfortunately, for New South Wales the data that outlines the rate of infection of Hepatitis C and sexually transmitted infections in Aboriginal communities is very limited.

The incidence of sexually transmitted infections in Australia is rising, noticeably among sexually active teenagers and young adults (NIASHS). One of the main problems with sexually
transmitted infections is that some of are symptom-less, so that many individuals are unaware that they are infected.

Many sexually transmitted infections can result in significant morbidity and mortality particular among women. If the individual is diagnosed early, most sexually transmitted infections can be effectively treated. If not, it can have a devastating effect on reproductive health (NIASHS, ???).

Sexually transmitted infections are currently a major concern for Aboriginal people, the prevalence of sexually transmitted infections amongst the Aboriginal population is up to eight times higher than for non-Aboriginal people (Bowden, et al, 1999; Kildea and Bowden, 2000 and; Australian Bureau of Statistics, 2003).

As discussed previously, the over representation of imprisonment of Aboriginal people exposes them to high risk of transmission of a blood borne virus (sexually transmitted infection). Also, another important fact is that there is a good chance that Aboriginal people may re-offend which is a repeat opportunity for becoming infected (Edney, 2001).

Most Indigenous literature that discusses the effects of sexually transmitted infections is predominately on women living in remote areas in the Northern Territories and Northern Queensland. Miller (1999) discusses the development and evaluation of effective treatment for sexually transmitted infections and also the improvement of access to health care services for Aboriginal people in remote communities. Access is limited for Aboriginal people in remote communities, which contribute to a high prevalence of sexually, transmitted infections (Miller, et al, 1999).

The Australian Bureau of Statistics (1992-1994) reports that the mortality rate for cervical cancer in NSW Indigenous Women is 8 times higher than that of non-Indigenous Women. Furthermore, Aboriginal women in NSW have the highest rates of Cancer of the Cervix of any other racial group. In NSW for the period 31st March 2000 to the 31st March 2002 59.9% of (eligible) women whose ages ranged from 20 – 29 years Pap smear results were negative (NSW Pap Smear Register). In Central Sydney Area Health there were 55.8% of women in the same age bracket.
Aboriginal people still remain the least healthy population in Australia. Compared to other Indigenous communities from New Zealand, Canada and the United States of America, Australia has not achieved any real improvement in health for Indigenous Australians (The National Aboriginal and Torres Strait Islander Health Clearinghouse, 2003).

In 2003, Aboriginal communities still experience poor access to adequate clean water supplies, safe and affordable housing, electricity and efficient sewage removal: all of which greatly contribute to the burden of ill health (NATSI Health Strategy (draft) Feb, 2001). The National Aboriginal Health Strategy outlines that Aboriginal people also have a high rate of premature death, excess illness, injury and disabilities comparative to non-Aboriginal Communities.

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To summarise, this chapter discussed the health of Aboriginal people and provides epidemiology surveillance on rates of infections in Aboriginal communities compared to non-Aboriginal populations. It outlines the area of concerns as Aboriginal people experience high levels of STT’s and Hepatitis C with little interventions from the broader community health services. This chapter reinstates that Aboriginal Health is still at the poorest level compared to non-Indigenous populations and they are only just over 2% of the whole population. It discusses high rates of teenage pregnancy and other health concerns that impact on health for Aboriginal people.
KEY FACTORS IN DETERMINING THE SEXUAL HEALTH STATUS OF NSW ABORIGINAL PEOPLE.

Key determinants that can influence and enhance the status of sexual health for Aboriginal people are;

"the capacity to enjoy sexual health and reproductive behaviour with a social and personal ethic; freedom from fear, shame, guilt and false beliefs which inhibit sexual response and impair socio-sexual response and impair socio-sexual relationships; as well as freedom from organic disorders, disease and deficiencies that interfere with sexual and reproductive function." (WHO, 1975)

The Ottawa Charter provides a framework for health promotion to work towards enhancing communities health and self determination and these prerequisites are; shelter, education, food, income, a stable eco-system sustainable resources, social justice and equity (WHO, 1986). The Ottawa Charter also identifies five major themes when developing health services that will address health determinants and they are:

- To build healthy public policy
- Create supportive environments
- Strengthen community action
- Develop personal skills
- Reorient health services

Health needs for Aboriginal people and Aboriginal peoples’ view on health and illness are different from the general population in many ways. When developing, implementing and evaluating health policies that affect Aboriginal people, the differences such as: policies for men and women’s business, and for older and younger adults need to be adhered to. Social, cultural and language differences must also be taken into account (The National Aboriginal Health Strategy, 2001) when developing these policies.
Ritchie (2001) outlined that health promotion in an Indigenous context is about ‘vision’, which he believes is the primary motivator in everything we do. Ritchie (2001) talks about the Ottawa Charter that describes health promotion as being a process that enables people to increase control over and to improve their health. It is an empowering and people focus document, which draws our attention to considering the health impact of social, political and economic factors for Aboriginal communities if the Ottawa Charter was implemented in all Aboriginal affairs.

Brown (2001) argues that good health is a right and not a privilege especially in a country like Australia as we are supposed to be the ‘Lucky Country’, this does not seem to be the case for the Aboriginal population. Brown (2001) also believes that the Aboriginal communities already have the answers to their health and well-being and all we have to do is ‘just ask’ the community. The problem here is that Aboriginal and Torres Strait Islander communities do know what is needed, but the availability of ongoing funding which is a crucial factor in the developing of health services for Aboriginal and Torres Strait Islander people is met with great difficulties.

As well, there are particular issues for Indigenous health promotion service providers. Shane Hearne’s paper to the Indigenous Health Promotion Forum highlighted, ‘Innovations and Priorities for Indigenous Health Promotion service providers’. As Hearne (2001) discussed, Indigenous health promotion service providers have a difficult role in the health arena, as Indigenous health promotion is a factor in health that receives very little attention. Indigenous health promotion carries an enormous responsibility in providing health pathways for Aboriginal people. It is a very demanding topic, as it covers such a large area in health from partnership building with other health service providers to providing cultural awareness education discussions to non-Indigenous health professionals. Workforce development issues, includes equity and pay for Aboriginal people as Aboriginal people are still fighting for the same wage as non-Indigenous people. Hearne (2001) also highlights the importance of improving education research, as this can also be a means for improving health. A holistic approach to Indigenous health is a must, but this requires multi-sectional responses, the skills and strengths that already exist in the communities need to be recognized and accepted by health departments and policy developers (Hearne 2001)
Brown also attended the Indigenous Health Promotion conference (2001) and discussed the core activities of the Australian Indigenous Doctors Association, which includes health policies, medical education for undergraduates and postgraduates and workforce development. The health promotion activities discussed by Brown at the forum was, the World Vision Australia Indigenous Programs, The National Indigenous English Literacy and Numeric Strategy and Croc Festivals. Brown (2001) discussed a project that was undertaken by World Vision (1996) that supported the development and the implementation of preventative health programs in the central desert region. This initiative was brought about by local Aboriginal community members, who expressed their concerns with the appalling health and social situation which they faced everyday. Because of the lack of funds for this project, a fund raising project was developed through the Walkabout Gallery, which sold local artwork in shows through their Sydney Gallery, which raised the funds for the community health project.

Another issue is control of research. Coory, et al, 2003) undertook a study on participation in cervical cancer screening by women in rural and remote Aboriginal and Torres Strait Islander communities in Queensland. Coory, et al, argue that even though there has been a National approach to the prevention of cervical cancer since 1991, there study indicated that screening rates for Indigenous women are well behind non-Indigenous women. They state that out of thirteen Indigenous communities that were part of the study, over 50% of Indigenous women from three of the communities participated in screening for cervical cancer. They also argue that there is a need for consultations and partnerships with the Indigenous communities for were the studies were being implemented, and that there was the need for more funding for continued studies in the Indigenous communities. However, in this case it is not clear that they actually consulted with the communities that were part of the study, and they do not indicate that it was a randomised controlled study.

In reply to Coorys’(2003) comments about the ‘pap smear participation rates of cervical cancer’ study, Larkins, et al, 2003 argue that the communities in Queensland were identified for the research but they were not informed that the study was being conducted. Larkin states that this approach is extremely disrespectful and it is deemed as reflecting a paternalistic attitude. Furthermore, without partnerships with the women and their communities the authors of the study
could only presume that the participation rates were better in centers with a primary-healthcare approach to screening. Larkin continues by suggesting that a more comprehensive approach to the types of services and choice of Pap smear providers should be available for each community and in doing the screening this way may produce more interesting rates of participation.

The key factors that arise with this study is that as Larkin et al states, the importance of community consultations for Aboriginal people is out of parallel. Coory, et al, study is indicative of good intentions for Aboriginal communities, but disrespect because they did not acknowledge that Aboriginal people are 'people' who have had a history of this type of research - where they just become a number in the study.

As previous documents (The Australian Bureau of Statistics, Year 1999: Hunt and Lynore ; 2002) have stated, there is a high level of cervical cancer incidence and mortality rates for Aboriginal and Torres Strait Islander women compared to non-Indigenous women. This is certainly an indicator that, while some services have been implemented in the past, they do not seem to be effective. As Hunt and Lynore (2003) suggest that now it is the time to listen to what Aboriginal and Torres Strait Islander women are saying with regard to the best strategy to use when dealing with healthcare services. The women in the study on participation in cervical cancer (Coory et al.) all came from a diverse Aboriginal and Torres Strait Islander background, but they all took a holistic view on health rather than having a narrow response (Hunt & Lynore 2003).

Research in Aboriginal communities is a sensitive area and needs to be thought out with care and a respect to the focused community. The process of community acceptance and consultation is a must before the commencement of any research study (Pyett, 2002). There has been much discussions about the advantages of collaborative participatory approach to health research in Aboriginal communities (Pyett, 2002), and the importance of working in partnerships to find solutions for enhancing Aboriginal health (Atkinson et al 2002).

If the researcher is not from the community, establishing creditability, trust and partnerships from the Indigenous Australian communities can be difficult - but not impossible (Pyett, 2002 and Atkinsen, et al, 2002).
To provide effective support to Aboriginal women, it is essential to recognize the importance of what women and men’s business means in Aboriginal culture. Establishing culturally defined and effective health services to Aboriginal women will help to reduce the high rates of infection by early detection and intervention Hunt & Lynore (2003). This can be achieved through implementing policies that support a whole of life view on health, involving consultations from the aboriginal community addressing access and equity (NSW Aboriginal Health Strategic Plan, 1999).

The development of the individual’s sexual identity is part of the process in the course of their lives, which can be influenced by early childhood experiences, as well as other aspects of individual identity, including Aboriginality and gender. Sexual identity also includes how comfortable they are with themselves, their choices and behaviours, which can have an impact on the individuals’ relationship to those behaviours. An affirmative sexual identity can assist people to develop a health conscious and positive approach to sex and sexuality. If the individual has experienced discrimination, rejection, ridicule by family, community, religious and cultural pressures, this can inhibit the individual to develop an affirmative sexual identity (Anwernekenhe Report, 1994) which may place them in a health risk position. In the past, Indigenous gay, lesbian and transgender people were also under-represented in health plan initiatives, but in 1994 the initial steps were taken to address their sexual health concerns by establishing the first Aboriginal and Torres Strait Islander Gay and Transgender Sexual Health Conference.

One of the major findings from the conference was the need for a national community consultation for Aboriginal and Torres Strait Islander gay and transgender people with the aim to discuss their sexual health concerns in a more appropriate environment. During the course of the consultations, many gay men and transgender people expressed their fear of being rejected by their community if their sexuality identity was known. They also expressed dissatisfaction with their lived experience of marginalisation within the wider, white, gay HIV agenda including the broader gay community. Two very important issues also arose from the consultations were sexual identity and sexual abuse. Most of the participants of the consultations disclosed that through their own experience, they internalized a lot of the pain and hurt that they had
experienced through sexual abuse and violence, which resulted in being forced in ‘at risk’ situations (Anwernekenhe11 Report, 1994). Many comments were made in regards to breaking the silence of sexual abuse for Aboriginal and Torres Strait Islander gay and transgender people (Anwernekenhe Report, 1994).

After the consultations were completed, the findings became the bases for the development of the Anwernekenhe11 Report (AFAO National Indigenous Gay and Transgender Project, 1994). This report paved the way for The National Indigenous Gay and Transgender Sexual Health Strategy, which is the first of its kind for Indigenous people.

The key priorities from this report, identifies, that HIV services, which include education, treatment access and care and support call for greater attention for Aboriginal gay and transgender people. This also includes Aboriginal youth and men who have sex with men but do not identify as gay (Anwernekenhe11 Report, AFAO National Indigenous Gay and Transgender Project 1994) as this population of Aboriginal people are more difficult to access (CSASH Strategy, 2004).

There is only a small number of transgender people in the population as a whole, which means that some communities may have no identified people with transgender issues while others may have a few. These low numbers make it difficult to find support for transgender issues, which assume a low priority in many communities. People with transgender issues are, however, at a high level of HIV risk due to factors such as the lack of emotional, psychological and mental health support (Anwernekenhe11 Report AFAO National Indigenous Gay and Transgender Project 1994). In addition, high profile Aboriginal people in their community who are experiencing transgender issues may become involved in sexual experimentations, or they may be the targets of assault, places them at a higher than average risk of HIV transmission (Anwernekenhe11 Report AFAO National Indigenous Gay and Transgender Project, 1994).

To raise community and health services awareness on HIV/AIDS, gay and transgender issues, it was recommended by the Anwernekenhe11 Report, that local AIDS Councils, NACCHO and local Aboriginal Medical Services are predominately in the best situation to carry out the education. The importance of delivering health messages to the community and health services
on safe sex education needs to be achieved through a supportive legislative cultural framework where issues of discrimination, marginalisation and sensitive social issues can be discussed (Anwernekenhêi1 Report, AFAO National Indigenous Gay and Transgender Project, 1994).

Because of the undervaluing of Aboriginal and Torres Strait Islander gay men, lesbians and transgender issues, there has been a consistent and under-funding of programs designed by and for this group (Forrest 1995: 13), resulting in closure of much needed services (Forrest, 1995).

Mainstream agencies in general need to be better educated about the diverse issues that affect the well being of Aboriginal and Torres Strait Islander people (Australian National Council on Aids Hepatitis C and Related Diseases, 2000). As well, it is imperative that when working equitably with people, to consider issues of cultural diversity. The recommendations of the National Indigenous Australians Sexual health Strategy 1997-98 to 2003-04, the National Gay and Transgender Sexual Health Strategy and the HIV/AIDS Strategic Plan should be on all health services agenda for future planning of sexual health services. Fry, et al, 1999) discussed the issues of sexually transmitted infections in Aboriginal Communities in the area of North Queensland to Cape York, where there are high levels of sexually transmitted infections in the Indigenous community (Radio National 1999) and Fry et al also comment that the government’s initiatives over the years are failing as over 40% of adults from this area under the age of 40 years have a sexually transmitted infection.

Fry, et al, (1999) from the Apunipima, Cape York Health Council, Queensland disclosed that there is also a real concern of HIV increasing in the Indigenous communities because of the high levels of sexually transmitted infections at this point in time. The authors commented that Aboriginal organizations are getting frustrated with having to wait for someone else to find the solutions to this problem when Aboriginal Communities can take control of the situation and design and implement health messages and projects that target STI’s in the Indigenous Community. However, Fry, et al, 1999) identify that the key factors for Aboriginal and Torres Strait Islander people is shame and fear when seeking treatment. Historically in Cape York, this may also be due to the permanent removal of a member of the community to Palm Island when they tested positive for a sexually transmitted disease.
The National Indigenous Sexual Health Strategy raises the concerns about under-diagnosed and under-reported STIs for Aboriginal people. There have been many papers that outline the lack of valid, acceptable and culturally sensitive interventions (NIASHS), even though recommendations for better interventions have been continuously outlined in Aboriginal policies and strategies, but very few health services have tailored health to the specific needs of the target population or individual (NIASHS).

There is no need to keep reinventing new solutions, new strategies for access to health services for aboriginal and Torres Strait Islander people as the Aboriginal Health Strategy has been around for ten years and provides the recommendations that is necessary to address the issues of health care services of Aboriginal and Torres Strait Islander people.

Access issues are related to cost, location, cultural and social acceptability, and the efficiency and effectiveness of the service. For Aboriginal and Torres Strait Islander people, access to health services are affected by simple matters such as the proximity and availability of the service and whether it is culturally appropriate in service delivery (Australian Bureau of Statistics 2001:46).

Services also need to work towards building effective partnerships with Aboriginal Health and Community Services to continue to enhance the well-being of Aboriginal Communities and to work together to address the legacy of shame and mistrust that they may have experienced in the past. Equity in health and access to health services are an ideal, but not yet a reality for Aboriginal people (Saggers & Gray, 1991) as this is evident when the key factors of determining sexual health for Aboriginal people is overcast with the poorest health of any group in this country. The way Aboriginal people have been portrayed in the media, past health policies and education systems have identified Aboriginal people as being independently responsible for the making of their own ill health (Saggers & Gray 1991).

In summary, there are limited sexually transmitted infections data for NSW Aboriginal population compared to other States and Territory. But one theme that kept coming up was poor access, under diagnosis and under reporting of sexually transmitted infections. The stigmatizations and attitudes of health professionals towards Aboriginal people, sexual health key
factors for gay and transgender Aboriginal people and the importance of health promotion and workforce concerns are all the issues worth noticing.
GUIDELINES AND RECOMMENDATIONS FOR THE PLANNING OF SEXUAL HEALTH PROGRAMS FOR ABORIGINAL PEOPLE.

For delivery of effective and efficient sexual health care, specific strategies are necessary in order to alleviate barriers that have been imposed on Aboriginal people throughout the history of colonization. It is also important to acknowledge the diversity within Aboriginal communities and to address the difference within the planning process. Aboriginal people do suffer disproportionately from sexually transmitted infections and blood borne viruses (NIASHS), which have a significant impact on fertility, maternal and child health, and pregnancy.

Because of the stigmatization of sexually transmitted infections, the individual may experience overt negative behaviour from community members and partners. For Aboriginal gay and transgender people, the consequence of being identified as having sexually transmitted infections could increase the exclusion from their family, friends and community (Anwernekenhe, 1998).

The risk of contracting a STI increases the chances of HIV transmission, and for Aboriginal communities, this would be another injustice as the availability of culturally appropriate, effective and efficient sexual health services, are far less compared to the non-Aboriginal population.

The key recommendations and guidelines relating to the planning and development of sexual health programs/projects for NSW Aboriginal people are guided by:

- the National Indigenous Australians Sexual health Strategy, 1996-97 to 2003-04;
- The NIASHS Implementation Plan for 2001-02 to 2003-04 and
- The NSW Aboriginal Health Strategic Health Plan 1999;
- The Aboriginal Partnership Agreement Framework).

These strategies represent Aboriginal and Torres Strait Islanders' sexual health concerns. They provide the tools to enable them to develop the best sexual health service for NSW Aboriginal people. This will mean that Aboriginal people will finally have a:
To achieve effective responses to Aboriginal sexual health there must be an inclusion of other supportive parties from disciplines other than the health sector. Even though OATSIm (Office for Aboriginal and Torres Strait Islander Health, year 2002) administers $12 million per annum to

- "Level of personal knowledge and skills to make healthy life choices
- An ability to enjoy and control sexual behaviour based on personal and social values
- Freedom from fear, shame, guilt and violation which affects self esteem and harms individuals, communities and relationships
- Freedom from diseases, unplanned and unwanted pregnancy
- The freedom and right to choose positive expressions of sexuality"

(NIASHS Implementation Plan, ???, p: 1) Therefore, the key recommendations and guidelines relating to the planning, development and implementation of sexual health programs/projects for NSW Aboriginal people are as follows:

Building Partnerships

Developing and maintaining effective partnerships with the AH&MRC, NSW Department of Health, Community Controlled Health Services and Area Health Services (NIASHS, NSWAHSP, NAHS, et al) is essential so that Aboriginal people have the best equitable access to appropriate sexual health services (Ensuring Progress in Aboriginal Health, 1999) for Aboriginal people.

The partnership approach is an effective process between all levels of government, community organizations, medical and scientific communities and people living with or otherwise affected by sexually transmitted infections or blood borne viruses (BBV) and other sexual health concerns (NIASHS Implementation Plan, 2002).

Core responsibilities for major stakeholders, regardless of the level and section from which they operate, are: to aid in the recognition of sexual health as a priority, actively identifying opportunities to be included in Aboriginal sexual health activities; and to encourage and support the participation of others in Aboriginal sexual health activities (NIASHSIP; 2002).

To achieve effective responses to Aboriginal sexual health there must be an inclusion of other supportive parties from disciplines other than the health sector. Even though OATSIm (Office for Aboriginal and Torres Strait Islander Health, year 2002) administers $12 million per annum to
support Indigenous sexual health services, but this amount does not cover the expenditure of implementing the National Indigenous Sexual Health Strategy Australia wide. Therefore, the funding bodies located in State and Territory and Commonwealth Government Departments also have the responsibility to strengthen their contribution to the Indigenous sexual health effort.

The principles that underpin effective partnership processes are: Indigenous ownership of Indigenous health, recognizing and respecting the value of the different perspectives, knowledge and experiences of partners, transparency of decision-making, localized identification of priorities and development of partnerships, evidence based decision making, agreed and meaningful evaluation and to ensure that there is robust representation (NIASHSIP, Year 2002).

**Federal & State responsibilities**

The NSW Aboriginal and Torres Strait Islander Health Agreement (1996) established an Aboriginal Health Forum, which facilitates the process of joint planning at a statewide level. This includes the NSW Department of Health, the Commonwealth Department of Health and Aged Care, the Aboriginal Health and Medical Research Council of NSW (AH&MRC) and the Aboriginal and Torres Strait Islander Commission (ATSIC). The NSW Aboriginal Health Partnership was formed in 1995 and a further Partnership Agreement was signed in 1997 following a review. Both the NSW and Commonwealth Agreements are consistent with the principles of the NAHS with respect to Aboriginal community control, a partnership approach and inter-sectoral collaboration. The NSW Aboriginal Health Partnership is to be repeated throughout the State by the establishment of Local/Area Aboriginal Health Partnerships.

New South Wales is at the forefront compared to other States and Territory in providing sexual health services for Indigenous people. The five elements that make up the Core Competency Standards are:

- The improvement of the sexual health status of Aboriginal and Torres Strait Islander people and;
- Equity of access to a range of comprehensive health services in order to: minimise the transmission of STDs; minimise morbidity from STDs; minimise morbidity associated with injecting drug use, sexuality, sexual function and relationship issues; promote the
maintenance and enhancement of sexual health; and increase access to sexual health services throughout NSW and the;

- Improvement of the quality of sexual health services to Aboriginal and Torres Strait Islander people throughout NSW.
- Community participation and involvement.
- Encouragement of the development of strategies to meet the needs of Aboriginal and Torres Strait Islander people, and the development of culturally appropriate services.

It is also important to note that even though there are Core Competency Standards, this is not a guarantee that professional work is totally covered by the core competency standards although they do offer a framework for service delivery.

The New South Wales Department of Health also outlined the need to have specialised areas of service delivery, which will help the sexual health worker to identify the differences in how sexual health is addressed due to the unique cultural values and traditions for each area. It also is important to note that NSW has the highest proportion of Indigenous people residing in the State.

**Health Promotion**

Health Promotion and HIV preventions are initiatives that The National Indigenous Australians’ Sexual Health Strategy emphasized with the focus being Aboriginal and Torres Strait Islander people. These initiatives are to be delivered in the context of sexually transmissible infections information. It is further understood that the delivery of sexual health information is often most appropriately delivered within a context of sexual and reproductive health with a particular emphasis on pregnancy and family. This of course will differ between sub-groups of the Aboriginal and Torres Strait Islander population.

Aboriginal Health Promotion received very little attention in terms of development and evaluation in the past, as the main focus was more on a clinical pathway than health promotion. Health promotion is a very important initiative when it comes to the wellbeing of Aboriginal communities and can be seen as a guide for the future of Aboriginal sexual health promotion (NSW Health Department, 2001).
Aboriginal health promotion has always had to rely on single strategy initiatives, which promoted health resources such as, pamphlets, posters and other resources that are usually one off projects (NSW Health Department). This type of single strategy is rarely sustainable and is unlikely to have an impact on the individual or community (NSW Aboriginal Health Promotion Guidelines, 2002), yet, due to the funding situation this can be the only initiative that is workable at that time.

The most important central aim of Health Promotion is that of empowerment, which enables individuals and communities to increase control over the determinants of their health and well-being (WHO, 1986). Empowerment is not just about the production of resources it is about building healthy public policy, create supportive environments, strengthen community action, develop personal skills, reorient health services (Principles for Better Practice in Aboriginal Health Promotion 2002). These are important tasks for the development of more effective approaches for Aboriginal Sexual Health projects/programs.

As the National Indigenous Australians Sexual Health Strategy points out, the very nature of sexually transmissible infections also influences how strategies can be deployed in order to be effective. Most STIs have no symptoms for much of the time they are present, yet serious complications can still develop and infections can be passed on. Therefore, unlike health services that are based on diagnosing and treating symptomatic illness, sexual health services rely on strategies that encourage sexual precautions to prevent infection and STI testing for those who have had risks - regardless of symptoms.

With notable exceptions, STIs are largely acquired through private behaviours between consenting adults. It is only by securing the voluntary cooperation of people who are at risk of having STIs that diagnosis and treatment can be offered (Central Sydney Aboriginal Sexual Health Strategy 2003). These considerations are further compounded because people generally don't develop immunity to STIs. They can become re-infected, their sexual partners will need to be treated and having had a risk for one type of STI, they may also have other STIs.
Sexual health services are extremely important to Aboriginal and Torres Strait Islander people because HIV and sexually transmitted infections are mostly preventable. This is why the National Aboriginal Health Strategy, the NSW HIV/AIDS Health Promotion Strategy for Aboriginal Communities, the 3rd National AIDS Strategy and, more recently, the Indigenous Australians' Sexual Health Strategy all provide a framework for the conduct of HIV/AIDS and sexual health services for Indigenous people.

**Treatment, care and support**

Sexual health services differ from other health and welfare services because of the level of unease associated with sexual health problems. As a result, special arrangements to protect privacy and to facilitate patient access are usually instituted. Moreover, many sub-populations who are a priority for sexual health services are themselves marginalised thus increasing the importance of being sensitive to their needs as well as making special provisions for culturally acceptable and appropriate treatment and support.

Mainstream services often complain that these marginalised populations don't often access their services. While this complaint acknowledges the difficulties that some groups experience in accessing services, it inappropriately places the onus on the client and doesn't acknowledge that health services are failing in their responsibility to access them.

Even strategies, which are generally effective at improving access, can be problematic in the sexual health context. For example, community-based health initiatives work well in most cases, but the need to guarantee privacy in a sexual health context can require the modification of conventional community-based approaches.

The National Indigenous Australians Sexual Health Strategy identified that Aboriginal Community Controlled Health Services “are the most efficient and effective way to deliver holistic primary health care to the Aboriginal community”. And furthermore, this also incorporates the principles of Aboriginal community control and cultural appropriateness, (NSW AHSP 1999) which in primary health care setting this has not yet been effectively achieved. Yet, improving access to health services for Aboriginal people is such an important...
element of health, especially when we look at the damning statistics on the rates of infection for Aboriginal people (NSWAHSP, 1999).

The importance of cultural understanding when providing sexual health services to Aboriginal people is one of the most important key recommendations that have been outlined in all of the National and State Health Strategies for Aboriginal people NIASHS, NAHS, NSWAHSP, Ensuring Progress in Aboriginal Health). Cross-cultural care in all sexual health services will definitely enhance the level of access to these services by Aboriginal people (Ensuring Progress in Aboriginal Health, 1999).

Treatment, care and support covers a range of concerns which include testing for HIV, early access to health services, management of illness and support for partners, family and carers. For people living with HIV, it is recognized their input is a key component of developing effective strategies that focus on prevention and treatment and support (NIASHS, 1999; National HIV/AIDS Strategy, 1999).

A number of key factors need to be taken into account when planning strategies that focus on treatment, care and support for Aboriginal and Torres Strait Islander people. The lack of culturally appropriate support services for Aboriginal people has a significant negative impact in the area of low access. Discrimination for Aboriginal people who are living with HIV/AIDS particular gay men also affects the type of treatment that they receive and also it will be a barrier for future access.

The Aboriginal Health and Medical Research Committee developed the Core Competency Standards for Aboriginal and Torres Strait Islander HIV/AIDS Sexual Health Workers as a framework to assist health workers to achieve the right level of training and development and to also provide a framework for effective HIV and sexual health work in NSW. This will also ensure the Core Standards will reflect the current National Indigenous Sexual Health Strategies 1996-97 to 1998-99. The principles of the Core Competency Standards will provide a benchmark that can measure skills and performance in the current work place.
Research and Data Collection

The Aboriginal Health and Medical Research Council (AH&MRC) has developed guidelines to ensure that Aboriginal Communities benefit from research projects and that appropriate methods are being used. The guidelines where possible, support Aboriginal peoples’ involvement in all stages of a research project including the actual research exploration if appropriate, and that all research material and data information should remain the property of the Aboriginal Community. (put reference) This will enable sexual health issues for Aboriginal people arising from research data to be addressed in a more strategic, effective and appropriate way through raising the knowledge level of Indigenous Australians, identifying the gaps and taking relevant steps to achieve positive outcomes (NIASHS Implementation Plan).

Through the collection of specific sexual health data for Aboriginal people and the appropriate dissemination of this data will be the first steps to the enhancement of the planning and decision making process for future effective and efficient sexual health services for Aboriginal people (NIASHS Implementation Plan).

To ensure that the actions, implementations and recommendations from the NIASHS Plan meet the needs of Aboriginal people, there must be mechanisms that ensure the policies and practices are fundamentally the best available for Aboriginal people include the:

- Measurement of performance of strategies, with a reference to cost-effectiveness
- Accountability
- Communication
- Social and epidemiological data sets
- Report mechanisms

In summary, this chapter provides recommendations, guidelines relating to planning and developing of sexual health services for Aboriginal people in NSW. There are the inclusions of roles and responsibilities for government bodies, the role of community controlled health services, funding bodies, the principles of health partnerships, health promotion and impact statements for future health services.
DISCUSSION
From the first contact with Europeans, diseases, which were brought from Europe to unsuspecting Aboriginal population started to emerge, and this legacy of ill health continues today. Rather than starting from the fact that Aboriginal people were once a strong and healthy race, they were treated as a problem that was to be overcome. This belief and the consequent colonialisit actions, which followed helped the transformation of health for Aboriginal people, into one of ill-health, grief and loss.

The annual ceremonies marking the change in seasons, births, puberty and marriage commitment and death (which is the connection to spiritual purpose) were uprooted and misplaced. Traditional healing became increasingly difficult to perform as the loss of land to the Europeans for cultivation methods made it difficult to utilise the plants and animals for the sick. Also, with the removal from ancestral lands to unfamiliar land without permission from the local healers and Elders, the performance of healing by others may not be acceptable. Another contributing factor for the breakdown in health for Aboriginal people was pollution of the lands and water, for the belief of oneness means that when the land is sick so are the people. When Aboriginal people talked sickness, western culture would interpret this to be physical which is not often the case for Aboriginal people.

During Australia’s history, government policies that were put in place after the land was taken, legitimized the extermination, protection/segregation, assimilation and integration of Aboriginal people. For some time now government policies identified that there had to be a major move towards policies that support self-determination and self-management (Rowley, 1971) for Aboriginal people if the status of health was to change, this process of change for Aboriginal people has been a slow one.

Due to the continued neglect by State and Federal policies, Aboriginal people continue to mistrust and be suspicious of any information that supports change, especially if these changes to policies have been implemented without community consultations.
Senator Ridgeway describes the deplorable state of Aboriginal and Torres Strait Islander health, in which, he believes, Australia continues to ignore. He argues that while health professionals’ primary concern is ‘healing’, this unfortunately does not seem to apply to Aboriginal and Torres Strait Islander people (National Health Summit, 2003).

Throughout history Aboriginal people have been depicted as being disadvantage victims summarized in mortality and morbidity data, rather than as being involved in the construction of their own history of resistance to colonial oppressions.

Sexual health has always been identified, but limited attention was given to Aboriginal people until HIV/AIDS was identified and diagnosed. Most sexual health services in the early days in NSW were predominantly western-focused, with special clinics for non-English speaking people, Chinese or gay men’s clinics. When we review the actions of health policies, it is with great sadness because even though there was a low level of health for Aboriginal people and high rates of sexually transmitted infections, actions to safeguard Aboriginal people were extremely limited.

The Aboriginal Medical Services carried the burden of most health concerns for the community, which resulted in their resources being stretched over many areas. There has been ongoing lobbying for an increase of Aboriginal Health Workers for mainstream health services by Aboriginal Employment Coordinators. This initiative is due to the high level of hospitalization by Aboriginal people.

The National Aboriginal Health Policy had been developed and implemented since 1987 and evaluated in 1994, which also recommended the increase of Aboriginal health positions to raise community awareness on health issues.

There can be no doubt that Aboriginal communities have suffered in every way possible, with the breakdown of the communities Aboriginal people have experienced a wide range of social
problems including abuse, personal dysfunction, ill health, addiction, poverty, political powerlessness and collective dependency and despair (Eckermann, et al, 1995).

In the 1800's there were high rates of infections and low life expectancy; in the 1900's there was high rates of infections and low life expectancy; in the 20th century there were high rates of infections and low life expectancy; and in the 21st century there are still high rates of infections and low life expectancy for Aboriginal people.

Poor access, under-diagnosis and under-reporting of sexually transmitted infections are such a great concern for Aboriginal people that many strategies and health plans have been devised to work towards improving sexual health for all Aboriginal people to a point where we are receiving the best health services available. However, many services have failed to reach their target groups. The attitudes of health professionals towards Aboriginal people have been another barrier as this type of stigmatizing behaviour is extremely detrimental to the uptake of health care.

The National Indigenous Australians Sexual Health Strategy provides a great plan in addressing the sexual health concerns for Aboriginal people, the same as all the other Aboriginal strategies, policies and work force frameworks, yet there has only been a small improvement in health for Aboriginal people.

It is incorrect to presume that Aboriginal people do not utilize primary health care services as Forrest & Plummer (1999) argues, but what they do point out is that these services are not designed for marginalized groups, such as Aboriginal people. This is indicative of mainstream services, which are seldom culturally appropriate and are not flexible enough to work with a diverse population.

One direction that a health service can make to begin to work with Aboriginal people, is to prioritize the health issues of the Aboriginal community, address the information received from the community and ask whether the information is accurate, reliable and involved community participation.
Improving sexual health for Aboriginal people does not solely depend on policy interventions it also depends on the development of community and family action, economics and spiritual healing (Public Health Association of Australia: Policies on Indigenous health).

The state of Aboriginal health is a serious one, so how can it change. There are strong supportive strategies that not only provide the best plans for the development of effective and efficient health services for Aboriginal people, they also have been guided through extensive community consultations. Yet, implementing these strategies in Area health sectors seems to be ineffective. Area Health Services in my belief need to be more accountable when addressing health priorities for Aboriginal people.
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