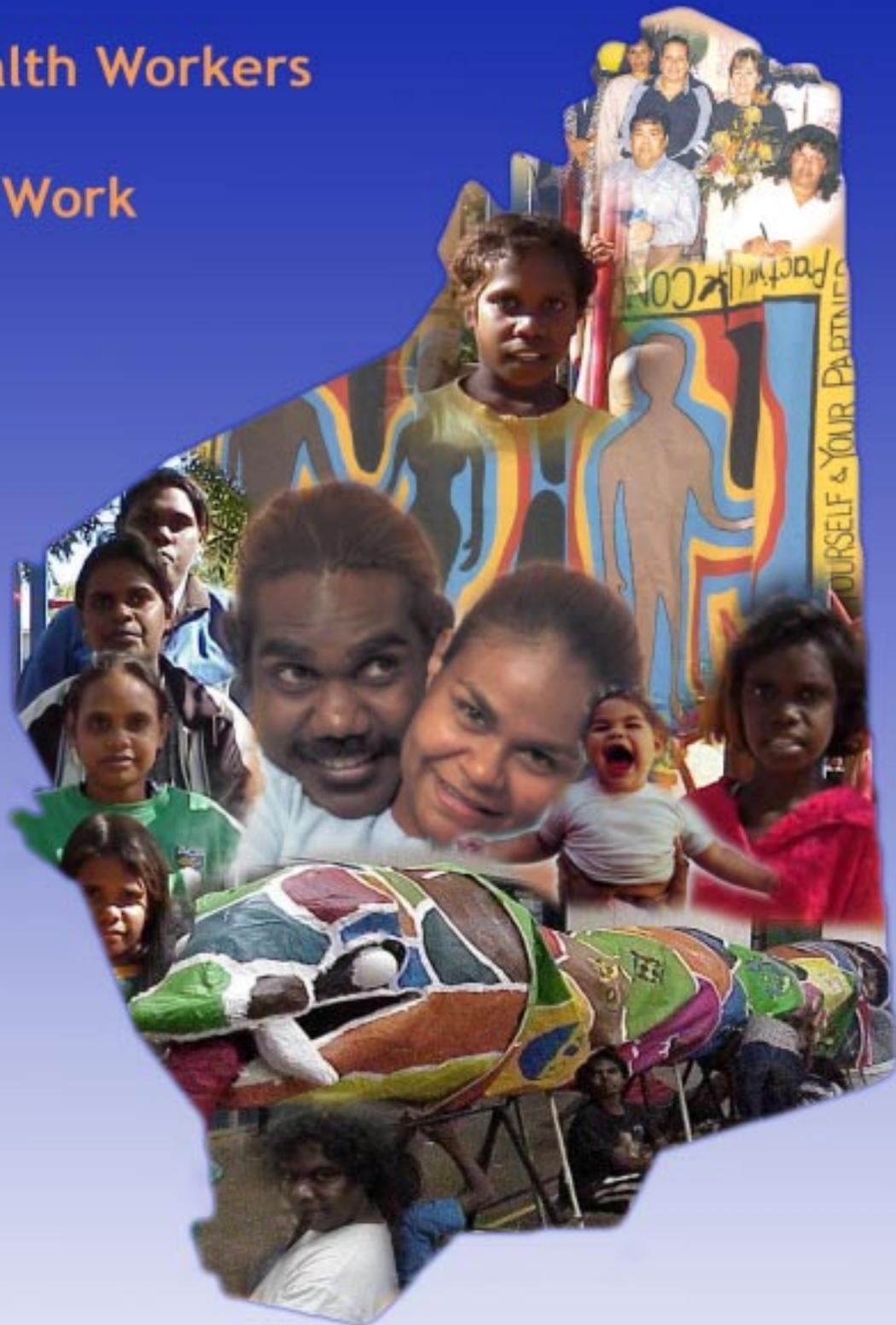


ngalypa muwarr

Stories from
Aboriginal Health Workers
involved in
Sexual Health Work



Recorded and edited by

Juli Coffin

Combined Universities Centre for Rural Health

ngalypa muwarr

Stories from Aboriginal Health Workers involved in Sexual Health Work



Back Row (L-R) Veronica Walsh, Josie Adams, Marilyn McKenzie, Cora O'Donahue, Roz Kelly
Front Row (L-R) Betty Logan, Donald Abdullah, Donna Schultz

1999 students in the 'Identification, Treatment and Prevention of Sexually Transmitted Diseases' course run through Bega Garnbirringu Aboriginal Medical Service, Kalgoorlie

Recorded and edited by
Juli Coffin

Combined Universities Centre for Rural Health

For the Department of Health, Western Australia

Cover:

Language used in the title belongs to the Nyangumarta people in the North West of Western Australia, specifically the Pilbara region. *Ngalypa* means good and *muwarr* is a yarn or story about something. In this case, the *ngalypa muwarr* is about sexual health work in Aboriginal communities.

Thanks to Bega Garnbirringu (Kalgoorlie Aboriginal Medical Service) for the use of the photo depicting the graduates from the 1999 sexual health course in 'Identification, Treatment and Prevention of Sexually Transmitted Diseases'.

This project was funded by the National Indigenous Australian Sexual Health Strategy, through the Office of Aboriginal and Torres Strait Islander Health, Commonwealth Department of Health and Ageing.

This publication has been produced by the Sexual Health and Blood-Borne Virus Program, Communicable Disease Control Branch, Population Health Division of the Department of Health (formerly the Health Department of Western Australia).

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FOREWORD

There is no doubt that it is timely for new information to be included into traditional ways and values. In the past, the paradigm for living had been accepted with very little change through the years. Now that the world has become a global village, the old and the new have to be woven together in such a way as not to disadvantage our people.

Our holistic approach to health care must be maintained to have meaning in our way of life, and because of our family values, language is very specific as to how, when and where we approach clients. It is fitting, then, that confidentiality and credibility must be maintained, especially in small communities. It is important for the Aboriginal Health Workers to be making the decisions about how, when, where and why treatment and education are given to their community for the protection of families and relationships.

We need to be the decision-makers because it is the Health Workers who know the dynamics of the families. This has been demonstrated quite clearly by the words of the Health Workers in this book.

If there are going to be any inroads into getting above this serious problem, then the medicos and nurses must listen to the Health Workers who are skilled in engaging their people in dialogue, care and treatment of sexually transmitted infections.



Joan Winch, A.M.
Centre for Aboriginal Studies
Curtin University of Technology
Western Australia

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Photograph courtesy of Kevin Dorizzi, 'Fathers and Sons Camp', Bremer Bay, 1999. An annual event designed to reduce the communication gap between our male youth and their fathers and to assist with all health healing.

ACKNOWLEDGEMENTS

I am most grateful to the following Aboriginal Health Workers for agreeing to be interviewed for this project, for granting the Combined Universities Centre for Rural Health permission to use the resulting material in the formulation of this document, and for approving the final draft for publication. Their enthusiastic participation has been very much appreciated.

Female Health Workers

- Pansy Sambo – Roebourne Community Health Centre
- Aimee Trust – Senior Aboriginal Health Worker, Wyndham Hospital
- Shirley McMahon – Gascoyne Public Health Unit
- Kathleen Satour – Laverton Health Service
- Joyce Dimer - South West Aboriginal Medical Service
- Karen Mitchell – Gascoyne Public Health Unit / Sexual Health Unit
- May Eckerman – Mid West Community Health Service

Male Health Workers

- David Cox – Kununurra via East Kimberley Aboriginal Medical Service
- Kevin Dorizzi – Kalgoorlie Public Health Unit
- Michael Doyle – Derbarl Yerrigan Perth Aboriginal Medical Service
- Cyril Hayes – Gascoyne Sexual Health Unit
- Rodney Monaghan – Pilbara Public Health Unit

The Western Australian (WA) Department of Health has been instrumental in the formulation of this project, along with the provision of funding and guidance. I am especially grateful to Sandra Thompson, Medical Coordinator of the Sexual Health and Blood-Borne Virus Program, and Heath Greville, Program Coordinator of the Sexual Health and Blood-Borne Virus Program, for their patience and direction throughout the project, and to a supporting reference group including Marian Kickett, the key person concerned with cultural security at the Office of Aboriginal Health, and Michael Doyle, an Aboriginal Health Worker with sexual health experience in both Perth and the Kimberley.

I also thank all the interviewees' employers and colleagues, as without their support the project would not have been possible. I would like to acknowledge the contribution of Dr Marisa Gilles, Director of the Carnarvon Public Health Unit, and Community Nurse, Charmaine Lingard, of Wyndham Health Service.

Thanks for support from colleagues at the Combined Universities Centre for Rural Health: to Ann Larson, for her advice and mentoring; to Liz Brain for transcribing the taped interviews and for helping with the presentation of the final document; and to Gill Hutcherson for editorial assistance.

PREFACE

Sexually transmitted infections (STIs) can be a difficult area for health care providers and community members alike. Sexual health touches on the most intimate parts of life and requires a very special range of skills and attitudes. Trusting relationships between community members and health services can be made and broken through this work. In Aboriginal community situations, the role of Aboriginal Health Workers (AHWs) is essential.

Juli Coffin and the Combined Universities Centre for Rural Health are to be congratulated for so carefully documenting the voices and experiences of AHWs who apply their professional skills to sexual health. It is great news that so many AHWs are finding work in the sexual health area both challenging and satisfying.

These stories introduce the people behind the roles and give the reader insight into the backgrounds and personal styles of AHWs, and the working environments that enable good outcomes in sexual health. The stories illustrate the approaches that skilled workers take, and provide lessons to both Aboriginal and non-Aboriginal health care providers.

It is clear that there are optimum conditions for this kind of work which are frequently not met. For example, teams which include both male and female AHWs, and appropriate clinic set-ups that provide separate male and female access, are not widely available. Comprehensive, sustained STI programs that include health promotion and community education, confidential testing and follow-up, condom availability, good data collection and regional protocols are still being developed in many communities. Aboriginal control and ownership of STI programs, while gaining strength in some areas of the State, is still developing in others.

Yet, while there may be barriers that are out of the hands of the workers, *Ngalypa Muwarr* documents some wonderful examples of AHWs working creatively to provide the best service possible for their communities. Workers who have successfully established good professional relationships with a range of health care providers across agencies, and developed innovative programs and ways of working with individuals, families and communities are to be applauded. It is great to hear their voices speaking through the pages of this book.



**Bob Kucera APM MLA
MINISTER FOR HEALTH**



INTRODUCTION

What is the value that you would place upon people who liaise between two totally different cultures to ensure results, policy uptake, compliance and so on, whilst still maintaining a position within one of those cultures? Would you consider them important? Essential? Integral? Or all of the above?

Sexual health involves working with extremely sensitive matters and deeply personal issues. It is work that requires courage, sensitivity, persistence and a very down-to-earth approach. Incorporating sexual health into Aboriginal Health Worker roles is not always easy, but today there are plenty of inspiring examples of how Health Workers have taken on the challenge brilliantly, be it in the community-controlled health sector or in the State system. This helps to ensure the cultural appropriateness of the work and of the individual concerned. Yet, difficulties for the Aboriginal Health Worker involved in sexual health still occur, which require commitment, ingenuity and creativity to overcome.

While the 'good stories' of some Aboriginal Health Workers describe encouraging indications of change in Aboriginal people's attitudes to the sensitive matters of discussing and achieving sexual health, sexually transmitted infections (STIs) are still a major Aboriginal health problem. To achieve further progress, it is essential to analyse the experiences, strategies and advice of Aboriginal people already working in this field.

Background to this report

Early in the year 2000, the Sexual Health and Blood-Borne Virus Program of the Department of Health called for expressions of interest in running a project to collate and examine the 'stories' of Aboriginal Health Workers involved in or specialising in sexual health work throughout the state. The tender of the Combined Universities Centre for Rural Health, Geraldton, was accepted. A suggested outline for the project was devised by a steering committee consisting of Health Workers, senior Aboriginal Health personnel and Sexual Health and Blood-Borne Virus Program senior staff. Their brief was to produce a report to be used as teaching material for people working or planning to work in the area of Aboriginal sexual health.

And so began the enormous logistical and time-consuming task of tracking down appropriate Aboriginal Health Workers, and recording their experiences and 'good stories'. Interviewees were chosen according to a mix of gender, age, community status, experience in sexual health work, location and employer (state or community). Community members were consulted in their selection, as were other Aboriginal Health Workers. Some of the latter felt it appropriate that more senior Health Workers be selected in preference to themselves.

With steering committee and community input as to the suitability of the questions, I devised an interview format, keeping the questions as open-ended as possible (see Appendix, page 59). The stories and experiences recorded in response were as varied as the individuals themselves. Interviews were conducted face-to-face wherever possible, otherwise by telephone. Face-to-face interviews usually lasted for approximately 40 to 60 minutes. Most telephone interviews took longer because of the necessary introductory and familiarisation process between the interviewee and myself. Participants stressed the importance of having privacy to do their interviews. All were happy to be interviewed, and thought that the project was worthwhile and would be a useful learning tool.

*I reckon what you're doing's fantastic. That's what I'd like to add. Yeah, I hope you have a lot of success in doing what you're doing. This sort of stuff needs to be done, and I hope there's a lot more people who are willing to work in sexual health in the future from this sort of stuff that you are doing. **Michael.***

PROFILES OF THE HEALTH WORKER PARTICIPANTS

Most of the interviewed Aboriginal Health Workers were from the region in which they now reside and work. Of the few who were originally from other regions, all had lived in their current area for some time now (average five years). Those who did not belong to the particular country where they were now working had family connections to the community through extended family. Community members were able to identify them because of their general knowledge of familiar Aboriginal family names and of the movement of the Aboriginal population throughout the State.

Most of the females were older and more experienced than the males. Seemingly, it is more acceptable for men to deal with the intricate work of sexual health at a younger age. Culturally, a young male is considered a man and treated quite equally, whereas a female is accorded respect after she has had children, rather than at any set age. Perhaps, also, a shortage of males in the field attracted younger men in the hope of gaining senior positions through specialisation. The average number of years of being in the Health Worker position varied greatly between males and females interviewed, the males averaging 3.5 years and the females 16 years. Of the females interviewed, several had been in the role for over 18 years, whilst the maximum for the male health workers was four years.

All were trained to Level 4 as Aboriginal Health Workers in the State health system, or to the equivalent level in the Aboriginal Medical Service. Some had completed the Advanced Certificate in Sexual Health, also called the 'Identification, Treatment and Prevention of Sexually Transmitted Diseases Certificate', or similar, though not all interviewees had completed additional training in the area of sexual health.

At the time of the interviews, there were four male Aboriginal Health Workers who specialised in the area of sexual health, and one female. The remainder of the interviewees were employed in generalist positions, often with an emphasis on Men's Health or Women's Health, which encompassed a more subtle sexual health role.

The yellow dots on the map of WA indicate where the Health Worker was based at the time of interview. It should be noted that some Health Workers have moved on since the interviews were held.



DAVID COX

Born: Broome, Kimberley, WA

Family Origins: Bardi/Nyulin

Background:

David grew up in Broome until Year Seven, when he went to Perth to do his higher education. After completing this, he travelled around the country until settling in Wyndham, where he has lived for the past 17 years. David has worked in a variety of areas, including the Katanning area where he was a Community Health Worker for three years, and the Kununurra region where he worked for the community and health services for a further year.

For the past six years, his main focus as an Aboriginal Health Worker has been on sexual health. September 2000 saw a change in roles for David as he became one of several Youth Health Workers. In his new role, David still has a strong emphasis on sexual health, but his target is Aboriginal youth.

Things that David enjoys about Aboriginal sexual health work:

- Travelling to Oombulgurri, Warmun, Kalumburu and different communities with the youth services;
- Working out-of-school hours with youth;
- Helping people with the Aboriginal Medical Service or mainstream.

Things that make David's job difficult:

- Having the time to get to know the community;
- Dealing with the religious aspect of some communities;
- Presenting information with the issues that are different in each place and different youth groups to talk to.





JOYCE DIMER

Born: Pingelly, South West, WA

Family Origins: Noongar (spelling from south west WA)

Background:

Joyce works for the South West Aboriginal Medical Service. She has been a Bunbury resident for the past 25 years and has a lot of community experience within the areas that she covers.

As an Aboriginal Health Worker, which she has been for three years, Joyce has covered sexual health in a general sense. However, she has recently embarked more specifically on a career in Aboriginal sexual health work in the Bunbury community. She is developing some specific programs and education sessions in the schools and surrounding community. She is very keen to develop more school education, and believes youth should be the focus of sexual education delivery.

Things that Joyce enjoys about Aboriginal sexual health work:

- Contact tracing;
- Seeing people;
- Doing education;
- Giving education to people who want to improve their health.

Things that make Joyce's job difficult:

- Cultural difficulties;
- Getting people to come into the clinic;
- Being new as a service in the area;
- Getting through to the young ones.





KEVIN DORIZZI

Born: Cue, Murchison, WA

Family Origins: Yamatji/Wongi

Background:

Kevin was raised mainly around the Cue area, where his father worked the railway tracks. He and his 12 siblings moved around a lot. After Kevin's father passed away, his mother and the family settled in Geraldton for some time. Kevin soon married and moved out to Eradu with the railways mob.

After 14 years with the railways and other employment, he went to seek out a new career. It was his sister who suggested that he look into becoming a male Aboriginal Health Worker.

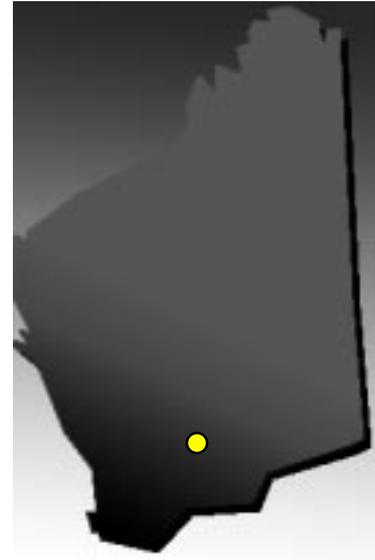
After working in Newman on men's health projects for a number of years, Kevin, with his wife and family, moved to Kalgoorlie, where they have lived for the past five years. Kevin has been heavily involved in Aboriginal sexual health work in rural and remote WA for many years, in both general and specific program capacities. Currently, he has the title of Men's Health Educator, and deals with many issues of general and sexual health for men in the Wongi area. He has been working with the Kalgoorlie Community Health Unit for three years, and has been based with the Public Health Unit for the last year.

Things that Kevin enjoys about Aboriginal sexual health work:

- Educational delivery;
- Being a Men's Health Educator;
- Running workshops;
- Forming links across the regions;
- Developing men's health materials.

Things that make Kevin's job difficult:

- Not having an Aboriginal female to do the women in the area in the same role as me;
- Contact tracing when the skin groups are mixed.





MICHAEL DOYLE

Born: Geraldton, Mid West, WA

Family Origins: Djarindjin community, Kimberley, WA

Background:

Michael completed high school in the Geraldton area, then moved to the family home at Djarindjin community. Michael's work has been around the Broome community, Djarindjin and Perth metropolitan area, where he has developed much knowledge and experience from his work in Aboriginal sexual health.

Michael completed his Aboriginal Health Worker training in 1998, and has also completed the Advanced Certificate in Sexual Health Work from the Kimberley Aboriginal Medical Services Council. He has been working in Perth now for just two years, and is currently employed with the Derbarl Yerrigan health service in a health promotion and clinical follow-up role. He runs up to four PASH (Promoting Adolescent Sexual Health) programs each week.

Things that Michael enjoys about Aboriginal sexual health work:

- Working with people and their reaction to what I am doing and teaching them about;
- Education in sexual health with the youth, for example, in the detention centres and schools;
- Liaising and forming partnerships with other agencies and organisations, and dealing with them to get a better outcome for Aboriginal sexual health.

Things that make Michael's job difficult:

- Bringing up a topic that people just don't want to hear about;
- Dealing with young women when it's not really appropriate.





MAY ECKERMAN

Born: Whim Creek, Pilbara, WA

Family Origins: Marble Bar (father/English, Port Hedland)

Background:

May was born approximately 100 kilometres from Port Hedland. She has worked as an Aboriginal Health Worker for some 18 years and directly as an Aboriginal Sexual Health Worker for two years. Most of her work has been around the Pilbara area, including both remote and town locations within this division.

May has many family members throughout the Pilbara, and has spent time living in Marble Bar, Port Hedland and now Geraldton. She was based at Community Health in South Hedland for seven years and Marble Bar commencing in 1982. During her career, May has been covering all areas of Aboriginal health work, from diabetes education to women's health, to contact tracing and STI education.

Currently, May is employed with the Geraldton Health Service, and is heavily involved with immunisation and community health work. May has a wealth of knowledge, and has completed many training courses and updated her skills through university courses such as the Associate Diploma in Aboriginal Health, through Curtin University of Technology, during 1994/95.

Things that May enjoys about Aboriginal sexual health work:

- Going to remote communities;
- Getting the trust of the communities;
- Sexual health education;
- Health promotion and prevention;
- Working with colleagues and other health professionals.

Things that make May's job difficult:

- The shyness and the shame of sexual health matters;
- Having to really build up trust before doing anything;
- Getting the message across to youth.





KATHLEEN SATOUR

Born: Alice Springs, NT

Family Origins: Northern Territory

Background:

Kathleen grew up in South Australia around Port Augusta. She has since lived in Alice Springs in the Northern Territory, around the Gulf country, and in the Kimberley and Pilbara regions. Kathleen has been based at Laverton for about three years, firstly with the Aboriginal Resource Centre and, in the last two and a half years, as a Health Worker with Community Health.

Kathleen has a strong involvement with Aboriginal sexual health issues, and often visits the local school to deliver education sessions. Being nominated by the local Aboriginal council, and knowing that the community has backed her to complete the Aboriginal Sexual Health Worker course, have given her a great deal of confidence in doing her job. Kathleen almost completed her teacher training qualification and utilises this in her varied tasks as a Health Worker.

Things that Kathleen enjoys about Aboriginal sexual health work:

- Being a woman and just working with women;
- Education and going into the schools;
- Using teacher training as a basis for education delivery.

Things that make Kathleen's job difficult:

- No male Aboriginal Health Worker based with me;
- Dissatisfaction from the local people with the health service;
- Some of the issues of working in a non-Aboriginal health service;
- Segregation of the town;
- Visiting health specialists' restrictions.



CYRIL HAYES

Born: Carnarvon, Gascoyne, WA

Family Origins: Onslow (Thalanji language group)

Background:

Cyril was based at the Carnarvon Mission in his early years, and grew up in the Carnarvon community during his schooling. He has many relatives in town through his mother's side. Cyril has been a Health Worker for four years now, and has specialised in sexual health for about the last three years. He has the trust of many in the Carnarvon community, and finds his work is getting easier as more people are talking about sexual health and the barriers are being broken down. Cyril works very closely with his female counterpart, Karen Mitchell, and with Dr Marisa Gilles.

Things that Cyril enjoys about Aboriginal sexual health work:

- A lot of people know me, they trust me and confide in me;
- The fact that it is confidential;
- Forming trust relationships with people;
- Breaking down the barriers.

Things that make Cyril's job difficult:

- The nature of this business, in that it is a hush-hush thing to talk about matters;
- It's hard to pick up family relatives and be neutral;
- Approaching people to do a contact trace at certain times and situations.



SHIRLEY McMAHON

Born: Northampton, Midwest, WA

Family Origins: Naaguja language group

Background:

Shirley grew up in Northampton and moved to Carnarvon in her late teens. After living there for 20 years, she applied for the job of Aboriginal Health Worker with the Health Department in 1978. She has been commended for 20 years of service with the Gascoyne Health Service; it was 22 years on 11 September, 2000. Shirley puts her long-standing position and continued service down to a few basic facts, one of which is the trust that she has developed within the community. As a stable face in the health system of Carnarvon, she has seen many changes in her role, the health system and the health of her people.

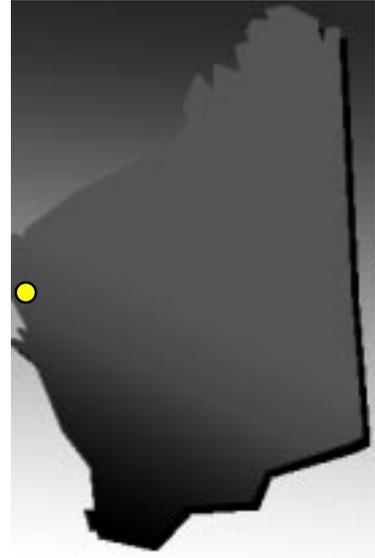
Truly a credit to the Health Worker profession for her commitment and insight into Aboriginal health in her region, Shirley never tires of learning and sharing her knowledge with others who may come and go. She attended Curtin University of Technology in 1994/95, and has achieved an Associate Diploma in Health.

Things that Shirley enjoys about Aboriginal sexual health work:

- Working with Aboriginal people;
- Finding the solutions to help our people overcome sickness and disease;
- Seeing people take responsibility for their own health and well-being;
- Seeing changes happen.

Things that make Shirley's job difficult:

- Covering up the reason for tracing a client, when, for example, the mother or aunty would ask questions about the nature of the business;
- Having to get the Health Department to intervene (just one time);
- Not having a male Sexual Health Worker based with our service (in the past).



KAREN MITCHELL

Born: Carnarvon, Gascoyne, WA

Family Origins: Yamatji

Background:

Karen went to school in Carnarvon and then worked for seven years as a domestic at the Carnarvon Regional Hospital. She then worked for seven years as an Aboriginal Health Worker at the Aboriginal Medical Service in Carnarvon. The following six years were spent working with the Gascoyne Community Health/Public Health Unit.

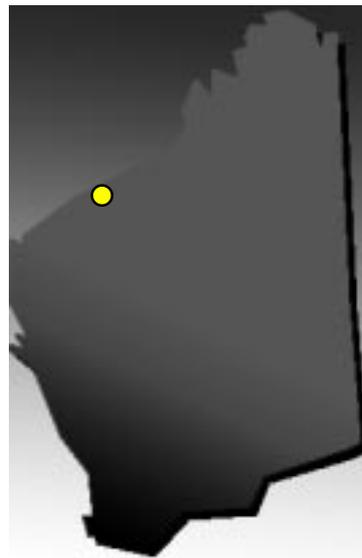
For the last five years Karen has concentrated on purely sexual health issues, and during this time she received an award from the Public Health Association of Australia (WA Branch) which stated 'Karen has been recognised for her outstanding contribution to public health in Western Australia and has been conferred the Public Health Association of Australia, WA Branch, Community Award for 2000'. Karen has also earned an Associate Diploma in Health and a Degree in Aboriginal Health. She is a member of the National Indigenous Australian Sexual Health Committee.

Things that Karen enjoys about Aboriginal sexual health work:

- Working mainly with young girls and talking about sexual health, family planning, contraception;
- Different types of STIs, explaining about the different types.

Things that make Karen's job difficult:

- Contact tracing, how and when to approach the individual, that is, the right time to approach them.



RODNEY MONAGHAN

Born: Moora, Mid West, WA

Family Origins: Nyamal tribal group, Pilbara

Background:

Rodney has been in the Hedland area all his life, and has close relatives throughout the Pilbara region. He originally did all his Aboriginal Health Worker training in the old system, and worked for two years with South Hedland Community Health. After this, he worked for over five years with the Youth Involvement Council.

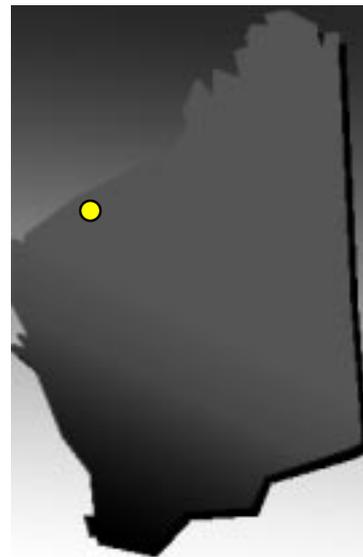
Upon Rodney's return to the Aboriginal Health Worker field, he had to re-do all his training. This is now nearing completion, with one unit left before graduation. For the last two years, Rodney has been employed as the male Aboriginal Sexual Health Worker with the Pilbara Public Health Unit. This job is due to change, allowing him more scope and involvement in other program areas such as Men's Health.

Things that Rodney enjoys about Aboriginal sexual health work:

- Showing slides and getting people thinking about their past sexual behaviours;
- Testing people;
- Contact tracing;
- Getting an immediate impact from people.

Things that make Rodney's job difficult:

- Contact tracing people who move around a lot;
- Having to do the initial contact on a woman;
- Telling a male that his wife will have to be notified or asking them to tell their partner;
- Talking to old people about cultural practices for men's business.



PANSY SAMBO (centre)

Born: On a station near Wittenoom Gorge, Pilbara, WA

Family Origins: Yindjibarndi language grouping, Roebourne

Background:

After 16 years as an Aboriginal Health Worker in the Roebourne community, Pansy has seen many changes and faces throughout her role. As a generalist Aboriginal Health Worker, she has dealt a lot in the areas of contact tracing and education. She does not get involved with the clinical side of the Sexual Health Worker role, but does educate and advocate the treatment and following of directions with all clients when appropriate.

Being a female who is related to many people and groups in the Roebourne area, Pansy often works in with other Health Workers from the local Aboriginal Medical Service to deliver education and treatment. Pansy works across tribal groups and, besides her own tribal group, has Ngarluma and Banjima links within the community.

Things that Pansy enjoys about Aboriginal sexual health work:

- Working at getting around the difficulty of approaching sexuality issues;
- Being in a position where I am able to help someone;
- Finding solutions;
- Being elected to do this job by the community.

Things that make Pansy's job difficult:

- Keeping things culturally appropriate;
- Not being able to talk to certain men about sexuality issues (this is to do with skin group);
- Domestic situations with a patient returning home when you have no control over them.



AIMEE TRUST

Born: Halls Creek, Kimberley, WA

Family Origins: Gidja tribal group, Halls Creek

Background:

After growing up in Halls Creek, Aimee moved to Wyndham in 1976, where she has been a Health Worker in the community for over 20 years.

Aimee has an integral role within the Wyndham District Hospital (Community Health) in the delivery of sexuality education to Aboriginal people, is in the respected position of being an elder, and has the support of the community. In her efforts to improve Aboriginal sexual health, Aimee works very closely with many other health professionals. Her advice is well respected and the approaches that have been taken with sexuality education are successful and varied. Each approach must be catered specifically to match the needs and style of delivery suitable to the particular community being targeted. Aimee's role as a guide and facilitator to the sexuality program is an ongoing example of how Aboriginal knowledge and culture can be utilised to formulate and deliver a successful and vital program.

Things that Aimee enjoys about Aboriginal sexual health work:

- Trying to get the message across to young people;
- Giving awareness education sessions on early pregnancy;
- Addressing the STI problems we are facing today;
- Education in general.

Things that make Aimee's job difficult:

- Talking about sex in general or during education;
- The issue of shame;
- Dealing with direct family relations (brothers and male side);
- Occasional friction amongst family members during work.

SECTION ONE

From the ocean to the desert: The diversity and the complexity of Aboriginal sexual health work in Western Australia

It's a good area to work in. We're working for our people, and health is a big issue amongst our people at the moment. And even though they do come across a lot of barriers that might make it difficult for them to work ... if they can just persevere there, it's a good area to work in. Cyril.

The diversity of sexual health work

Aboriginal Health Workers in WA work in a vast array of locations (desert, rural, coastal and urban) and in a variety of positions within the health system, be they within community-controlled or State health organisations. Community-controlled Aboriginal health services, such as the Geraldton Regional Aboriginal Medical Service and other Aboriginal Medical Services, are funded by the Commonwealth through the Office of Aboriginal and Torres Strait Islander Health (OATSIH). State health services, such as the South Hedland Community Health Centre and Wyndham District Hospital, are funded by the State. Each of these two health systems also provides its own career structure and award levels, which can sometimes create a problem when a Health Worker trained in one system takes a job in the other (see Section Three).

Work roles vary amongst the services and the range of jobs is very diverse. For example, within the Aboriginal Health Worker role there could be screening for trachoma and otitis media, immunisations, providing appropriate health education, and advocacy for health service delivery. Specialisation does occur within both the State and community-controlled health systems, for example, in the areas of sexual health, renal dialysis, infant and maternal health and so on. Some health centres provide Aboriginal Health Workers with additional professional training to specialise, or provide on-the-job training to those who wish to take on a specialty role.

While some Aboriginal Health Workers specialise in sexual health work, for many others this is only part of their role. Urban-based Aboriginal Health Workers, in particular, may fill a specialist role in sexual health, in which case they will divide their time amongst education for sexual health, testing for STIs, 'contact tracing' (i.e., tracing everyone who may have been in contact with a positive case), treatment, follow-up, and sometimes counselling-type activities.

Many Aboriginal people live in a physical environment that would be considered unyielding by most outside observers. Their local Community Health Clinic or Aboriginal Medical Service is usually their only point of contact for health care and all medical conditions. In these more remote locations, such as Laverton, the Aboriginal Health Worker must be a 'Jack of all trades', shouldering increased responsibilities and a higher diversity of everyday activities. In such cases, sexual health work becomes only one of the Aboriginal Health Worker's duties.

Sexual health is a complex and difficult area to deal in, particularly within Aboriginal communities. An analysis of the final section in each of the 12 preceding Health Worker Profiles suggests that the difficulties can be broadly divided into cultural, personal, ethical and practical categories, although it is not always easy to separate these out. Despite the difficulties, however, Aboriginal Health Workers both enjoy and gain considerable satisfaction from their sexual health work, and some have noted definite signs of progress in getting their message across.

Cultural complexities

In this section, the terms 'Lore' and 'Law' are used to describe two different issues in Aboriginal culture. Lore refers to the knowledge of kinship, cultural protocols and Aboriginality issues, whereas Law refers to the business of becoming a Man in an Aboriginal social context.

The most obvious cultural difficulty is the shyness and the shame attached to talking about sexual health matters in Aboriginal communities. As Cyril said, *'It is a hush-hush thing to talk about sexual matters'*, and Michael found it difficult *'bringing up a topic that people just don't want to hear about'*.

*You don't get many Aboriginal people talking about it. It's taboo in our culture, and we find it very hard sometimes, what we should be giving our kids. **Aimee.***

*Some of the cultural difficulties are dealing with some of the more traditional people. They just don't want to hear about sexual health at all, and that's because of their bringing up and their views. Although you've got to say about being safe and so forth. **Michael.***

*With the cultural difficulties, I think it still goes into the shame. Even with ... our Pap smears, also, it's hard to get the ladies back in. **Joyce.***

*The shyness of it, the shame ... They are very shy at first and, of course, the shame part of it. **May.***

Shame, or the fear of shame, amongst Aboriginal people is a concept that often hinders sexual health work, as people do not like to be singled out or to be made to feel different in any way. Sexual business is private and not openly discussed unless you are with the right family member. Shame may not only be attached to talking about sexual matters. Shame may arise merely from being asked for a urine sample. Shame may prevent people from coming into the clinic when they need to, and especially so if they know a relative is working there.

Particularly inappropriate is discussing sexual matters with members of the opposite sex. Ideally, there should be both male and female Health Workers available to every community, but this is not always possible. In the remote and more rural areas especially, a shortage of Aboriginal Health Workers means that only a male or female may be available and, due to the stricter protocols of these areas, it is often hard for the Health Worker to actually get through to the people who need his or her help the most.

*Yes, sometimes, like for the men, they really do miss out. They will, if there's something wrong - you know how they give little signs - they'll look at me funny, so I just know they don't want me there. There's all those sort of things. I mean, we do have a male Aboriginal Health Worker in Kalgoorlie but he, because of time restraints, can only come here [Laverton] a couple of times every year. So our men really miss out. **Kathleen.***

A lone Aboriginal Health Worker's ability to carry out contact tracing successfully is also affected, as contacts are likely to include members of the opposite sex.

Certain Aboriginal ceremonial traditions, such as Men's Business and Sorry Business, can lead to further complications. For example:

*The hardest part was, like, talking to some elders about when they do law business. That's the hardest part because, you know, a lot of the old people are set in their ways, but we just like told them about other people getting diseases from the blood and stuff like that. **Rodney.***

*We try to avoid those times ... sorry time and men's business ... we try to do lots of the education before men's business starts. **Kevin.***

*If there was law business, we didn't go out to the communities ... or a funeral ... We'd ring before we went out there anyway, to make sure that we were allowed out there, and they'd tell us. But, yes, there were barriers there ... there'd be weeks when there were funerals on or law business. **May.***

Specifically Aboriginal social structures can also make things challenging. For example, in many areas, Aboriginal people are divided into what are known as 'skin' groups, and sexual relations are only appropriate between members of certain skin groups.

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

Some other Aboriginal social structures mentioned also create issues for health care provision. For example, conversation between people in certain relationships is prohibited, and men may have more than one wife, which changes the way in which health professionals - be they Aboriginal or non-Aboriginal - tackle the health issues.

One Aboriginal Health Worker commented that when skin groupings prohibit his talking to particular community members, he was able to ask the male Aboriginal Health Worker at the Aboriginal Medical Service to follow-up.

It should not be forgotten that Aboriginal Sexual Health Workers have themselves been socialised in the same way as other Aboriginal people. Having sometimes to work in a manner contrary to learned protocols can be uncomfortable for them, too.

Personal difficulties

The Aboriginal Health Worker's age may present some problems. In Aboriginal society, the respect accorded an individual tends to grow with age.

*One of the other difficulties I've found is - 'cause I'm quite young myself, I'm only 24 - when dealing with young women, I've found, I dunno, difficulties with them. It's not really appropriate to talk to them about sexual health and everything, but when I have been involved from time to time I find that they just laugh, and they don't pay any attention to anything that I'm saying. **Michael.***

*Because of my age, people look at me and say, 'Oh, he's an older guy', you know, sort of show that respect for me. **Kevin.***

The main personal problem, however, lies in the dual role of the Aboriginal Health Worker. He or she is both health professional and, at the same time, a member of the community being served. Relationships with family and community must be preserved. If things go bad, the Health Worker cannot simply get up and leave.

Aboriginal family relationships are extensive, and loyalty to family is an emphasised value. Sometimes, the need for family loyalty may conflict with the requirement for professional neutrality, particularly if someone is fighting or has become 'off side' with a member of the Health Worker's family. It can be hard to be professional and abide by the family at the same time. Particularly in the smaller communities, this places a strain on the Health Worker and on his or her family relationships. It can also work the other way, affecting potential clients.

*Like family feuding ... As a Health Worker, I avoid the people, you know, that I don't want to see; but I have no problem if they wish to see me, you know, if they want to come in. But ... like if someone's got an STD, and [there's] feuding with them, and they know that you're a Health Worker, you know that they're not going to come in. **Joyce.***

*I was up in the community, and I was actually related to both family groups [being contact traced] ... and it was really difficult, going between each family. But in a way each family sort of knew, that's Michael, that's what he does, that's his job, and it wasn't taken out on me or anything, and I did manage to work between both family groups quite well. **Michael.***

In other situations, some Health Workers actually see it as a bonus not to be closely related to all the people in their community, as this avoids them being placed in a position of having to take sides. Such Health Workers feel they are viewed as neutral, and can go about their business as usual.

*I find [working with many different tribal groups] easier because I don't get involved with family business. **Kathleen.***

*Even though I'm not from here, I'm well accepted by the community and I do mix with a lot of people in town. But even though they're not directly related to me, they respect my position in the community. **Aimee.***

*A lot of the people in the community are transient, and since I have been up in the Pilbara, people up there had learnt to know who I am and respect me, and they knew that the work I've done is confidential and respected. I have got trust from people ... they are often transient and when they move down here they know who I am. **Kevin.***

Health Workers also sometimes find it difficult having to deal professionally with family members and remain neutral, for example, having to pick up, treat, or contact trace a family member.

*I found it difficult at first because [of] being related and going out to people, but I also worked at getting round that difficulty ... I don't ever do the treatment [with a relation], like treating the very personal things, like swabs and things, required. I encourage them for taking the treatment and, knowing that person is related, I also confirm the confidentiality. **Pansy.***

Family and community attitudes to the Health Worker's job are important, particularly when it involves specialisation in sexual health. In most cases, it seems that family members are becoming more comfortable with, and accepting of, the varied roles that the Aboriginal Health Worker covers.

*I have got my family's support 'cause they reckon it's a really good job to do, Aboriginal health, and they do know I do a bit of sexual health with that. Like my family is just really happy that I do this job really, and ... [also, when I was living in my community] I sort of thought that I had community support, in the way that people just listened to what I said. **Michael.***

More recently, members within their own community have elected some Aboriginal Health Workers into roles of sexual health; the community was consulted and formed part of the selection and employment process. This form of consultation ensures that the correct person is chosen and his or her skills are widely acknowledged. This means that, in some instances, many of the community members know the role of the Aboriginal Health Worker in relation to sexual health issues. Community support has improved vastly from years past.

*It was the community who sat in with the nurse who interviewed me at the time, so it's always the community makes its choice and says, 'Look, we want this person to be a Health Worker because we know she'll have a good rapport with people in the community'. I think I do have support not only from the family but also from people in the community, because that was a very strong background for me ... There was others that applied, but they saw me as the particular one to be able to work well, because I know the families and because I belong to here ... There were others who belonged to here, but being very Aboriginal [lore way] I guess they look at me as being the best person for health work. **Pansy.***

Ethical difficulties

Ethical considerations are not always clear-cut, and may cause considerable anguish for the Health Worker. On the one hand, health professionals owe it to their clients to maintain confidentiality. On the other hand, the client's partner(s) have a right to know that he or she has an STI. This is a difficult area, where health professionals must act with great discretion.

Maintaining confidentiality is a huge issue, particularly with contact tracing, although just keeping initial testing confidential is an obstacle in itself.

If I would go and look for a person and that lady wasn't there, a lot of times the aunty or the mum would say, 'What do you want to see her for?'. And I could not say what I wanted to see her for. 'Oh, I just want to have a talk with her.' And that was the hardest thing, because all I could say was, you let her know I came to see her and I'll come back, or if she wants to see me to come to the office. Shirley.

In a small town it is not hard to imagine how things get around. In the Aboriginal community, which is fairly tight knit, such information can spread very quickly and be detrimental to many involved. Domestic violence, for example, may result from the implications of one partner having been tested, or the discovery that one partner has other sexual partners.

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

Health Workers are very aware of the dangers, and their own part in bringing such a situation about. Concern for their clients may sometimes cause them considerable anxiety.

If I pick up a woman from the community who needs to come up for treatment, for example, and you're always going to have opposition from the partner ... I always feel a bit saddened by that, or like I always feel that I'm putting someone in a position where they'll get questioned by their partners, like, 'Oh, why did you go up to the clinic and what was it for?', and it goes between the woman and the partner or vice versa ... I always wondered, 'Oh, what happened to that particular one, was she alright after being called in for treatment?'. But that's the biggest worry I have with sexual affairs, especially bringing someone up who's been a named contact. Pansy.

Other difficult issues raised by project participants relate to young people. When named contacts are minors, should their guardians become involved or not? Simply going to the house to ask to see the son or daughter arouses suspicions in the parent. In this case, the Aboriginal Health Worker may try to camouflage his or her reasons for visiting by discussing other issues or perhaps topics outside of health, in order to get the young person away from the family environment.

*There was an incident where a young girl was picked up for treatment and the mother was really going off. She wanted to know why and ... I think there's still a lot of learning in that area, because the consent has to be given by a parent for a kid still under age, like 15, if they're still under the parents ... I find that very difficult and [I've] never really been able to ... I mean I think that's something I need to work at with a nurse, like how ... you know. You don't know whether you have to keep it confidential with the parent, or because the kid is under age do you tell them? It's very hard. **Pansy.***

In the sexual health field, developing trust is obviously supremely important. May found that 'having to really build up trust before doing anything' was one of the major difficulties of her job.

*I think you have to earn trust, and it's a two-way process, and that's what's really made it good about this job, that people have learnt to trust me over the years. **Shirley.***

*They've got a lot of trust in you to talk to you about things involving sexual activities. The other thing is it's pretty confidential, so you don't have to put in reports at a staff meeting or anything like that. **Cyril.***

*I got around it [issues of trust and confidentiality], I suppose, ultimately 'cause the family that I had contact traced and everything all know what I'm like, that I just don't talk to anybody about what they say to me. They say it to me, they don't say it to everybody, and that's how I got around it. It was just my family, my cousins, and everybody just knew that when I came around to speak to them ... I wasn't going to go running down the street telling everybody about what they've got, and this and that. **Michael.***

Practical difficulties

Western Australia is a large state, and Aboriginal people tend to move around a lot. This can make contact tracing, for example, very difficult.

*Sometimes, the hardest part is our Aboriginal people: one day they're here and the next day they're in another town ... So we have to, like, ring other medical services and get them to follow them up. **Rodney.***

Time constraints are relevant here, too, because official policy is that contact tracing for STIs should be completed as soon as possible. Reducing the period of infectivity is a key strategy in reducing the incidence of STIs. It can take a long time to find one person and get a sample. Sometimes this causes great anxiety, as the Health Worker is told to find and bring in a certain person, and that person cannot be located within the set time, or, even if found, refuses point blank to come in and be tested.

*I find it a bit stressful ... You contact trace, OK, and you should do it within two days. If you haven't caught up with a person, or like they say they were notified by their partners and things like that, and nothing's happened, and then you're thinking, 'Now what am I going to do? How am I going to approach this?'. It does get a bit mind-boggling. **Karen.***

Another difficulty for some participants is that their job never really ends. However, others see this as helpful or as a positive indication of success. In large urban centres, working out of hours is less likely to be the case. In smaller community settings, however, the Health Workers are easily accessible at most hours, and at times feel as if they have not knocked off at all for the day. On the other hand, due to the intensity of sexual health issues, this can work well for the clients accessing information and service, as they can approach the Health Worker in a more relaxed and confidential way, rather than turning up at the clinic, only to see many familiar faces and possibly relatives. Also, as community members themselves, Health Workers have a great understanding about all aspects of their clients' lives, which improves the services they provide.

*Like you're out with friends and that somewhere, and they [clients] want you to listen to them at that time, you know ... late in the evening or [when] you want to do something else, but they want to talk to you about something ... like you haven't really knocked off; they still want to talk to you about something ... usually when you're down the pub and that, they want to talk to you about something. **Cyril.***

*It was ongoing. You couldn't say, 'I'm not working now, come over at 8 o'clock'. No, you just speak to people whenever they want to speak to you. **Shirley.***

*[In dealing with tired or difficult children at school] I know, I understand too, like I know who's been up all night because [of] what's going on at home. You know how, you just know, because people just come and tell me things, too. See, if somebody's sick or that, I already know because people will tell me on my way to work or down the shop, because you're really doing it all the time, aren't you? **Kathleen.***

*I don't talk about my work outside of work. As far as everyone's concerned here, I work as a senior Health Worker and that's it, and I work at the Public Health Unit and that's it. **Karen.***

*Well, the best part of my job is sometimes I've finished work and people at the football or the basketball, they ask me for condoms, you know, the young boys. And I've always got them on me, so I give it to them. And sometimes they come out home late at night knocking on the door, 'Oh, I've got a problem', you know, so I fix them up on the spot. That's good because I'm always available for them, and they might be too shamed to come to the clinic. So I fix them up on the spot, and, you know, they're not shamed to come and see me. So that's good. It's like they feel really comfortable, you know. **Rodney.***

The positive side: enjoyment, satisfaction and progress

Despite the complex difficulties discussed above, the Aboriginal Health Workers interviewed find their sexual health work enjoyable and satisfying. The aspects of their work particularly enjoyed vary with the individual (see the preceding Profiles), being to some degree dependent on experience, support and location. Some people even find it fun at times.

*I just had an interest in sexual health. I don't know how I got it ... When you're dealing with that and people's views, and what they say, and this and that, it's quite fun. It is fun, yeah, it gets you going. Like ... a number of blokes I talk to said, 'Oh, the condom break'. And if you had a look at the condoms, he'd stretch it and this and that and everything else - it's bloody hard to break them - so, yeah ... that sort of story that people come up with, you just sort of have a laugh to yourself. **Michael.***

There is also, however, a consistency about the Health Workers' general comments about their role. Helping people is satisfying.

*What's given me satisfaction is to be able to help Aboriginal people, you know, to see the results. And I know there is always room for improvement, but, like things have really improved over the years and I hope they continue to do so ... Especially when you're working for Aboriginal people, you feel so much better, because with our people there's been so many problems. **Shirley.***

*It's helping people mainly, if it's anything to do with health. Doesn't matter where it is, with the AMS [Aboriginal Medical Service] or mainstream. **David.***

The Aboriginal Health Workers have a feeling of usefulness at tackling a big issue that is sometimes not out in the open or being treated in the most appropriate way. They feel that they are doing a real job, an important job, not just on the side of reducing the incidence of certain diseases, but even more so for the fact that they are making a difference. Many comments also indicated that it was reward enough to be respected and acknowledged as someone in the community with a certain specialised kind of knowledge and skill.

Being presented with a challenge and making progress, no matter how slowly, is also rewarding in itself for most Aboriginal Health Workers involved in sexual health. They find that seeing results, however small, is not only satisfying but also keeps them motivated. The steps may be small - seeing more young people in the clinic or giving an increasing number of presentations - but they are happening.

*Just keep at it. I've been at it for four years, and I've noticed a change in them [the people in the community], just being able to speak to them about safe sexual practices and stuff like that. That's been broken down in the four years that I've been in, and in another four you never know what could happen. **Cyril.***

*When you see them pulling you up and saying, 'Oh, I need to get tested ...' I'll say, 'Why, you got disease or what?'. They say, 'Oh, no, no, I just had unsafe sex'; and this is all the drinkers saying this to me. And I think, after talking to this mob all the time, it's finally getting there, you know. Sometimes you think you're talking to a brick wall, but when they say that, you think, at least you're getting to somebody, so you're not talking out of your you know what! **Rodney.***

*I think the younger ones ... want to know more these days ... STDs out here now, with a change of the environment, you know: we've got ... more night clubs, and you've got shipping ... Sailors come in, and I've just recently heard, you know, after the sailors come in, this is the time when a lot of the community are looking to get check ups. **Joyce.***

*I feel I am getting through to the girls, because from time to time they will come up and say, 'Oh, is my Pap smear due yet?'. Or if they've noticed anything funny going on - burning in passing urine, or any discharge, and that - they will come up and let me know straight away. Instead [of], like I found before, [when] they had these things ... they'd leave it thinking that it's going to go away, when in fact it gets worse. **Karen.***

*Sexual health has come a long way. The younger people ... have more confidence to be able to not feel shy or frightened to come up here ... Because of the teaching passed on to the young people, there's more younger kids asking for condoms and things like that. **Pansy.***

*Even the young girls [with me being male], they're coming up to me and talking to me and asking questions, it's really good. **David.***

*Now ... people are starting to take their own responsibilities. You think, 'Well, after all that talking over the years and reinforcing it, people ... a lot of people, are taking their own responsibilities' ... People are coming forward and asking for help, and to me that's a great story. **Shirley.***

These are all 'great stories' to hear.

SECTION TWO

The inside story: How Aboriginal Health Workers go about sexual health business

*People think it's easy just going around getting the screening of people, telling them to piss in a jar. It's not easy. You've just got to know how to talk to them and get their trust and there's all sorts of other stuff, you know, get them at the right time. It's an art, you know. **Rodney.***

How Aboriginal Health Workers carry out their role within a community is, at times, creative and resourceful. It involves keeping a fine line and balance between what is expected by non-Aboriginal health authorities, and what is realistic among Aboriginal people. Health Workers are more successful when they are allowed to interact with clients in their own way and develop their own strategies for overcoming some of the difficulties of sexual health work pointed to in Section One.

The Aboriginal way

Being responsive to the situation is one such way of working:

*[People in the community] know that I will sit and talk with them, whether it's on the football field, in the supermarket, whatever, and I won't say, 'Well, come back tomorrow at eight o'clock and I'll speak to you'. We would sit there and we'd talk, whether it was about the baby was sick or ear problems or whatever. And, not only that, if they wanted to go over and sit on the Fascine, well, we'd go and sit on the Fascine, wherever they wanted to sit and talk. **Shirley.***

I actually love working with the people. I can sit down with my arm around them, give them a smoke and do things like that with them ... I might sit there and have a coffee, and you know how you just start talking and then you bring things in slowly? You know what I mean? I might be, with some people, it might take me about an hour and a half, just to get to that one question answered.

*[With the children] I'll just sit on the chair, and I'll make them come and sit down by the side of me, and I'll do my lessons like that, you know, instead of [them] sitting at their desks. Then I don't worry about the teachers, I just do it my way ... I show them what I'm doing though. I work in with them ... and they don't mind how I do it. **Kathleen.***

*Well ... we have been doing that, like group sessions, just going to some family groups or friends, meet them when they're sitting around having a yarn and maybe having a few, and get them before they get too many in them. But we're planning a camp away, taking them out of town and spending a couple of days by the water or something like that ... and having a good yarn out there away from town. **Cyril.***

Recognising the importance of older people is another.

Getting the elders involved in everything we do [is very important] because we can't do it without them, because they are the front line people in our communities.

Aimee.

I've lived and worked in a lot of communities, so I've learnt along the way ... I go to the older people. Like we have a lady here, who's one of the elder women from this area, and if I have a real problem I go to her or any of the other older women. I sit there and talk to them, have a coffee, they tell me, swear at me sometimes ... **Kathleen.**

Contact tracing, testing and treatment

As Rodney said in the opening quote of this section, carrying out the practical side of sexual health work with Aboriginal people is an art, which combines a deep understanding of the culture with strategies for overcoming all the difficulties outlined in Section One. Even just knowing what days are suitable for approaching people is a basic factor that many people involved in health delivery do not consider.

Sometimes it's hard, too, with our job, when it comes to pay days and things like that, with people drunk. Well, I just keep away, because I've learnt ... to sort of try and do most of the big jobs on Monday and Tuesday and Wednesday mornings, before the cheques start coming in, because I know after that it's not worth it. **Kathleen.**

Contact tracing is beset with difficulties requiring creative approaches for getting around them. To begin with, sometimes people do not want to, or even cannot, tell you contacts' names.

They'll just say, 'Oh, look, I can't remember a name ... I don't know what she looked like, it was dark, I was drunk', things like that ... Sometimes I can get around that, like saying, 'So you had a party last night?' ... and they say, 'Yeah, yeah'. And I say, 'What were you drinking, and so on, at so and so place? Who was there?'. And somebody will say, 'Oh, so and so was here, and so and so was there'. So you can get back to the [original] guy, and then you go into follow-up, and just say, 'Look, some of these names come up. Do you recognise any of these, and were these any of the persons that you had?' ... That has happened, and we're able to get a named contact off a person and then treat it as right [correctly identified]. **Kevin.**

Some Health Workers advocate giving both the original client and their contacts choices, although you need to keep an eye on what is happening to avoid unacceptable delays.

When anybody has come in and they've got an STI ... they can give us the contacts, [or] they are given the options if they wish to tell these people themselves. I mean like Mary could come in and say, 'Well, look, I've been with Joe Blow and this one and that one, you know'. I'll tell them [the client] they have got a choice of where they want to be checked and if they want to tell their partner(s) or they would like me to.

*We do come across the difficulties of 'Yes, we will tell them', and then we give them three or four days and nothing's come through, and then you go back and see them and they haven't told them yet. And that's when we sort of tell them 'It's been too long; you've got to ...' [Or] you got to suss out for yourself that [they do not intend to tell them] and know when to move in. **Karen.***

As has already been pointed out, contact tracing can be difficult due to distance and time constraints and the way Aboriginal people often move around, for example, to fulfil family obligations. Rather than getting upset over these constraints, it is less stressful just to accept them and do your best within these limits.

*Especially when we get all the lands people in around law time and whatever, or our sports weekend, people camp everywhere, you know, out in the bush ... I suppose it's because I've been here for a while, you get to know whose camps are whose, but sometimes it takes a while because they've nicked off from there to there. And so you're driving around out in the bush. But really, in a way, I don't care, because I just take my time; I do it like that. **Kathleen.***

Even when found, it is not always easy to get a named contact to agree to testing, let alone treatment.

*There were times they'd say, this is with contact tracing ... 'No, I haven't got a problem'. So what I used to say is, 'Well, you think about it and you know where I am. If you want to do something about it, you come and see me'. And there were a lot of times that happened. They would come when I wasn't expecting them to come in. They would come and say, 'Well, I thought about it; I know you're here to try and help me'. And I thought, 'Well, this is good'. So then you go through the right channels and you know what to do. **Shirley.***

There was a young mum who had to have a Pap smear and swabs and all that done, and came back with an STI, and she was quite ropeable about it. And when I asked for contacts, she just wiggles her face and says, 'Well, I'm living with a man and that's the only man I've been with, he's probably been running around ...'. He was very, very difficult and flatly refused to come in, and flatly refused to give names, flatly refused to take medication.

*So we sort of done everything through her, [getting her] to say [to him], 'Well, you do have an STI, you need to take these tablets'. And also [we said] ... that you need to watch people take these tablets. And so all we could do was give her the tablets to give to her de facto to take. And the only way we could follow up on that, to see if she was all clear - you know how you do your follow-up check and all that - well, because she was clear, so we obviously thought he's taken his tablets and he's clear. But it's patients like those that we do have difficulty with. **Karen.***

The testing itself is not always straightforward, and the Health Worker must be awake to possible upsets. Even just collecting a urine sample, for instance, may not be straightforward.

Now you have to be a bit wary, and be able to know the people ... You can give them a jar and ask them to do wee in it. You have to be careful, because they can turn around and get somebody else to wee in that jar and it's not theirs. Also, I have concerns that when we have girls, boys, come in, you give them a jar to wee in, and I don't know, because we've never tested this, whether they've added water or added some things to it and it's not pure wee, and that sort of thing. So you have to be careful like that. Some people will say ... 'Oh, yeah, yeah, well give me the jar and I'll go in and do it'. And if they go into a house, well, we don't know how many people are there; they could grab somebody else to do it ...

*It doesn't happen a lot, but you just have to be aware of it, because you can get some really smart-alec young boys who think it's a bit of a joke ... And they might pee in it a bit, they might put a bit of beer in it, you know, all those sort of things. Well, that's not going to be an advantage to them ... That's why you need to explain to them, 'OK, you have been named as a contact, now you may have something wrong with you down below, you may not, and the way we can find out is by doing this urine test ... And if that comes back all clear, then all well and good. But if there is something going on there, well, you can be treated for it'.
Karen.*

Finding ways of maintaining confidentiality is crucial.

*When contact tracing we don't name the person who's named them. They do ask, yeah, but we just explain that we're not allowed to tell them who ... just like if it was one of them we wouldn't let everybody know who's the person who told them.
Cyril.*

*It's always like a secret thing when you're going out to pick somebody up. Like, you've got to call them out by themselves and just work out how you can get her away or him away without it being too noticeable by the others around. I guess I've learnt ... that what's always required of me, as a Health Worker, is never to go and collect someone if they're sitting with a big mob of people ... [I] just have to work out ways for catching her at the right time when she's on her own.
Pansy.*

It's just like if I come out to see you about an STI, [because] you were named as a contact, and if people know or judge me as an STI worker and they see me talking to you, they'll click straight away that you must have an STI ... So when I go out and see people ... I say something like, 'Oh, is Rose Window here?'. They'll say, 'Yeah, she's here; why, what's wrong with her?'. 'Oh, nothing, I've just come to get some money that she owes me It's pay day now', or 'It's pay day next week'. So they'll call her out and I'll start talking to her and say, 'Oh, Rose, when are you going to give me the money', or that sort of thing, and some of them will be looking at you and thinking, what the bloody hell's she talking about!! And then I'll say, 'I need to talk to you about something else' ...

*So even talking to somebody like that, it's not always directly to the subject that I want to see them for. It could be about ... 'How's your little girl going, is she up to date with her needles?', and that. And she might say, 'Oh, I don't know'. But I might start walking away from her, hoping that she'd follow, and then once we get walking and talking, that's when I tell her what I'm really after.
Karen.*

*When I first started going to houses it was a bit hard, because, it's true, a lot of the mothers come out and want to know this and that. And I know [the person I want] is there, and I'll say, 'Oh, I need to speak to this person', usually the men. And they usually ask, 'Oh, what do you want to see them for?'. And I'll say, 'Oh, you know, "men's business"'. Then they don't say nothing after that. A lot of our old people use those words, you know, when we talk about men's business and the women don't say nothing then. That's a good way to cut everybody off, you know, stickybeaks. **Rodney.***

Many of the Aboriginal Health Workers felt that, rather than waiting for clients to come to them, screening should be organised more often in order to pick up STIs that people do not know they have.

*The most amazing thing was, when I do random screening around the back - you know I might do 20 or 30, and just waiting for the results to come back ... you know most of these mob have no symptoms. And the results come back, and maybe 15, 16 of them are positive for gonorrhoea, chlamydia or both, you know, and they've got no symptoms. So it just shows that a lot of our people that are walking around with no symptoms have got something. **Rodney.***

Education for sexual health

Educational strategies that Aboriginal Health Workers thought were working were very similar, regardless of location. The use of several different activities, frequent visiting, back-up visiting, and support for those most at risk, all came up as common strategies for success in sexual health education. The use of youth in an advisory capacity to set out ideas of what they want was mentioned, as well as gaining the support of community and elders in certain programs.

*We had a thing going here where we had members from the community, like community educators, from different families and all that, and trained them up, and they went out and got to members they knew. That got across to a lot of them. But then it sort of dropped off after a while. **Cyril.***

A successful strategy utilised in the Derby region of the Kimberley was having an elder present at the youth education sessions, so that they could relate to the kids better in between visits of the Aboriginal Sexual Health Worker, or when the latter was away.

What I usually do when I go into the community is take an elder with me, just for respect and to let them know what I'm doing. It's good for me, too; just in case I might say something wrong or do something wrong, they can correct me. Most of the time I have an elder with me.

*We're going to do a lot of educational stuff and try and make it look exciting, like take them [youth] for abseiling, and bush walks, and how to hunt and how to eat bush food, bush tucker. Fishing and that, teach them how to fish, because most kids in town, they don't get a chance to, and opportunity to, do that sort of thing. It's a good outlet, sort of in a traditional way, because most of the guys, especially from Oombulgurri and Kalumburu, they're still into the traditional stuff which has got a lot of elders still alive, that's good. **David.***

Education is not a straightforward matter of preparing one presentation that will do for all. It is obvious that children and adults require different presentations, but less obvious that all children, for example, will not react in the same way to the same presentation. Each presentation needs to be tailored to its particular audience.

*One of the main problems is presenting things, presenting the workshops, what you've got to say, how far you got to go and how you present it. You're speaking to Aboriginal kids, that's one problem, and the other one is I've got to adjust my teaching to different areas. I find there's a lot of difference. Like Kununurra, I teach kids here. Where if I go to Kalumburu it's totally different. I've got to sort of adjust and plan before, what I do. I've got quite used to that now. I found it hard at first, but I'm getting there. **David.***

It is important to realise that the message seldom gets through in one presentation. Reinforcing the message of sexual health is an ongoing process.

*The thing is you have to keep on going back and doing education again and again and again. So you don't do it just once and forget about it, because after a while they'll forget about it. **Rodney.***

*Well, it [safe sex programs] made everybody aware, but the thing is about doing stuff like that you have to follow up. I mean, after a while they'll forget about it ... Slowly the message is getting through, which is good now. But it's ... an ongoing education program. Yeah, I just come along and give a session, and a doctor comes and gives a session again, and maybe a teacher might come along and they give a bit of that topic again, which is good. At least the kids are getting the message all the time. We're prone to forget; the kids are prone to forget, too, especially on sexual issues. **David.***

Other activities need to be used to reinforce the spoken word. Below are some of the ideas used by Aboriginal Health Workers.

*I think the kids are very wise on the education body parts, but they're not very well educated on the disease itself. I mean to say, they need to have some sort of pictures up to say well this is what gonorrhoea looks like, and this is what thrush is ... or warts, you know, and what they can do with it. **Joyce.***

*I made up my own resources. I made up folders ... I've got pictures and I wrote it all down, so I was able to, not just talk to them about it, but show them the pictures of it ... And I had a lot of visual stuff with videos and slides. I travelled with the 'No Prejudice' play, all around the Pilbara - and that was a success story. And that's getting the message across, too, with plays ... I also did 'The Story In Our Hands' with the male Aboriginal Health Worker to schools around the Pilbara. I found working with small groups is more successful. **May.***

*When we do have mainly young girls ... they might come in and sit down and put on a video and help themselves to tea or coffee or Milo. And we have a few ... visual aids that I talk to the girls about. And we have got flip charts, too. **Karen.***

This is a little kit that I make up and give them out ... A lot of vital information there in them, about Hep C, HIV/AIDS. They've got condoms in them, they've got my card in them ... they have little comic books and stuff like that. Kevin.

I do different things just to make the workshops interesting, so the kids won't get bored. I use overhead projectors, videos, lots of videos on health. I also do artwork with them: face painting, painting, woodcarving, you know ... It's one way of them getting the message, too, you know... [With the kids you need] something simple and won't take long to do. So what I do easily is do the teaching first, and use whatever material I can use in the teaching, and then do the art work. David.

I'm always talking about using condoms. It was a big campaign for a while: posters, competitions, stuff like that. Cyril.

Kalumburu, Oombulgurri and Warmun, they're going to paint a mural in front of the clinic. What we're going to do is have a poster competition, and the ones we pick out we'll probably paint in front of the clinic. It'll be on the safe sex thing, you know, STDs, prevention and whatnot; that's one of the things we're going to do. Another one is, I think in Kalumburu, they're going to do shirt screenprinting, put a message on it. Again, we're going to have a poster competition; the best one will be chosen to be put on T-shirts and posters. Somebody out there will do some music, teach the music and get kids to write their own songs on safe sex and self-esteem and all that. David.

They like the music stuff, and especially when it's one of the Aboriginal mob singing. Rodney.

I did a radio program in Broome as well. Michael.

Our target group is 12 year olds to 25 year olds, and we have a lot of craft things up, and we make banners and we make beads and we make play sculptures and we make screenprinting. We do a lot of craft, so we don't just have the lesson; like we have a play activity and a craft activity, dance and drama and songs to get the message across as well. And we use sports personalities. Charmaine (nurse) and Aimee.

Special events can give an educational 'boost'.

We're doing a big safe sex basketball carnival on this next school holidays, for three days, for the Pilbara and Kimberley and Gascoyne, anybody. It's for youths, safe sex basketball carnival. We got a grant for that, so that's going to be big. We're running the carnival, and there's some mob doing art for us, big banners about safe sex and stuff. [We'll be] giving out condoms each day, and we're going to have a lot of information at the PCYC [Police and Citizens Youth Club] ... Give them a lot of things to read and talk about. David.

Recently, we had a condom day, where we had all the condoms just for people to, you know ... and we handed around pamphlets. We had a display in here, in the Centre here. And we had a Men's Sexual Health Workshop, which a lot of the men came into. And [from] what I heard, it turned out to be really successful. Joyce.

A successful event like the Fathers and Sons Camp (see photograph on page 5) is likely to be repeated in a variety of locations. This camp is designed to give education in relation to health and other issues, and to try to decrease the communication gap between the generations of Aboriginal males.

*Yeah, this is our camp, and I've been recognised there as one of their elders. Last year it was held down in Bremer Bay. It's beautiful there. There was a lot of activities going on, fishing, getting boys involved in canoeing, swimming, golfing. It was youth, fathers and sons ... so it was educational things for both. We had great community feedback. It's an annual thing. Each year the numbers increase, and word is getting around ... It went for four days. **Kevin.***

Some things make a particularly strong impact at presentations.

*Well, like when you are showing pictures on the slides, the thing they're really worried about is the HIV. They know that you can get fixed for things like syphilis and gonorrhoea and chlamydia and all that. But, like when I show them slides, I explain to them that when eventually you get HIV we really can't give you anything to cure it because there's no cure. We can just give you drugs to help you live longer and stuff like that. So when they start to get the worry about that, that's the impact that I can do when I do the education. And when they ask to be tested - because I explain to them if you get tested and you know you are negative, you can start from fresh - you know, [they say,] 'Oh, from now on I'll use condoms'. **Rodney.***

Just as in testing, Aboriginal Health Workers feel that it is important to take education to where the people are, not wait for them to come to you.

*I cover the prison, education in the prison. I do screening there, and with the screening in the prisons it's more effective ... because people are there, and they do present, and you can do the one-on-one sessions which is good. And then I take them out into ... a classroom there where I do an educational session. **Kevin.***

As the last quote indicates, education is not necessarily carried out as a separate activity on separate occasions, but is sometimes better integrated with other aspects of sexual health work.

As with all sexual health matters, it is more appropriate for women health professionals to carry out educational programs with females, and men with males.

*She [the senior health nurse] does education with the people in all these communities, and I actually do all the men, so that's the role for me with the Aboriginal people. **Kevin.***

However, at least if you begin this way, it is not impossible for these boundaries to be at least partially overcome.

*They [the kids] sort of class me as one of them, and they've learnt to trust me, and I've gained their trust, which is good, especially the young girls. I got surprised actually; they ask me what I'm doing. I usually go into the schools with another female with me ... They've [the female counterparts] got a fair idea what's happening. **David.***

SECTION THREE

Best practice: Supporting Aboriginal Health Workers

*The hardest part of being in sexual health is trying to keep motivated all the time ... because sometimes you see clients coming back every month with STDs, and you think you're not getting nowhere. See, every six months, there are more and more STDs. STD rates are getting higher and higher. **Rodney.***

In such circumstances, it is imperative to give Aboriginal Health Workers all the support they can get. In this section, supportive management practices, professional development and program strategies are discussed.

The work environment for the Aboriginal Health Worker involved in sexual health is becoming more supportive and appropriate. Often, things done in the past that have not worked have led the way for better and more appropriate health service provision. We need always to be alert to the possibilities of still better training, promotion practices, service provision, attitudes and conditions, and be willing to learn from past mistakes.

Specialist versus generalist positions

Whilst the choice as to whether to specialise in sexual health work or to remain a generalist may sometimes be a personal one, Aboriginal Health Workers often have no choice in this regard due to the structure of the health service in which they are positioned and the needs of the community at the time. In some health services, the generalist Aboriginal Health Worker fits best with the activities, the level of support and the structure of health care delivery. In other services, such as Public Health Units specifically covering issues surrounding sexual health, specialist positions are appropriate - within a communicable diseases unit, for example, or perhaps within a specialist funding area such as the PASH (Promoting Adolescent Sexual Health) program. Whether carried out in a specialist position or integrated into more general health work, however, sexual health work has the same focus - the promotion of general sexual health and the prevention and treatment of STIs - and faces the same obstacles and issues already discussed.

Just as every health service and community differs, so too do the Aboriginal Health Workers employed within these services and locations. Whilst some have the desire to specialise in sexual health, others prefer to rotate it with other health issues.

Those favouring the generalist position may enjoy the diversity involved for its own sake. However, such diversity also has specific advantages in relation to sexual health work. Importantly, it camouflages the Health Worker's role in relation to this sensitive matter, enabling clients to be dealt with in this area without everyone jumping to the conclusion that they have an STI.

*Being fairly flexible and liaising between the community and here [the clinic] ... I mean I don't have one particular thing when I go out into the community so that they say, 'Oh, here she comes to pick someone up for STD', or that sort of thing. **Pansy.***

*Some people would think ... because I've got some people in the car with me, that there's something wrong with them. But, in doing my job every day ... it's not about whoever I've got in the car. There's not always something wrong with them, because I could go out there to pick somebody up for a post-natal check or something, and they could jump in the car and other people could jump in the car for rides into town. **Karen.***

Many generalists felt good about community perceptions of their multi-faceted jobs.

*When I was actually in my community, I was very supported by the community in the sense that when I went around to see people and talk to people, not just about sexual health, but about other things - like 'You've got to come down and have a [general] check up', and that sort of stuff - I never had any problems with speaking to people, and they all said 'No worries', and people just went down to the clinic. **Michael.***

Some thought that it was definitely not a good idea to specialise only in sexual health, or that if Health Workers did specialise, their role should be concealed.

*I don't want the Health Worker to be thoroughly tied [allocated to a specialist area], particularly if it's a Health Worker just out of training. I don't want them to be plonked with a sexual health thing ... I don't ever want a Health Worker to ... don't want everyone to know his business, his title or ... it's pretty hard, like I've had to learn it over the years and how to combat these things as I went along ... But don't ever say, 'Look, this is your title, you're a sexual health person'. That particular Health Worker needs to be involved in other areas of programs. **Pansy.***

*I believe if somebody's coming up, or if somebody's being employed to be a Sexual Health Worker as such, I personally wouldn't want people to know that that was my role, that was my title role, as sexual health work. I would keep that camouflaged with other things. **Karen.***

As against the advantages of the generalist position, it must be noted that, because sexual health work is just one component of a multi-faceted role, it may not be allocated the real time that is required for the Health Worker to be more than just responsive to an already existing situation. Intervention and treatment may take up all the time available for sexual health, leaving no time for prevention, no time to sit down and provide education sessions and so on. This is particularly likely in small community situations, where the Aboriginal Health Worker has a broader task than most.

*I think Aboriginal Health Workers in these little towns and communities play a bigger role than the hospital-based nurses anyway, and we probably play a bigger role than the Health Workers in the cities ... We seem to be more important in these places, and you've only got just you and just the little hospital staff, but they'll come to you before they go to hospital or anything else. **Kathleen.***

Some generalists, however, may be able to incorporate a limited amount of sexual health education into their work with youth groups and schools, into community functions such as health displays at local shopping centres and into various other activities.

Specialist Aboriginal Sexual Health Workers, on the other hand, have the advantage of being able to concentrate on more focused education sessions, and many are happy to do so. They do not seem to miss the variety of work that a generalist Health Worker has, and find enough diversity within the field of sexual health work itself.

The best thing is telling the kids about sexual health and about all the different areas of sexual health. People think sexual health is just STDs and this and that ... Sexual health is relationship issues, it's domestic violence type issues, and pregnancies and all the different parts of that as well. Michael.

Though some Aboriginal Health Workers are very comfortable specialising, they may actually still 'mask' their role. Even at the specialist level, the job must still be diverse enough, and integrated enough, to keep the stigma low and the compliance rates high.

Yeah, that's the only thing wrong about the job ... Everybody know you do that sort of job, so when you're walking away with somebody they think, 'Oh, somebody got STD'. Well, I mix a bit of stuff with my job. I do a lot of youth work stuff. You know, I'm with the Yellow Ribbon mob (Youth Suicide Prevention Program), so I talk to a lot of kids and help to run stuff at the PCYC [Police and Citizens Youth Club]. So I've always got the young fellas around me, so that covers it a bit, you know; I can talk to them about STDs or something else, you know. I mean, people always see younger people around me all the time, so I guess it's not so bad. Rodney.

We camouflage the Health Workers. They see them as part of the youth services, because they are attached to the youth services in these communities. Aimee.

Management practices: Personnel

Two aspects are important: first, the provision of sufficient numbers of Aboriginal Health Workers trained in sexual health, and, second, relationships between Aboriginal Health Workers and their non-Aboriginal colleagues.

(a) The provision of Aboriginal Sexual Health Workers

As already indicated, the 'best practice' is for both male and female Aboriginal Health Workers to be regularly available to all communities to deal with members of their own sex. This does not mean having an Aboriginal Health Worker of one sex readily available and the other visiting, say, only every six months. STIs do not wait six months before spreading. Additionally, just as two heads are better than one at solving a problem, it is likely that two opposite-sex Aboriginal Health Workers working together will ultimately achieve greater than double the benefits for the community.

I won't be feeling like I'm just doing half a job. I'll sit down and talk to her [the female Aboriginal Health Worker] about men's sexual health, and she'll tell me about women's stuff, and we'll just sort of come up with a plan of getting the whole community, not just half of it. Michael.

If funding does not allow constant availability of both male and female Aboriginal Health Workers, or at least frequent regular visits by both, Aboriginal Health Workers should at least be paired with a non-Aboriginal nurse or other appropriate health professional of the opposite sex.

*We've got a senior nurse here for communicable diseases. She comes to these areas with me, 'cause she does the women and I do the men. **Kevin.***

This gets over some of the difficulty, but unless this non-Aboriginal nurse or other health professional is particularly approachable, it is unlikely that, as a first point of contact about such sensitive matters, he or she will get the response from Aboriginal people that an Aboriginal Health Worker may be able to get.

*They'll often talk to me first before the nursing staff. They'll tell me things first ... Probably because they see that black face and it probably makes them feel better. **Kathleen.***

*People know it's [the new Sexual Health Centre] there, they know the people are there, there's Aboriginal people there ... A lot of times ... they're frightened to go over to the hospital. I must [say] that, when I first came up here, there was so much racism at the hospital, it wasn't funny ... Thank heavens, it's changed for the better now, but the Sexual Health Centre is the best thing I've seen. **Shirley.***

Unfortunately, in some areas, even urban areas, there is a shortage of Aboriginal Sexual Health Workers of either gender.

*They don't have Nyungars, like contact tracers, here [Bunbury], and even with the Health Department they didn't have a health educator, a Nyungar person. I think I was the only one in Bunbury who was educated enough for that sort of thing, you know, and with the amounts of disease around, I'll most probably be the only one who would be going through the [training course to gain] education and prevention strategies. **Joyce.***

Whether shortages such as this are due to a shortage of funding for provision of Aboriginal Health Workers or due to a shortage of Aboriginal people willing and able to undertake the necessary training, they certainly do not represent 'best practice' for Aboriginal sexual health. The usually demanding and stressful nature of the Aboriginal Health Worker's role, as already discussed, also means that not all those who are trained are prepared to continue at length in the job.

(b) Relationships with non-Aboriginal colleagues

The 'good stories' that some Aboriginal Health Workers are now telling about change in Aboriginal attitudes to sexual health and disease seem due, not only to hard work and dedication on the part of the Health Workers themselves, but also to lots of changes in the way their non-Aboriginal managers are now allowing them to complete their work more in their own individual way, suitable for their own area and community.

This is 'best practice', not only in terms of achieving success in the Health Workers' professional roles, but also in terms of their other roles as members of the community. After all, it is they who have to walk down the street at night and still be part of the community long after the health service is shut for the evening. It is they who will be in the community for years to come, not usually their managers.

Non-Aboriginal colleagues seem to be developing more understanding of the cultural problems involved in doing sexual health work with Aboriginal people. For example, they seem to be developing a better understanding of the Health Workers' difficulties in dealing with people to whom they are related, and are willing to work in with the Health Workers to avoid such difficulties.

*I never actually did the treatment because ... being in a relationship to a person, I was not able to actually do the whole procedure ... My role was mainly to liaise between nurse and contacts, that sort of thing ... I always let the nurses know, 'Look, I can't talk direct to this person', if they were called in for contacts and things like that. But I wouldn't let it pass because I was related to that person ... I work around it to be able to get that particular thing done. **Pansy.***

*Well, I use the nurse or the other Health Workers, you know, from Community Health, so that way I don't see that person. If I know a nurse is bringing my relation in here to the clinic, I take off for about an hour, then come back ... Usually, I tell them [the nurse] where they live, [that] this person needs to be done, and they go pick them up, and I just take off. Because the client's my relation, they'd be shame to see me as well. **Rodney.***

Note that in the last quote Rodney referred to using personnel from Community Health, which is a different health service from the one that currently employs him. This willingness of different health services to work together to support the Aboriginal Health Worker in difficult situations also represents 'best practice'.

*[For] those ones that I'm not able to talk to, I really appreciate AMS being here as well. And [also] they've got male Health Workers there ... Because I know there's a fellow that does sexual health at AMS ... I call on him. **Pansy.***

As noted in Section One, it is also sometimes necessary to call on other organisations when named contacts are found to have moved to a different area, and management practices need to be flexible enough to allow for such requests to be dealt with. The provision of support by other agencies is vital to overall success. In some locations, the community-controlled and State health services are actually working together, not just side by side, to share resources and get results. Hopefully, this co-operation will spread to all areas, and, where it already exists, strengthen.

When asked which colleagues they found most supportive or understanding about doing sexual health work with Aboriginal people, the responses of the Aboriginal Health Workers varied. If they had an Aboriginal opposite-sex counterpart to their own position, they most commonly put that person first in response to this question. To both male and female Aboriginal Health Workers, the opposite-sex counterpart seems the most important link in doing a successful job in regard to contact tracing, education, follow-up and counselling.

In the absence of such a person, however, it was the nurse or doctor with whom the Health Worker worked closely, or the Director of the particular health service. Accounts about these non-Aboriginal colleagues were very promising, and many positive stories were recited.

*Well, she [the Director of the Public Health Unit] encourages us, like if she can see that we're tiring out a bit and that, she encourages us to have time out. Like, she always says, 'I want the best out of you, not the most'. So when we start off ... getting a bit peed off around the place, you know it's time to have a couple of days off or something like that. So she's really good in that sense. She's very understanding, especially in a sense of Aboriginal culture, and just Aboriginals, and how they socialise and their social behaviours. And in saying that, also my co-workers, those who I work with [both Aboriginal and non-Aboriginal], are really good sometimes to work with. **Karen.***

*Because we haven't got an STD clinic here, and like there's a lot of cover up, the doctor was really good, and the Health Department, when we had to go out to the people's houses. They weren't afraid to sit down and have a good yarn with the clients. And, of course, I said, 'Well it's a Nyungar's place, you know. You'll get all different sorts of homes, and they're really not all that flash you know, and come in and sit down and see how the other half, you know'. The girl that I worked with, she was really good. **Joyce.***

Health Workers also appreciated the encouragement to further training, both on and off the job, provided by their Directors.

*They give me time out. I get Abstudy and they pay me while I'm away, so they're very encouraging to me to study. See, I'll be doing mental health, too ... It's all in one sort of thing [degree] you know, and I've got one year to go ... So, that's good ... [they] give you opportunities to study. **Kevin.***

*Well, they've given me a program, when I was with EKAMS [East Kimberley Aboriginal Medical Service], on sexual health. Also, I do other courses with[in] the last five years, like Train the Trainer, Youth Suicide Course and this Gate Keeping. Did a HIV and AIDS one-week course in Broome, and they show you how to do counselling. I sort of learnt from that. It's a lot easier. **David.***

Sadly, despite advances in non-Aboriginal understanding of Aboriginal culture and of the need for Aboriginal Sexual Health Workers to be permitted to go about their work in their own way, sometimes non-Aboriginal people in more senior positions still do not understand the delicacy or timing of cultural events, and want things done now, not later.

Some may not, at first, understand either, the Health Workers' need to attend certain family or cultural events themselves, though this, too, is improving.

*Before, the Health Department would never let Aboriginal people go to funerals. This one particular lady said to me, 'You seem to want to go to every funeral'. Well, they're related, that's our culture. So, in the end, they learnt. Non-Aboriginal people [working with us] have to know all that. **Shirley.***

Management practices: Resources

In addition to supportive personnel, Aboriginal Health Workers involved in sexual health everywhere need good resource support. Health workers agree that Aboriginal clients need health facilities where they feel comfortable. Some are luckier than others in this respect.

*This is only new, like because we've got Public Health as such, and they've designed this area to be a Sexual Health Clinic where all sorts of people can come in for various STI reasons, for Pap smears; like we hold Pap smear clinics here. Like the Well Women's Clinic, we hold that here, and just girls in general, inquiries about contraception, pregnancies. **Karen.***

*I know the people, because I work for Community Health, they are really dissatisfied with the health services in this town. Some of the visiting specialists now, [the people would] like them just to come over there [to their communities] and do it. Not so much coming into this little clinic because it's so white orientated. Like we get some in here, but there is the other half. **Kathleen.***

*I think that we should have, like, a Well Women's or an STD clinic, you know, or someone trained up in that field to do swabs and that. And looking at the course which I done in Bega, looking at all the different STDs what you can get, I mean it's a big issue. **Joyce.***

In the case of small communities, as indicated earlier, Health Workers feel the need to be able to go there and carry out regular education or screening. Face-to-face talking, rather than using the phone, was also felt to be a 'better practice'.

*Face-to-face more, and doing things with the people. You know, sitting down and talking to them at the grassroot level, and not by phone because they tend to get the messages all muddled up. So you need to be going out and doing consultation with most of the communities, and that's the best communication. We can't really do it over the phone because people like to see who they're talking to as well, you know. **Aimee.***

Unfortunately, although such face-to-face communication is possible in some areas, resources do not currently allow it in all areas. Obviously, both regular access to a four-wheel-drive vehicle and the allowance of sufficient time to drive to distant communities are necessary to achieve the wishes expressed by the Health Workers.

Professional development

Sometimes skills learnt in formal training courses may not be utilised in the role that Aboriginal Health Workers find themselves in. This is particularly true for screening and drug administration in relation to sexual health. In a recent review of the Advanced Certificate of Sexual Health Course [run by Bega Garnbirringu and KAMSC], only six of 11 Aboriginal Health Workers interviewed are administering prescribed drugs, and only seven are taking bloods in relation to sexual health. Time constraints, often mentioned as being the enemy of effective preventative education in STIs, can also lead to a mismatch between training and application. Only three out of the 11 interviewed were involved in community health education on STIs. These details could also be relevant to the type of role that the Aboriginal Health Worker fills, that is, a generalist or specialist one.

All the things I've learnt I can't really practise ... And that's the difficult part, because when there's no nurse here - like now there's no nurse here till 1st May because she's gone away - so I run this whole place on my own. I've run it on my own too, also, for eight months. And then when we get a nurse that starts here, oh, you're nothing again, and I think that's wrong.

*I think we really need a good strong union to fight for Aboriginal Health Workers here. And I actually love this job, really. I really love it, but those sort of things turn me off. **Kathleen.***

Often Aboriginal Health Workers are restricted due to policy or role description as to what they are allowed to do, and what they are not. At times, an Aboriginal Health Worker may be the only one available to treat an acute STI, for example, or new-born complications from an STI passed from mother to child during birth. In some health services, medications are not to be administered by Aboriginal Health Workers. If they were to administer drugs without the medications certificate or Medical Officer's permission, and complications arise, then the Health Worker's liability would come into question. Training for the medications certificate is available for Aboriginal Health Workers to gain such accreditation (not always meaning they will be allowed to dispense medications), but in an emergency they would at least be covered. Often the structure within the organisations where Aboriginal Health Workers work does not give them enough support to enable them to do their job in its entirety, that is, what they were trained to do. Support, in the way of policies within the workplace, would allow Aboriginal Health Workers with specialised training, for example in drug administration, to actively practise their qualifications. Regular re-training would allow the Health Workers to be constantly updated and fully accredited.

Program strategies

Some programs developed for the mainstream population have been successful with Aboriginal people, for example, the Promoting Adolescent Sexual Health Program (PASH). With adaptation and relation to local environment such programs can be made appropriate and used as a base.

*[At Banksia Hill Detention Centre,] I've been doing the PASH Program ... I just reckon it's a really positive program. When I did the training for it, I thought, 'Oh, yeah, right, is this going to work?'. And when I actually did [it], I ... [did] ten sessions, because we cut it from about 16 ... When I did the whole ten sessions with this group of blokes out there, I found that to be really positive ... It got them talking, and they really annoyed me at times because they wouldn't stop talking about it, and it stuffed up what we'd just brought up. But I felt, even if they didn't change their behaviour and stuff, at least they were educated and they could talk to other people their age about it. **Michael.***

When asked about promotion campaigns aimed at the mainstream population, such as World AIDS Day, the Aboriginal Health Workers generally thought that the current promotional material could be made more culturally appropriate.

One of the things with World AIDS Day is, in Australia, the gay community really

think they own the World AIDS day, but they don't, it's for everybody ... We have to start doing stuff as a community on those sort of days ... The ads and stuff on TV, yeah, they are all quite relevant, but ... it could be done in a culturally sort of better way. Like, I know the Kalgoorlie mob were here to do that AIDS song, and that's just deadly the way it comes off. Yeah, if we can do more stuff like [that]. **Michael.**

Nearly all the Health Workers mentioned the campaign from Bega Garnbirringu (Kalgoorlie Aboriginal Medical Service) using a singing message for condom use, and said it would be good to have more of these Aboriginal-specific campaigns. Such campaigns, targeted at specific issues in their own communities or areas, were generally thought preferable to mainstream campaigns.

Some programs were mentioned as being successful because of the high level of community consultation and the bottom-up approach. Basically, if the program is not owned by the community and presented in the right way, it will generally fail, or be very short-lived.

Well, just go out and have a conversation asking people ... tell them ... what I've got to offer, and basically get some feedback from there and understanding, and see what they know about the community and what do they think are the problems in the community, and see if we can work together and improve that sort of ... These problems are out there in the communities. **Kevin.**

Every time I do it [an education program], at the end of the session I always give them a piece of paper and ask them what else they want me to teach them about. And the response is tremendous. The amount of questions they ask is incredible. I have to go by that. Usually when I give a session, I usually talk about what they want more of. **David.**

It's got to come from the community; it cannot come from an agency. They've got to decide that it is a problem for their community, and you've got to speak to the kids and ask them what they want us to tell them, and how do they want us to tell them. Like the kids told us they wanted more fun. So that's why [we have a lot of fun activities]. But, it's consultation. I think we've done maybe 95% talking to everybody else and planning, and five per cent standing up and doing the actual talks. **Charmaine (nurse) and Aimee.**

SECTION FOUR

Advice to the Aboriginal Health Worker new to sexual health

You have to be dedicated, you know; don't kid yourself. And I think the more you put into a job, the more you get out of it. Shirley.

When asked what advice they would give to a new Aboriginal Sexual Health Worker, all participants in the project had a common theme, that is, get to know the people before you start trying to impose programs and education about anything, especially sexuality issues. Get to know the community on a social level as well as having a professional association.

Know the tradition and the culture and take things slowly; don't rush things. Get to know the people first. Get to know the kids. David.

It is helpful to be introduced to the community by another Health Worker, if possible.

Well, if I got the opportunity, I'd get them to work with another Health Worker for the introduction, to go out and meet the people ... I think it's your first impression that you've got to make to the people, you know, and build that trust up with them. You can't go out there and say, 'Well, I'm so-and-so and I've come here to see you about contact tracing'.

We've got quite a few new Aboriginal Health Workers here, but I work with them and take them round to my clients and introduce them. And most of the time they ask who your family background is, and if they know you, then they'll talk to you about, 'Yeah, I know your mother and father' and all this. And I just say, 'Well, this is our new Health Worker'. I haven't come across anyone who says, 'Ahh, what are they doing here because they don't live here?' and all that. Joyce.

Then it is a matter of developing rapport and trust. For this, one of the most essential skills to master is being a good listener.

I'd say to them, you've got to learn to trust people, you've got to be a good listener; you've got to listen to what people say. Don't chop them off. Let them have their say, and you listen. Then, you try and help people. And if you're not a good listener, well, then people are never ever going to trust you ... But ... you have to build the trust. You've got to earn it. As much [as] you trust people, they trust you, you'll always get on. Shirley.

Before they [the new Aboriginal Health Workers] went out there, they would need to get to know the people, to develop a good rapport and trust, you know, not go straight out there ... The people have got to trust you before they come to the sessions ... And you've got to really put forward that strictly confidential aspect, because that's very important. May.

Get the men to trust you and show them that you care to do things confidentially ... I mean, if you're going to go out there and start pulling people around, you're just not going to get anywhere, anyway. [If] people don't want to listen to you, they won't; they'll avoid seeing you ... Show respect for men's health, for men's only business. Don't interfere with things. For example ... just make it clear that the men need to restock this box [men's health resource box], it's to be done by men only. Kevin.

To be successful and to create success for others, you also have to be supportive, and use the support around you. So, it is important to gain respect and develop rapport, not just with clients, but also with your colleagues. Unfortunately, all this takes time, and, sadly, due to funding and policy development, the time allowed is too often unrealistic and rigid.

Other important qualities stressed are being neutral and non-judgmental.

*You've just got to not take sides. Yeah, just don't judge anybody or anything like that, and everybody's sexual behaviour is their own sexual behaviour ... The most important lesson is to respect everybody, don't judge anybody. Regardless if someone you know is sick or whatever and they're running round the countryside ... You are not there to look at somebody and say that person's a bad person or anything like that. You just have to go ahead and do your job and educate ... The biggest lesson I've learnt is just to be neutral ... not to have a view on this or that. **Michael.***

*The thing I never did was to blame, you know, never put the blame on anyone. **Shirley.***

The way Health Workers communicate with their clients must be appropriate if their message is to be effective.

*Your language, you know, just make sure it's not too high. **Rodney.***

*Always talk to people on their level ... I speak in my own tongue, and that's how I speak to my people, on their level. **Shirley.***

*It's really talking, talking, just using their language. The main thing in getting the message across ... is using their language. Being part of the whole process is important, not handing over the patient to the nurse straight away; if the patient wants you there you should follow them through. **Karen.***

As noted in Section Three, Pansy and Karen both suggested that Aboriginal Sexual Health Workers should not openly refer to themselves by that title, particularly if they are new to sexual health, but should try to camouflage their roles in some way.

When it comes to actually beginning work, participants emphasised that it is best to work if possible with Aboriginal Health Workers who already have some experience in the community.

*If you're only just new in the field, always consult with your co-workers before going out and doing anything, before going out and talking to anyone. If you're actually doing anything, always consult with your co-workers first. **Karen.***

*I guess always liaising with the most senior Health Worker in your community [is important], and I think the learning is always working alongside a senior Health Worker if that was possible in an area where there is a senior Health Worker ... I always went to another Health Worker who had been in the area for a long time for advice, that sort of thing. **Pansy.***

*My Auntie [the female Sexual Health Worker in the Broome Aboriginal Medical Service] was a bit older than me; she went to school with my mum and stuff ... She's just a really good support to have there ... 'cause I'd sort of say, we'd better do this now, do that, and this, and that. And she knew from experience to slow down, and this is the way it's going to be done. So she taught me a lot about being patient ... just going ahead doing the job, but doing it in the right way, sort of thing. **Michael.***

*When they first start they need a lot of support and being shown the ropes, you know, for at least six months. Because it's like you've got to try and create your own work. Like you go out there and do screening and get the results; then that's how to start work off. You've got all these positive people to chase up and all their contacts, and so you make a big job out of a little job. So you did screening and it all comes back positive, so you've got a lot of people to chase up. That's from a little molehill and then it's a mountain. You start off with maybe five people and end up with 20 or 30. **Rodney.***

However dedicated and enthusiastic a new Aboriginal Sexual Health Worker may be, he or she must be realistic about expected results, if disappointment and let down are to be avoided.

*I think that we have to say that they must realise that it's going to be a very, very slow progress. And they're going to have to go and speak to everybody that they want to be involved. **Aimee.***

And a final tip: *They must make it fun for the kids. **Aimee.***

SECTION FIVE

Advice to the non-Aboriginal health professional new to Aboriginal sexual health

You've got to have that understanding, and culture is everything. You've got to make it culturally appropriate, accessible, affordable for Aboriginal people, and you'll get results. Shirley.

Aboriginal society is socially complex, and there are many differences between Aboriginal and non-Aboriginal cultural norms and values. From an outside perspective, people tend to make judgments depending on their own personal experiences and orientation. However, if, instead, you go into an Aboriginal community and are prepared to be open to new ways of looking at things and doing things, without imposing your own values, you are more than half-way to being successful. Listening seems to be the key to creating better programs and achieving more successful results in sexual health.

My advice is that they should just come in with an open mind, and just mainly come and listen. Just listen ... I mean, come in with really good ideas and that, but not put it on the table and expect to run with it, and expect results there and then. Aimee.

They need to know and get involved with the people, and let them know they're there to help, not try to dominate and talk above them. Shirley.

It is important not to make generalisations regarding Aboriginal people and their environments; sometimes differences are not so obvious, but rather deep and complex.

Get to know the community, talk to the local people first. Like here in Perth you'd talk to Nyungars for a while, in other communities you'd talk to other people and just get to know the community ... A lot of them [non-Aboriginal people] just wander in from another part of the country, thinking, 'This mob of blackfellas is the same as that mob of blackfellas, and I'll just treat them exactly the same', and it doesn't work ... So you get to know the people that you're dealing with, and what their family structures and everything like that is. Michael.

First of all they have to [learn to] know the culture ... [It is] not for them to say, I know this and I know that about Aboriginal people. I don't care how long a non-Aboriginal doctor has worked for Aboriginal people; they don't think like us, they don't know how we feel, you know, and a doctor has to have all that understanding about Aboriginal people before they can really work for them ... Shirley.

I think it would be a good idea for health professionals who are coming into our regions for the first time, to have a meeting with local Aboriginal people. The meeting would be to talk about the Aboriginal people of this region, cultural awareness workshops and act as an introduction to the Aboriginal community. Something like that would be a good idea, because not all Aboriginals are the same. For different groups, you need to change a bit. Cyril.

Learning to know an Aboriginal community and its culture can be very difficult for non-Aboriginal people. It is never easy, in learning to know any culture, to take on board cultural values that are different from your own, or to accept that what is valued by you may not be valued by people of the other culture. This can have a disorienting effect, leading to feelings of bewilderment, lack of self-confidence, mood swings and so on, that is, to what is known as 'culture shock'. This can be very emotionally draining.

*We have a great difficulty in keeping our nurses because they're only Agency nurses. They find it hard because it's such a little town, you know what I mean, and you're working with the people; well, it's like a culture shock sort of. They do have things ... cultural orientation programs at the hospital, like where nurses go and you learn to work with Aboriginal people, but I sort of think it's prejudiced in a way, because we should learn to work with them, too. Should be that reverse thing. **Kathleen.***

Some Aboriginal people obviously recognise and understand non-Aboriginal people's difficulties, and are prepared to go half-way to meet them. However, if you wish to make a success of your work in such a sensitive area as sexual health, you will need to try your hardest to understand and accept the values of the people you are working with. Above all, avoid being judgmental.

*I suppose the first advice would be not to be judgmental towards their appearance, their behaviour, their language. I find that very important. And don't make judgments to them, directly to them, you know, whilst they're present. And if people are going to be working in the area of Aboriginal sexual health, they should be working from within their heart, because you get all sorts of Aboriginal people, young and old, dress appropriately, personal hygiene - it's OK to them. Their personal hygiene is OK to them, but it may not suit the person who's dealing with them and they may make comments towards that. But those sort of things you should never, ever do. **Karen.***

Work in Aboriginal sexual health can be very rewarding. It is a matter of gently gaining trust, respect and the capacity to see situations from a different perspective. Some people need more support and time than others. The ability to listen and ask questions when required, and sometimes to be accepting of information even if the reason is not evident at the time, is a valuable skill to learn and practise.

Because non-Aboriginal health professionals may not choose to live or associate with Aboriginal people within the Aboriginal social context after work hours, it is essential that they be guided by the Aboriginal Health Workers, or by senior and suitable Aboriginal people representing the community or a group of people. You can learn a lot from their experience, skills and knowledge of the people, and of the cultural implications involved in doing sexual health work.

*Have a cup of tea with people, with the staff here ... With that non-Aboriginal person, the doctor or nurse or whatever, if they've got Aboriginal staff, it'll make it a lot easier. If they're actually in an AMS [Aboriginal Medical Service], there'll ... be Aboriginal staff that they can just say hello to, and just ask some questions about what's going on. **Michael.***

*It's a good idea to speak to somebody from that community, like a Health Worker who's from that community, to find out how they should go about it and what time they should go about doing their visit out there. **Cyril.***

*I'd advise them to work with the Health Worker, go out with the Health Worker when doing sessions on sexual health - male and female Health Workers. **May.***

*Always let the Health Workers lead - they know the community better than anybody and they know the people ... instead of just coming and trying to do this and that ... Let the Health Workers steer the way for them. We learn a lot off the doctors, but they can always learn a lot more about the community-based stuff from us and other communities, because we not only know our people here, we know a lot of Aborigines in other communities. **Rodney.***

*They should work closely with their Aboriginal workers and, I mean, like with myself, I like to use the non-Aboriginal people to my advantage also, because I ask them lots of questions, why is this done, why is that done that way and all that, that's just for myself. But, yeah, always first, never mind who they are, if they're coming into a sexual health area and dealing with Aboriginal people, if they have got Aboriginal staff there, they should be their first line of contact in regards to patients, clients, whatever. **Karen.***

While this is excellent advice, a note of caution must be introduced. It seems that some Aboriginal Health Workers may find constant consultation a bit overwhelming. It is necessary to be sensitive towards the Health Worker's feelings, just as towards the feelings of Aboriginal clients, and be considerate of their needs. An increase in consultation also carries extra responsibility for the Aboriginal Health Worker. If something is done incorrectly even after advice, it is s/he who must bear the repercussions from the community, not the non-Aboriginal Health professional.

*Well, I'll give you an example, for here, just in my work place. What happens, say, for example, if a doctor comes, it's always come to the Health Workers. They [a non-Aboriginal person] always ask me how things should be done ... If he's treating an Aboriginal client from the community, it always comes on the Health Worker's head to ask them things, how do they go about it, what do they need to know and do. That's what happens nine times out of ten here - maybe because of me being a community member, knowing those people in the community - it always comes on my head. **Pansy.***

Health Workers can find it trying when their non-Aboriginal colleagues fail to remember what they have told them.

*I've found, when you tell something, like how to go about it, they won't listen to it. Because there are so many times we've had to keep telling them, over and over. If they listened to it once, for that visit, then you've got to tell them again for the next one, who's connected to what and everything. **Cyril.***

Again, remembering is not always easy. Aboriginal social relationships are complex and sometimes very difficult for the non-Aboriginal person to understand and remember. Making a determined effort to remember, however, will be rewarded by the people's pleasure in your interest and understanding. It is one way of becoming closer to your clients, and, therefore, more trusted and more successful in your work.

It can be very unwise to ignore an Aboriginal Health Worker's advice, as the following story suggests.

*The first thing, she [the nurse] would have to tread very lightly. It has happened to me here, because she didn't want me to handle a client. We had a fellow from Warburton, and what she wanted was for the fellow to come in here, and I told her the way she was going to do it was not going to work. Anyway, I enticed him to come over, he did come over, and he told her 'No, no, no, I haven't got a disease, I'm a clear man', and all this, and he would not take his tablets, and he would not do anything, and that was it. But she has never done it again, because as I said, I did tell her to be very careful and that it was probably a lot easier for me to do it. But she wanted to do it herself, so I let her go, and I knew what was going to happen. I stood out the back and had a smoke and a laugh because I knew he would get wild. **Kathleen.***

In some situations, where there are no Aboriginal Health Workers available to provide initial advice, the non-Aboriginal health professional will have to get on with the job, but tread very carefully (remembering, of course, all the advice given above).

*If they're in a situation where there's no Aboriginal staff, I would say if it's an important job, go ahead and do the job. If you've got to do contact tracing or whatever, go and do it, because it's got to be done. But ... don't make any presumptions about anything, don't just presume these people don't know anything like that, that is, treat them as less than yourself. **Michael.***

Finally, some words of warning to all health professionals, whether they have local advice available to them or not, about confidentiality.

*Be very aware that there's nothing like the blackfella grapevine. Aboriginal people are very connected and talk freely amongst themselves. You've got to be careful about what you say to any blackfella, because they will know other people that know the person that you're talking to and ... it'll get spread around everywhere like that. **Michael.***

*Something that just recently happened where Sue, another health worker, and myself went out and I went and saw a girl. Then I came back and jumped into the car and I ... just completely forgot that we had somebody else in the car, and she's a very, very quiet, reserved person ... and she just sat there. And I said to Sue, 'Oh, I wish you would do this and do that' - I didn't say any names, I didn't say anything that was wrong with her or anything. And then I heard a little shuffle in the back, and then I went on to say, but she must be happy and all that sort of thing. And then I turned around and I said to the girl in the back, 'Do you think she's happy or has she been sad?', or things like that, you know. I didn't want to stop the thing, I just wanted to keep it flowing. Be aware of who's around. **Karen.***

CONCLUSION

At the end of the day we all want the same thing: improved outcomes for the health of Aboriginal people. Sexual health, however, is such a delicate area and needs special consideration. Sexual health work is complex in its own right, and the added complexities of Aboriginal societal issues make it a specially sensitive area. Aboriginal Health Workers involved in sexual health need time and support to develop their skills around the tasks ahead of them. Job-related stress must be kept to a minimum as Health Workers have the added stress of family and community relationships to maintain.

Policies and working environments are often in conflict with the dual role that the Aboriginal Health Worker must maintain. That is to say, that he or she must make sure, within cultural and family bounds, that the job of sexual health work is carried out the best way possible. Health services have changed and there is now more understanding of Aboriginal cultural issues. However, the health services must continue to make systems (service provision/protocols) and policies locally specific, and worked out with the individual community to maintain the best possible care for sexual health issues. A policy is not enough to eliminate gaps in service.

A positive step in sexuality issues is education; the Aboriginal Health Workers involved in sexual health have developed a great range of different mediums with which to explore sexual health concepts and education, especially when trying to reach high-risk groups. Many great strategies for the improvement of sexual health education and delivery of messages have come directly from the Aboriginal Health Workers themselves.

Overall, a generalist role suits most Aboriginal sexual health working situations, but every area is different. Specialist positions situated within a supportive environment have proved very successful. Great results reinforce the need for Aboriginal Sexual Health specialists in the right locations.

Professional development and support structures must be in place to support any Aboriginal health positions, but especially those in sexual health because of the personal burden that may have to be endured. Support for debriefing and personal growth of individual Aboriginal Health Workers needs to be more responsive to their situation and some of the hidden tasks that surround such a job. Emotional support, having male and female team members, networks for those involved in Aboriginal sexual health, and a more preventative approach to sexual health are all elements that improve outcomes for health workers and communities. Programs that incorporate a community perspective are more likely to be successful and sustained over long periods than those that rely on the short-term efforts of one or two strong individuals.

Holistic programs have greater impact and allow more freedom for sexual health to be addressed at any level within the community. Aboriginal people, at all levels, need to be given the major responsibility for program design and delivery if success is to be forthcoming in sexual health. Active listening on the part of those surrounding the Aboriginal Health Worker involved in sexual health is imperative to this process.

Involvement of Aboriginal people is one thing; letting the task of Aboriginal sexual health work be done by the right people in the right way is another. It's about trust, and acknowledgement that the task can be completed effectively in another way.

The good stories told by Aboriginal Health Workers show their tremendous strengths as clinicians and educators. Their cultural knowledge and commitment to their communities are an inspiration. Non-Aboriginal health professionals who are able to form trusting, mutually supportive and respectful relations with Aboriginal Health Workers have much to gain. The result will be holistic sexual health programs that will do much to reduce the burden of disease among Aboriginal people.

APPENDIX

Questions asked of the Aboriginal Health Workers participating in the sexual health work project

1. Initial discussion concentrated on the Health Worker's background:
Where were you born?
How long have you lived in this community?
What is your tribal/language grouping?
How long have you been an Aboriginal (Sexual) Health Worker?
What training did you do?
2. What are the main duties in your current role?
3. What things do you enjoy about doing sexual health work?
4. What things do you find difficult about Aboriginal sexual health work?
5. Have you ever faced cultural conflict in your work; at sorry time [funerals], law business, etc.?
6. What is the community perception of your job?
7. How do you keep confidentiality, when you are contact tracing, for example?
8. How do you interact with other staff and supervisors?
9. What strategies in sexual health improvement are working in your opinion?
10. What are some good news stories in Aboriginal sexual health?
11. Why are these success stories; that is, why have the programs been successful?
12. Which person or people do you find at work are the most supportive or understanding about Aboriginal sexual health work; that is, they let you get on with the job in your own way?
13. What advice would you give to a new Aboriginal Sexual Health Worker?
14. What advice would you give to a new non-Aboriginal person joining the team in sexual health?
15. What sort of networking and with whom do you think would be the best/most useful?
16. What are your opinions on promotion campaigns aimed at the mainstream population, such as World Aids Day?

