Access to HIV Prevention Information among selected culturally and linguistically diverse (CALD) communities in Victoria

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ACCESS TO HIV PREVENTION INFORMATION AMONG SELECTED CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) COMMUNITIES IN VICTORIA

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Glossary

ACON: AIDS Council of New South Wales.

AIDS: Acquired Immuno-Deficiency Syndrome

ASHM: Australian Society for HIV Medicine

FARREP: Family and Reproductive Rights Education Program

FGM: Female Genital Mutilation

DHS: Department of Human Services

DIMA: Department of Immigration and Multicultural Affairs

HIV: Human Immunodeficiency Virus

MHSS: Multicultural Health and Support Service (Vic)

MHAHS: Multicultural HIV/AIDS and Hepatitis C Service (NSW)

VAC: Victorian AIDS Council
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EXECUTIVE SUMMARY

Victoria has seen significant increases in migration since the 1990's from a range of countries that are currently experiencing high levels of HIV. The most notable increases in migration have been from the Horn of Africa (Sudan, Somalia, Ethiopia and Eritrea). Eight percent of new HIV diagnoses in Australia in 2004 were in people from Africa and the Middle-East.

With increased flows of people coming to Australia or undertaking return journeys to high prevalence countries, the provision of culturally appropriate information about HIV prevention has been necessary. This research project identified available support structures and materials relating to HIV/AIDS prevention, which have been developed specifically or translated for Horn of Africa, Arabic-speaking, Vietnamese and Thai communities in Victoria. Our selection of communities for this research was based on the priorities set by the Victorian Department of Human Services for the Multicultural HIV/AIDS Support Service (MHSS), established in 2003.

This 12-month Victorian based study reports on the availability of HIV prevention information for these communities, and specifically on how appropriate the information is to their cultural background and their needs. The study addresses issues such as what is the most appropriate language for young people and the challenges communities face when dealing with explicit material. Newly-formed communities often rely on informal channels of communication. Furthermore, their ability to absorb information is often compounded by a range of refugee and resettlement issues. The study outlines the channels of communication for HIV prevention considered the most appropriate for each of the communities, including communities with low literacy levels.

Over 25 key informant interviews were held with representatives and service providers, in addition to 10 focus groups from a wide range of people within the selected communities. Some of these sub-groupings addressed in this paper include:

- Iraqi men from Shepparton
- Lebanese & and Iraqi mothers of teenage children
- South Sudanese men from the Dandenong area
- Young people from the Horn of Africa
**Aim/Background**

This Research Project had the following objectives:

1. To provide a comprehensive audit of currently available materials (written and audio-visual) and support structures for each of the communities. This also reveals what gaps exist in each of the communities.

2. To provide a comprehensive content analysis of all materials, which will explore how culturally and linguistically appropriate the products are.

3. To explore knowledge and understandings of HIV prevention that these communities develop from this material.

**Methodology**

Initial consultation with key organisations who provided recommendations on the selection of co-workers and were instrumental in the collection of existing prevention material about HIV in the selected languages.

An Advisory Committee consisting of the Associate Investigators, representatives from the selected communities and the principal researchers met at key points in the research to provide feedback on the findings from Key Informant Interviews and advice on the recruitment of focus groups; and findings from the focus groups.

The research involved 4 stages:

1. The collection of all publicly available materials about HIV for each of the communities in Victoria and the analysis of selected material.
2. 26 Semi-structured Key Informant Interviews with community representatives and service providers
3. Analysis and selection of material for focus group testing (with co-workers)
4. 10 Focus Group discussions

Four co-workers were recruited from the selected communities to provide cross-cultural advice for the duration of the project. Bilingual facilitators were recruited to organise and run the focus groups. Training was provided by ARCSHS staff.
Main findings
The main results we drew from this research are:

- Almost all participants were unaware of the existence of HIV prevention material produced in Australia in their language.

- Participants often held a false sense of security concerning HIV in Australia. Due to Australia’s practice of screening migrants for HIV; the different dominant modes of transmission from their home country; and much fewer highly visible public prevention campaigns, most participants believe that HIV is not a major issue for themselves or their community in Australia.

- Participants often rejected a format that used a personal sexual approach, preferring to see HIV as a general community health concern.

- The high level of sensitivity around HIV/AIDS and around how the content is presented means that at times, there is a risk of material being rejected.

- Most participants valued information delivered face-to-face. This allows for sensitivity to be addressed and helps place information within its cultural context.

- The language and literacy differences between and within communities means that no one method of communication will be appropriate for all.

- Bilingual information was identified by all communities as essential for addressing differences in language and literacy levels.

- The English template used in most material tested in the study often includes information that is not appropriate for some communities.
Recommendations/Actions for Implementation

1. A broad campaign is required to accompany the production of all material in languages other than English. Consultation about content and delivery needs to take place with each target community. Appropriate means of distribution of material should be discussed within the community consultation process.

2. In order to make HIV prevention relevant to these groups it is essential to raise awareness of incidence in Australia and in their own communities and to address concerns about stigma and support.

3. Information about HIV prevention will be more readily accepted if packaged within a community health framework and not within an individual sexual/relationship approach.

4. A particular effort must be made to investigate ways to negotiate the conflict between the sensitive nature of the material and the willingness to know about HIV. How to deliver sensitive information which does not alienate audiences will require community input.

5. The prime form of information delivery needs to shift away from the reliance on written information to face-to-face interactions (information sessions and one-on-one). In many cases this will include bi-cultural and bi-lingual community workers.

6. All information, including written material, should be delivered in community languages and in English. This will accommodate the range of language and literacy skills within each community and facilitate communication with English-speaking service providers.

7. Written material should be based on an English template that was developed specifically with CALD communities in mind. This will help to address concerns regarding appropriate terminology and presentation of material.
PART ONE

PROJECT OVERVIEW

&

CROSS-CUTTING ISSUES
Part One –
Project Overview & Cross-Cutting Issues
PART ONE - PROJECT OVERVIEW & CROSS-CUTTING ISSUES

PROJECT BACKGROUND

Victoria has seen significant increases in migration since the 1990’s from countries experiencing high levels of HIV. National Surveillance Data reveals that a significant number of new HIV diagnoses are in people from countries of high prevalence residing in Australia, temporarily or permanently. The HIV clinic at the Melbourne Sexual Health Centre noticed that in 2003, ‘a large proportion of those coming to grips with a new HIV diagnoses were from culturally and linguistically diverse (CALD) backgrounds’.

The pattern of HIV exposure among people from CALD backgrounds is predominately heterosexual. Thirty three percent of HIV infections attributed to heterosexual contact in Australia from 2000-2004 were from people from a high prevalence country and a further 27% were from people with a partner from a high prevalence country. In 2004, 119 women were newly diagnosed with HIV and over half were from a high prevalence country.

The Annual Surveillance Report 2005 from the National Centre in HIV Epidemiology and Clinical Research reports that 7.2% of new HIV diagnoses in Australia in 2004 were from people from Sub Saharan African, 7.2% from Asia, and another 0.6% from the Middle East and North Africa. People born in Africa were also more likely to be late ‘HIV presenters’ to health and support services.

With an increased number of people coming to Australia or undertaking journeys to high prevalence countries, the most effective way to limit the spread of HIV is prevention, through education. The provision of culturally appropriate information is all the more necessary as these new communities experience many barriers to accessing health care, such as language, the refugee experience, or a lack of understanding of the Australian health system. In research conducted in NSW in

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2 Melbourne Sexual Health Centre (2004), Increased numbers of new HIV diagnoses in People from CALD backgrounds at MSHC, HIV Clinic Newsletter, July 2004
4 Twenty five percent of heterosexually acquired HIV cases in Australia from 2000 to 2004 were from people born in sub-Saharan Africa, a further 18% of cases were from people born in Asia.
5 Keynan M (2004), Late HIV Presentation among African Communities, Talkabout Feb-March 2004
1997 amongst communities of non-English Speaking Background (NESB), the Multicultural HIV/AIDS Service found that NESB communities had:

- Low level of knowledge of the difference between HIV and AIDS
- Poor knowledge of behaviours and practices to avoid HIV
- Low levels of knowledge and access to HIV/AIDS services
- Prejudicial attitudes towards People Living with HIV/AIDS
- A strong perception that HIV/AIDS is not present in their respective communities

In its 2002-2004 HIV/AIDS Strategy, the Victorian Department of Human Services identified people who have come from high prevalence countries, or who travel regularly to these countries as ‘people at particular risk’ of HIV infection and ‘[in need of] appropriate health promotion programs and initiatives’.  

**Target communities**

The following communities: Horn of Africa, Arabic, Vietnamese and Thai were the target groups selected by the Victorian Department of Human Services for the Multicultural HIV/AIDS Support Service (MHSS), established in 2003. In 2005 it was decided that MHSS would no longer focus its attention on the Thai community and would direct its attention towards the remaining communities.

Our selection of communities for this research was based on the priorities set by the Victorian Department of Human Services for MHSS.

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7 Multicultural HIV/AIDS Service (1997), *Inequity and Hope, a discussion of the current information needs of people living with HIV/AIDS from Non-English Speaking Background, MHAHS, Sydney*

### Characteristics of selected communities in Victoria

<table>
<thead>
<tr>
<th>Community</th>
<th>Size</th>
<th>Language</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vietnamese</td>
<td>56,664</td>
<td>Vietnamese</td>
<td>Buddhism, Catholicism</td>
</tr>
<tr>
<td>Thai</td>
<td>5,487</td>
<td>Thai</td>
<td>Buddhism</td>
</tr>
<tr>
<td>Arabic-speaking</td>
<td>47,147</td>
<td>Arabic</td>
<td>Islam, Christianity</td>
</tr>
<tr>
<td>Sudanese</td>
<td>9</td>
<td>Not available</td>
<td>Islam</td>
</tr>
<tr>
<td>Somali</td>
<td>2,311</td>
<td>Somali</td>
<td>Islam</td>
</tr>
<tr>
<td>Ethiopian</td>
<td>1,970</td>
<td>Amharic, Oromo , Arabic</td>
<td>Coptic Christianity, Islam</td>
</tr>
<tr>
<td>Eritrean</td>
<td>996</td>
<td>Arabic, Tigrinya</td>
<td>Islam (75%), Christianity</td>
</tr>
</tbody>
</table>

Source: ABS, 2001 Census of Population and Housing, VOMA

The most notable increases in migration flow to Australia in recent years have been from the Horn of Africa (Sudan, Somalia, Ethiopia and Eritrea). The number of humanitarian entrants coming to Australia from Sudan, for instance, has increased by 104.9% between the 1996 and 2001 census. Another Horn of Africa community who has experienced a significant growth since 1996 is Ethiopia, with an increase of 29.9% of the number of migrants. The 2001 Census reported 6,264 Victorians from Sudan, Somalia, Ethiopia and Eritrea, but this figure has now changed dramatically.

Between 2002 and 2004, 3,125 Humanitarian Entrants from Sudan, Eritrea and Ethiopia settled in Victoria. Informants from these communities estimate that there could be between 15,000 and 20,000 migrants from the Horn of Africa living in Victoria today.

The Horn of Africa continues to experience high rates of HIV infection. For instance, in 2003, it was estimated that 380,000 adults (2.3%) were infected in Sudan, 1.5 million people in Ethiopia (4.4%), and 60,000 in Eritrea (2.7%) – no figures were available for Somalia.

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9 Arabic-speaking communities come from 22 countries. Statistical information provided by the 2001 Census is organised by country of origin, not language spoken at home.

10 The Sudanese migration to Australia (including Victoria) is very recent and continuously increasing. There were no figures available from the 2001 census, however the census singled out Sudan-born migrants as the third fastest growing overseas birthplace group.


The number of migrants from the Horn of Africa in Victoria is small but their needs are vast, and they encounter many barriers to settling in their new country. For these newly arrived communities, particularly those from the Horn of Africa that have not come to join an existing, more established community, there is an acute need for information in their language about an array of topics, including HIV. Many have lived in refugee camps for years, their education has been disrupted or non-existent, and in some communities, such as the Ethiopian community, the majority are not literate in their own language.

Traditional channels of information, such as written material or the press, may not reach people from CALD backgrounds, particularly if the material is in English or translated from English without taking into account the cultural barriers that may interfere with the promotion of messages. This is compounded by the fact that these new communities are only starting to create structures and services for their members, and the channels of information and communication are therefore still unclear to most ‘mainstream’ Service Providers.

Other communities
Another refugee community that has experienced a significant increase in new arrivals is the Iraqi community with an increase of 77% between 1996 and 2001. In recent years there has also been an increase in the arrival of ‘stateless’ people, including ethnic Kuwaitis, Somali, Darood Somali, and Arabs.

In line with the Department of Human Services’ selection of communities for the MHSS, the Vietnamese and Thai communities were also identified as in need of HIV prevention information. Victoria has a Vietnamese population of almost 48,000 people. One of the groups of concern for HIV infection is Injecting Drug Users. It is well documented that Vietnamese who inject are at particular risk of HIV infection in Vietnam and in Australia. Another area of concern in regards to access to HIV information is the broader Vietnamese community, due to the low level of English language proficiency. Despite the fact that the Vietnamese community is not an emerging group, English language difficulties prevail and as a consequence barriers to accessing health care indicate that there is a need for information and services that address this group’s particular needs.

15 ABS 2001 Census, op cit
The Thai community is relatively small in Victoria (5,460 people). There is however a high number of Thai-speaking Sex Workers in the Victorian sex industry who constitute a group at high risk of HIV infection. It was decided that a focus on Thai Sex Workers was beyond the scope of the study. The focus within the Thai community for this study was on overseas students from Thailand. The combination of youth, freedom from parental discipline and cultural obligations, and a tendency to live in a close-knit group, preferring the comfort of speaking their native tongue and the safety of being cocooned by a shared culture\(^{16}\) makes Thai students studying in Australia particularly vulnerable to sexually transmissible diseases such as HIV.

This Project investigates these communities' information needs in regards to HIV prevention. We have identified and analysed all materials available to these communities in Victoria relating to HIV/AIDS prevention, and conducted Interviews and Focus Groups to determine how appropriate these materials were to the communities' needs.

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\(^{16}\) The Age newspaper (2005), *Hello Stranger*, Melbourne, 19/09/2005
RESEARCH OBJECTIVES

The field work for this research project was conducted between February and September 2005. The research objectives were as follows:

1. To provide a comprehensive audit of currently available materials (written and audio-visual) and support structures for each of the communities. This also reveals what gaps exist in each of the communities.

2. To provide a content analysis of all materials, which will explore how culturally and linguistically appropriate the products are.

3. To explore knowledge and understandings of HIV prevention that these communities develop from this material.

This project does not aim to research the behaviour or personal experiences of people in the selected communities. It is solely concerned with their knowledge and understanding of HIV prevention in relation to the available material and structures.
INITIAL CONSULTATION

Information was gathered from Associate Investigators and key community organisations in the initial research. They provided recommendations on the selection of co-workers and were instrumental in the collection of all current prevention material about HIV in the selected languages.

An Advisory Committee consisting of the Associate Investigators, representatives from the selected communities and the principal researchers met at key points throughout the research. The committee guided the research and provided feedback on the findings from Key Informant Interviews, advice on the recruitment of Focus Groups, and findings from the Focus Groups.

Co-Workers

Four co-workers were recruited from the selected communities to provide cross-cultural advice for the duration of the project. Their support to the project included:

- Providing relevant community contacts
- Cultural understandings of HIV and Sexual Health
- Advice on suitable Key Informants
- Insight in content, appropriateness and relevance of material collected
- Identification of material to be presented to Focus Groups
- Recruitment of other facilitators and supervision of Focus Group process
- Insight in interpretation of preliminary findings

Choice of Focus Groups, line of enquiry, location, recruitment and composition were determined in consultation with co-workers. This research was informed at all times by the comments of co-workers, members of the Advisory Group and findings from the Key Informants.

**Bilingual facilitators** were recruited to recruit, organise and run the Focus Groups. Focus Group training was provided to all facilitators by ARCSHS staff.
RESEARCH STAGES

1. Collection of all publicly available materials about HIV for each of the communities in Victoria
   Analysis of selected material

2. Semi structured Key Informant Interviews with community representatives and Service Providers

3. Analysis and selection of material for Focus Group testing

4. Focus Group discussions

Stage I – Information Audit

An audit of currently available material in languages other than English for each of the selected communities was conducted within the first month of the project. Languages targeted were:

- Arabic
- Somali
- Tigrigna
- Oromo
- Amharic
- Vietnamese
- Thai

All relevant organisations that provide support to these communities were identified and contacted to obtain lists of materials used in their community education and information work. Research reports and articles published about HIV information and understandings in the selected communities were obtained. This was achieved
through an Internet search and through direct contact with the following organisations:

- Working Women’s Health (Information centre)
- Multicultural HIV/AIDS and Hepatitis Services (NSW)
- Multicultural Health Communication Services (NSW Health)
- Victorian Aids Council
- Melbourne Sexual Health Clinic
- Centre for Culture, Ethnicity and Health (North Richmond Community Health centre)
- Access Information Centre (Alfred Hospital)

Stage 2 – Key Informant Interviews

Twenty-six interviews were held with community leaders, community workers and other health Service Providers. A range of topics were discussed, including: the communities’ support structures, channels of communication and key issues for the community around HIV prevention. The interviews were also used to identify the most commonly used HIV prevention material. Key Informant Interviews helped to inform stage three of the research: the recruitment of Focus Groups.

Key Informants were identified in collaboration with Associate Investigators. Interviews lasted between 45 and 60 minutes. Topics covered in the interviews were:

- Perceptions and understandings of HIV prevention in the community
- Sensitive issues around sexual health and HIV/AIDS
- Issues related to sub-groups: young people, newly arrived, women, men
- Community channels of communication
- Input on Focus Group composition and recruitment approaches.

Interviews were conducted in Melbourne, Shepparton and Sydney.

Stage 3: Selection of materials

The most commonly-used documents for each community were identified, based on feedback from the project’s co-workers, Associate Investigators, organisations that
the material was obtained from and Information Officers in key organisations. The selection was refined through advice from community leaders and community workers obtained during Key Informant Interviews.

Materials (pamphlets, posters etc.) were analysed in collaboration with co-workers, with specific reference to cultural appropriateness and correctness of language. Particular attention was paid to the following questions:

- Is the information written in a way that is sensitive to the specific cultural context of the target communities?
- Is the imagery adapted to appeal to these communities?
- How much information is translated directly from English and how much is written specifically for these communities?
- Are the materials gender-disaggregated or is the same material used for men and women?

**Stage 4: Focus Group Discussions**

**Focus Group discussions** were held in each selected community to discuss:

- identified material’s cultural and linguistic appropriateness
- participants’ understanding of the material
- participants’ perception and understanding of HIV prevention
- preferred channels of communication for HIV information

A total of 10 Focus Groups were held:

1. Young people from the Horn of Africa
2. Women from the Horn of Africa
3. Iraqi and Lebanese women
4. Somali women
5. Men from Southern Sudan
6. Young people of Arabic background in the Dandenong area
7. Iraqi men in Shepparton
8. Vietnamese men
9. Vietnamese Injecting Drug Users
10. Thai students

A small Focus Group discussion was held with Family and Reproductive Rights Education Health Project (FARREP) workers at the end of the field work to obtain their feedback on the findings of the Horn of Africa (including Somali) women’s groups.

Discussions were semi-structured, to allow facilitators to adjust lines of enquiries to the cultural specificity of the groups.

Focus Groups were conducted in the preferred language of the participants. This could be their first language (e.g. Vietnamese), the common language from their country of origin (e.g. Arabic), or, for some groups, English, either because it was their common language or because it was the language they spoke best (e.g. young people of Arabic background). When several languages were spoken the group was run in these different languages and two facilitators were used.

Discussions were recorded, with the participants’ consent, in order to help report writing.

Bi-lingual facilitators from the target communities were trained in recruiting and facilitation of Focus Group prior to the Focus Group discussions. These training sessions included:

- Description of the project and its objectives
- Discussion of the Information Sheet and Information & Consent Form, their objectives and content
- Consultation with facilitators on best way to approach lines of enquiries in each community and sub-group
- Any foreseen issue
- Reporting (a pro-format was provided)

A Line of Enquiry was provided to all facilitators and explained during training (see Appendix 2).

Following each Focus Group discussion, facilitators prepared a report and then met with the project research officer for debriefing and discussion of findings. Reports
were then analysed thematically and collated. Cross-cutting issues were identified, as well as differences between groups. We have chosen to present findings for each Focus Group under these major themes, as this allows readers to select the findings that are most relevant to them.

**SELECTED MATERIALS**

Material was obtained, in person or online, from the following sources:

- Multicultural HIV/AIDS and Hepatitis Services (NSW)
- Victorian Department of Human Services (Victoria)
- Royal Women’s Hospital
- Working Women’s Health
- Multicultural HIV/AIDS Support Service
- Centre for Culture, Ethnicity and Health (North Richmond Community Health Centre)
- NSW Department of Health
- Family Planning Australia

The material collected was then analysed according to the following criteria:

- Availability in Victoria
- Internet-based/existence of hard copy
- Existence of an English version/written directly in language
- Inclusion of diagrams and illustration
- Proportion of text versus illustration
- Inclusion of contact details

Material was then selected to be presented to Focus Groups in consultation with co-workers and based on comments from Key Informants. For most groups, we included one piece of material produced by DHS (in language or/and in English), one ‘Getting it Right!’ booklet (widely available) and another piece of material with interesting characteristics for which we wished to obtain feedback (colours, bilingual, specific target audience).
A small number of materials selected were not directly related to HIV but were included in order to obtain feedback from the groups on presentation characteristics not offered by available HIV prevention materials: some were designed specifically for the target community, others were bilingual, well illustrated, etc.

The key materials selected were:

- **Getting it Right! (MHAHS):** widely distributed, used by Service Providers, produced by a community consultation process, some pictures, basic information.

- **HIV/AIDS, Your Questions Answered, Sexually Transmitted Disease and Safe Sex (Victorian DHS):** these A4 pages, which can be downloaded from the Internet, are the most up-to-date information produced by DHS. The booklets produced in 1998 were updated in 2003, but no hard copies were printed and they are only available through the Internet.

- **Going Home Safe (MHAHS):** described by co-workers and Service Providers as ‘very good’, instantly recognisable presentation as South-East Asian, even in English, colourful, contains many illustrations.

- **Healthy African Women (Women Health West):** this material was included due to its specifically African presentation (colours, pictures and general presentation). It was used in Focus Groups to obtain feedback on material that is immediately identifiable as addressing a specific group (along the same model as Indigenous Australians material).

- **Don’t Be Afraid to Ask (MHAHS):** bilingual material that provides clear information and ethnically relevant pictures.
MAJOR FINDINGS

- Almost all participants were unaware of the existence of HIV prevention material produced in Australia in their language.

- Participants often held a false sense of security concerning HIV in Australia. Due to Australia’s practice of screening migrants for HIV; the different dominant modes of transmission from their home country; and much fewer highly visible public prevention campaigns, most participants believe that HIV is not a major issue for themselves or their community in Australia.

- Participants often rejected a format that used a personal sexual approach, preferring to see HIV as a general community health concern.

- The high level of sensitivity around HIV/AIDS and around how the content is presented means that at times, there is a risk of material being rejected.

- Most participants valued information delivered face-to-face. This allows for sensitivity to be addressed and helps place information within its cultural context.

- The language and literacy differences between and within communities means that no one method of communication will be appropriate for all.

- Bilingual information was identified by all communities as essential for addressing differences in language and literacy levels.

- The English template used in most material tested in the study often includes information that is not appropriate for some communities.
CROSS-CUTTING ISSUES

The following issues have emerged from this study as issues of relevance across all communities, although there were many variations in terms of their importance or the manner in which they affected HIV prevention.

Cultural appropriateness of material

As Health Educators, we need to find appropriate ways to deliver that information. It's our challenge, not theirs. (Key Informant)

The level of sensitivity around HIV was high in all communities, although it was greater in the newly-arrived communities than in more established ones. All Focus Groups acknowledged that HIV was a sensitive topic for reasons of stigma, its association with homosexuality and drug use, or, in some communities, the fact that it is associated with ‘loose behaviour’ and casual sex.

Despite this, most Focus Group participants were very interested in gaining more information and in accessing material about HIV. Women in particular were keen to increase their knowledge to then share it with other women and with young people in their community. This thirst for information often led to a tension between wanting to know about the topic and feeling embarrassed by the nature of the information or the way it was presented. This in turn led to contradictory statements about the appropriateness of some of the available information.

In regards to the material currently available, sensitivity was mainly associated with:

- Diagrams showing how to use a condom
- Mention of sexual practices (oral and anal sex)

The perceived lack of appropriateness of some of the material limited its potential use:

- by leading to outright rejection of material, as it was too shocking to handle – even though some of the less sensitive information included would have been of great interest to participants.
• by affecting how comfortable people were with taking brochures home, picking up written materials in public and sharing the information with community, family and friends.

When material was seen as inappropriate, this was sometimes interpreted as a sign that it had been written for others. Subsequently, the relevance of the topic and the material was then questioned.

**Health Literacy**

*People will come to the health system with a whole history … of living in outback Somalia and it’s a completely different experience. I don’t think you can ignore that.*

(Key Informant)

Assumptions are often made that health terms and conditions are understood or if not, that this can be addressed by translating those terms into the preferred language. Findings show that these terms are often not understood in either English or in the preferred language. Typically, words such as ‘immune system’, ‘Chlamydia’, ‘intercourse’ or ‘lubricant’ were not understood.

Health literacy also includes knowledge of the Australian health system and of one’s rights as a consumer. Service Providers reported that such knowledge may be lacking and that materials needed to take this into account.

When terms were not explained, this resulted in either confusion or frustration with the material and in the impression that the people or organisations who wrote or published the material had little understanding of the community’s needs.

In order to help them better understand the material, participants requested that terminology be explained in their language, and that words be included in English (as well as translated). In many cases, they were more likely to have come across those terms in Australia than in their country of origin, and knowing the English terminology allowed them to discuss the issue with their health care provider.

Knowledge of HIV varied widely between participants, depending on their educational and professional background. It ranged from advanced (for community health workers, nurses and doctors in the groups) to very limited, to non-existent. Some
groups showed strong beliefs in ‘conspiracy theories’ to explain HIV infections and the development of the epidemic.

Most people had seen more information outside Australia than since they had lived in Australia: through media campaigns in Thailand and Vietnam, billboards, information sessions and awareness raising activities in refugee camps. This led to a sense that HIV was not an issue in Australia, as it was seldom discussed. Knowledge of HIV incidence in Australia was extremely low.

**Intergenerational communication**

> In an African context of living, they function completely differently, there’s an understanding of freedom, a respect for the elderly... but once they come here, I think it becomes looser, and parents actually lose their grip … (Key Informant)

Service Providers and Focus Group participants expressed a high level of concern about young people and the difficulty they have in reconciling their parents’ culture and the youth culture in Australia. Adults who are first generation migrants are concerned about the level of freedom enjoyed by their children in Australia, and the loss of the sense of community and respect for elders.

This ‘gap’ experienced by young people between their culture and that of their parents’ can lead to risk-taking behaviour, through a combination of freedom, peer pressure and lack of information. All groups conferred that HIV was a problem mainly for young unmarried people, who enjoyed more sexual freedom and many temptations in their new country. Adults sometimes felt ill-equipped to deal with these temptations. They felt that their children’s need for sexual health information was high – and rarely met by parents or other community members.

Women, as mothers, felt a responsibility to provide information to their children to ensure their welfare, including information about sexual health. They were often torn between their desire to inform their children and their own feelings towards the sensitive nature of the information.

For new communities, the first twelve months in Australia, when everything is new, presents a particular area of risk.
It shouldn’t be assumed that young people speak the language of their parents – or that they don’t. This depends on how long their community has been established, whether they have attended school in Australia, and how old they were when they arrived. In the group of young people of Arabic background, all bar one spoke English better than Arabic (several did not speak Arabic at all, while others spoke a ‘broken Arabic’). On the other hand, Thai students, even though they are attending university in English, used Thai in all their interactions. Young people from the Horn of Africa were fluent in English and their parents’ language, but expressed a preference for information in their parents’ language over English.

Language is not the only ‘tool’ to communicate effectively with young people. An acknowledgement of their cultural (including religious) background can also increase the relevance of the information provided. Without it, there is a risk that they will see the information as not targeting them, particularly if it is in English. One way of acknowledging their cultural difference and making information more adapted to their needs is to use a presenter from the same cultural background.

**Role of resettlement and the refugee experience in access to HIV prevention information**

*I tested these people for malaria last week, and (...) the little boy had the worst kind of malaria, and I had to send him to the hospital in an ambulance. They had been in the country five days, you know? HIV was the last thing on their minds. (Key Informant)*

For newly-arrived communities, resettlement and the many priorities that accompany it take precedence over other, more secondary, needs. Housing, income support, education and urgent health care are the highest priorities. Learning a new language and the many new structures and services are also important. In this context, there is little place and time for HIV prevention information.

On arrival in Australia, people accepted under the Commonwealth Government’s Humanitarian Entrants program are overwhelmed with written information relating to Medicare, Centrelink, opening a bank account, or enrolling children at school. It can be difficult, with few English skills, to differentiate between official forms and educational brochures. This and the enormous amount of information, means that
any written information that is not directly related to one of their priority needs is likely to be discarded.

The chaotic nature of this settlement period can also make it difficult for new arrivals to process information. Alternatively, this is also a time when people form a 'captive audience' that can be reached through English Language Schools or re-settlement programs, and can be given information in a more accessible and appropriate way.

For refugees, the fact that they had been screened for HIV before being accepted in Australia created a ‘false sense of security’ that HIV was a problem of the past, and was not present in their community (see more on this in the ‘Returning Home’ section). Some new arrivals who spent several years in refugee camps or as refugees in other countries felt that they have been already exposed to a lot of HIV prevention information before their arrival in Australia.

Service Providers suggested that including HIV information in a context of general health and with an emphasis on the well-being of the community, and particularly of young people, would be an effective way to reach new-arrivals as these are issues of high importance for them.

**Returning home**

*The fluidity between the two countries is a big thing in certain groups.*

(Key Informant)

The risks associated with trips to the country of origin or the country of temporary residence was often mentioned by Service Providers and participants alike. The links between the communities settled in Australia and their relatives and friends in the country of origin remain strong and visits are frequent. This is an issue for HIV prevention when the country of origin is a country of high HIV prevalence. This issue was brought up by some participants in relation to their concern about HIV rates in their community in Australia. Because of the screening process when applying for permanent residency, they identified these trips as opportunities for infection – as there is no HIV testing on re-entry.

Women in the Vietnamese community were concerned about the risks taken by men when visiting friends and relatives in Vietnam. They blamed men for infecting their
wives upon their return. With more recently arrived communities (such as Horn of Africa), such trips are beginning to occur, and this also caused concern to women in these communities.

In other instances risk behaviours takes place in Australia, as a result of estrangement from one’s family. For some men, their wife and children may have remained in the country of origin. Overseas students, away from parental influence, enjoy more freedom in Australia than in their home country.

**FINDINGS ABOUT INFORMATION PROVISION**

*If a community was consistently telling you that was offensive ... I don’t think the information should be there. The difficulty is how do you reach the people within that community who are engaging in those practices?* (Key Informant)

**Language and literacy**

Our study has highlighted the differences between, but more importantly within, communities: differences based on gender, age, time of arrival, resettlement experience, social and educational background. HIV Prevention is a sensitive topic, and is intimately linked to cultural norms, which vary between communities and sub-groups. Within the Arabic community for instance, there are vast differences between the way young people feel and talk about sexual relationships and the way their parents do. There are also differences between Lebanese, Egyptian and Iraqi’s levels of comfort (or discomfort) with the topic, and within these communities: Muslims or Christians, established groups or recently arrived refugees, may address these issues differently.

No conclusions can be drawn that apply to all communities in regards to the best ways of providing information about HIV prevention. Even the most basic elements of information provision (language and literacy) differ widely between groups. The preferred language of participants cannot be assumed from their nationality. Their ethnic background (as opposed to nationality) and their migration history often determine their preferred spoken and written language/s. In Focus Groups of women from the Horn of Africa, no two participants showed the same ‘equation’ of language spoken at home/preferred written/preferred spoken languages.
It also became clear through the Focus Group process that the participants’ literacy in English or in their preferred language varied from one person to the next: here too, history of migration, time spent in refugee camps and educational opportunities determine peoples’ literacy levels. It was not uncommon for women who spoke a language other than English at home (for instance Somali) to only be literate in English, as they had had no opportunity for education before migration to Australia.

**Different approaches for different communities**

‘The utilisation of strategies that take account of the cultural shaping and sensitivities relating to sexual health’ are a challenge for service providers. Given the diversity outlined above, there is not one approach that meets the needs of all communities. Whatever material (written or audio-visual) is produced, it needs to be flexible enough to be adapted to the different needs – or to be produced specifically for one community, after a consultation process.

A limited number of themes emerged with consistency across all groups:

- The preference for face-to-face interaction.
- The lack of awareness that material was available about HIV in their language. Participants, whatever their cultural or socio-economic background, profession or age, had never seen material about HIV in their language in Australia and were not aware that such material existed or of websites offering translated health information. In many cases, they were adamant that such material was not available.
- The need for privacy when accessing material about HIV.

While most participants raised these issues, there was little common ground in the way they were approached.

In regards to channels of communications, Focus Group findings highlighted the vast differences between communities and sub-groups on how they obtain information of this nature:

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17 Gifford S and Temple-Smith M (2005), *Diversity and difference: the cultural shaping of sexual health*, in Sexual Health, an Australian perspective, IP Communications, Melbourne
• Internet use and confidence in the medium. The internet was surprisingly popular and its use was high, in great respect because of the privacy it allowed. Most participants were not aware that material published in Australia in their language was available on the Internet.

• Language ‘pull factor’: for some groups, such as women from the Horn of Africa or Iraqi men in Shepparton, the availability of materials in their language is vital. For other groups, such as young people of Arabic background, material in English is preferred. Many participants across all groups recommended the inclusion of English terminology to describe symptoms and diseases as this allows them to discuss their concern with their GP, and as they may be more familiar with the terminology in English than in their preferred language.

• Preferred Service Providers ranged from GP, community workers, friends and family, the internet, to community leaders and books.

• How much the material’s design and general appearance influenced readers’ uptake and perception of material also varied between participants.

This diversity presents a challenge for the writers and publishers of such information, as they can rarely afford to design information or materials specifically for each sub-group.
THE ROLE OF GPs

The role of General Practitioners as information providers was discussed by Key Informants and by Focus Group participants alike. One Service Provider felt that GPs are in an ideal position to do that kind of brief intervention. However, for Focus Group participants, asking their GP for information about sexual health was often the result of a perceived lack of alternatives.

For many participants in this research, visits to the GP were their only contact with health services, the ‘first port of call’ and the only source of health information they knew of. People often turned to their GP for information because they did not know where else to go, and held little hope of receiving detailed information. A frequent comment was that General Practitioners have little time, and will only provide information if specifically requested. A GP working with refugees confirmed that consultation time was limited and that HIV prevention would only be addressed if there was a certain context in the consultation.18

While some participants were nervous about confidentiality and privacy issues when discussing sexual health, this was mainly the case in small communities where the risk of inadvertently meeting a GP outside the consultation setting was higher.

Service Providers working in the sexual health field reported that people of CALD background were often reluctant to consult with GPs for sexual-health related issues, but this was not reflected in the Focus Groups. Young people were more comfortable than adults discussing sexual health issues with their GPs.

When people are reluctant to consult a GP from their community background, they can lack alternatives if their English-language skills are poor.

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18 In November 2005, the Commonwealth Government announced that from May 2006, refugees would be given a new Medicare item that covers them for a full medical check up, particularly targeting diseases such as HIV/AIDS, cholera, malaria and TB.
The perceived level of confidence in GP’s knowledge and competence was high – apart from Thai students who found the health system in Australia less satisfactory than in Thailand.

Other sources of health information mentioned were community workers: while some participants suspected that they may not be as knowledgeable as GPs, they were likely to be more aware of the community’s needs and cultural context.

Dealing with sensitivity

A great deal of sensitivity was raised concerning the inclusion of sexual practices such as oral and anal sex in information material. It was frequently claimed that such practices were not relevant to the community and were in fact very offensive. As a consequence, it was often resolutely stated that such material would not be read.

Whether or not we give credence to the claims that oral sex does not occur in these communities, it is important that we listen to the reaction to the inclusion in HIV prevention material of this sexual act as a risk practice. If a document is rejected as a whole because it includes description of oral or anal sex, or a diagram of how to use a condom, then the whole effort put into producing this document amounts to nothing, and information that would be useful and would respond to the expressed need for education, does not reach its target audience. As stated by a service provider: *If it's not culturally appropriate, well, then it's just not going to work.* This leaves health professionals and service providers with the challenge of responding to cultural sensitivities without omitting useful information.

Most material is currently translated into languages from a common English template, written for an English-speaking audience, no doubt in the belief that ‘the process of translation will ensure understanding of the content in the destination language’. As a result, it keeps with the ‘Anglo-northern communicative preference for ambiguity avoidance’ and ‘precisely defines sexual acts’. According to Fletcher, this English-language blueprint ‘directly affects the ability of non-English speakers to internalise and act on messages which could save their lives’.

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19 Fletcher G (2002), *Mind your language? Deconstructing an HIV/Aids information leaflet in English and in translation*, unpublished, La Trobe University, Melbourne
20 Ibid
The difficulty of producing material for such diverse needs is made even more complex by the sensitivity of issues related to HIV. As discussed above what is seen as acceptable in a community may be perceived as highly offensive by another, and result in the rejection of the material as a whole.

We asked Key Informants and Focus Group participants to make suggestions on the best way to provide information that meet their needs and respect their sensitivity. They offered the following suggestions:

- placing the description of sexual practices further in the documents – not on the first page
- placing sensitive information on a separate, detachable leaflet
- announcing the presence of such information as a ‘disclaimer’, admitting that it may shock some readers.

Ultimately, these suggestions are about choice and respect: giving readers a choice instead of imposing the information, and respecting their sensitivity by acknowledging that this information, however useful, may seem offensive.

**The role of written information**

For most, written information was not the preferred way to receive information about HIV prevention. Face-to-face communication, through information sessions or one-on-one discussions with a health or community worker, was preferred. Written information was seen as a support or an extension of this direct and personal interaction.

Participants highlighted many positive aspects of written information, such as:

- It is easily accessible
- It offers the advantage of presenting all the necessary information at once, in one document
- It is generally clear
- It can be read in one’s own time.
Negative aspects that were also mentioned included:

- The terminology used can be difficult to understand
- The inclusion of insensitive diagrams
- It cannot be accessed by the illiterate members of a community
- There is a risk of being ‘found’ with it.

If written information was to be used, Focus Group participants offered suggestions that would encourage members of their communities to pick up the material and read it. For example: a Q&A format, simple and clear content with no ‘jargon’, pictures and diagrams representing people and families, a clear indication of the language of the brochure on the front page (as this can be the reason for picking up the material), and a culturally-specific presentation that makes the material instantly recognisable as being addressed to one community.

**Face-to-face communication as a way to address diversity**

Written materials in themselves are not sufficient to get the message of HIV prevention across: while it is an important part of the jigsaw, the key to making it specific to its audience resides in when and how it is used. If it is presented by someone who understands the group’s cultural context and where discussion of sexual health sits in this context, and who acknowledges the sensitivities, then this opens a space where boundaries can be pushed and sensitive information can be introduced.

This need for material to be accompanied by face-to-face interaction is one of the few findings common to all the communities researched. Information sessions were seen as the most effective way to pass on prevention information about HIV. While there was some acknowledgement, particularly from men, that these may be difficult to organise, information sessions were seen as a way to address the heterogeneity of communities, cultural and language differences, differences in literacy levels, and to place information in a context that makes it acceptable to audiences. Information on HIV transmission, for instance, is better received if it is presented in a context that audiences can relate to, such as in relation to religious background, to migration, to the refugee experience, etc.
At the same time, our Focus Groups with men also showed the reluctance men may have in exposing and acknowledging gaps in their knowledge in front of other men, or in admitting to sensitivity around certain issues when they realise this may be interpreted as conservatism or lack of sophistication. This has to be taken into account when organising information provision as it may limit the value of group sessions.

Information sessions require informed multilingual and multicultural community educators, supported through regular training and professional development. Based on their experiences as advocates in their community, they can provide input when material is written and designed. They are an essential link between institutions and communities, an ‘ear to the ground’ that can inform the way the public health sector works with the CALD members of our communities and develop a stronger awareness of HIV prevention.
RECOMMENDATIONS

1. A broad campaign is required to accompany the production of all material in languages other than English. Consultation about content and delivery needs to take place with each target community. Appropriate means of distribution of material should be discussed within the community consultation process.

2. In order to make HIV prevention relevant to these groups it is essential to raise awareness of incidence in Australia and in their own communities and to address concerns about stigma and support.

3. Information about HIV prevention will be more readily accepted if packaged within a community health framework and not within an individual sexual/relationship approach.

4. A particular effort must be made to investigate ways to negotiate the conflict between the sensitive nature of the material and the willingness to know about HIV. How to deliver sensitive information which does not alienate audiences will require community input.

5. The prime form of information delivery needs to shift away from the reliance on written information to face-to-face interactions (information sessions and one-on-one). In many cases this will include bi-cultural and bi-lingual community workers.

6. All information, including written material, should be delivered in community languages and in English. This will accommodate the range of language and literacy skills within each community and facilitate communication with English-speaking service providers.

7. Written material should be based on an English template that was developed specifically with CALD communities in mind. This will help to address concerns regarding appropriate terminology and presentation of material.
COMMUNITY FINDINGS

ARABIC-SPEAKING BACKGROUND
BACKGROUND

COMMUNITY PROFILE

The information in this section is based on Australian Bureau of Statistics 2001 Census data, and on data from the Department of Immigration and Multicultural Affairs. As such, it gives a broad picture of the main trends but does not reflect the diversity within each community in terms of language, educational and employment levels, or literacy. The diversity between and within Arabic-speaking communities is highlighted later in this chapter.

In a nutshell

The Arabic community in Victoria is:
- diverse in countries of origin (22 countries)
- diverse in religious beliefs (Christians, Muslims, Greek Orthodox)
- diverse in date of arrival (some established communities and some recent arrivals)
- mainly based in metropolitan Melbourne (north and north west), but there is a large Iraqi community recently-established in Shepparton

With 47,147 speakers, Arabic is the fifth most common language spoken at home in Victoria. Far from monolithic, behind this figure lies a disparate community with 22 countries of origin. These can be roughly grouped as follows:

- Middle-East (Syria, Lebanon, Egypt, Palestine, UAE, Kuwait)
- Horn of Africa (Sudan, with many Eritrean and Ethiopians speakers)
- Iraq

This complexity is compounded by differences in dates of arrival and settlement circumstances, with a combination of Arabic-speakers arriving in Australia during the 1960’s and 1970’s and more recent refugees groups, some of whom have experienced life in refugee camps overseas or in Australian Immigration Detention.

For the purpose of this research, we have focused on the Lebanese and Iraqi communities. People of Lebanese background form the largest Arabic-speaking

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community in Victoria. Iraqis are the largest Arabic-speaking emerging community (outside Sudanese, whom we have researched under the ‘Horn of Africa’ groups): 6,093 Iraqis had settled in Victoria by 2001 – a figure that has since greatly increased, notably with the settlement in Shepparton and Cobram, in Northern Victoria, of up to 2,000 Iraqis and Kuwaitis.

**Lebanese**
About 20% (14,168 people in 2001) of the Australian Lebanese population lives in Victoria. However, this is not inclusive of those who identify as being of Lebanese ancestry (31,136). Most live in metropolitan Melbourne, mainly in the local government areas of Moreland, Hume and Darebin. This is a relatively established migrant group, with more than half the community arriving before 1981.

Those who are Lebanon-born are of young to mid-adult age, with the majority aged between 25 and 45 years old. There are slightly more men than women. The community is religiously diverse, with about 45% identifying as Muslims, 20% as Western Catholic, and some as Greek Orthodox, Maronite Catholic and Antiochian Orthodox.

**Language & Education**
The main language is Arabic, spoken at home by 9 in 10 of those who are Lebanon-born. Other languages spoken at home are English, Armenian and Assyrian. Seventy per cent of the community assess themselves as speaking English ‘well’ or ‘very well’.

Post-school qualifications were low: 75.2% of Lebanon-born had no higher degree qualification, and only 4.6% hold a Bachelor degree. Unemployment is more than twice the state average (17.8%).

**Internet use**
Computer use is very low: only one in five had a computer at home and one in six accessed the Internet.

**Iraqi**
The 2001 census reveals that more than half the Iraq-born population arrived between 1996 and 2001.
Many Iraqis were amongst the asylum-seekers reaching Australian shores in 2000 and 2001. More than 90% have since been recognised as refugees and released on Temporary Protection Visas. Many of this recently-arrived group has settled in the towns of Shepparton and Cobram, Victoria. Although census statistics are not available to support this fact, research, local workers and press articles confirm that the population has grown markedly since 2001,\(^2\)\(^3\) with figures reaching 3500 in the Shepparton/Cobram area in some estimates.\(^4\)

In Melbourne, Iraqis live mainly in the local government areas of Hume and Moreland.

The Iraqi community is mainly an adult and male population, with almost one in two Iraqi aged between 25 and 44 years old, and a ratio of 124 males to 100 females.

In 2001, more than half (51.1%) of Victoria’s Iraq-born community identified as Western Catholic, and only 28.5% as Muslim. Of the Shepparton-based Iraqi population, the majority are Sunni and Shi’a Muslims.

**Language & Education**

Most of the Iraq-born community members spoke a language other than English at home: almost half spoke Arabic, and another half Assyrian. The remaining 10% spoke either Kurdish, English only or other local languages. This community also presents a relatively high English-language proficiency, with 68% assessing themselves as speaking English either well or very well. One in five Iraqis spoke English ‘not well’ and another 6% ‘not at all’.

The community comprises a high number of members without post-school qualifications (65%), which is in great part due to their migration and refugee experience and to the difficulties of accessing education for certain groups in Iraq.

**Internet use**

Computer use is very low, with only 26.6% of the Iraq-born having access to a computer at home and less than 24% having access to the Internet.

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\(^2\) ABC Radio, AM, 28/01/2005
\(^3\) Human Rights and Equal Opportunity Commission (2003), *Consultation with students from Goulburn-Ovens TAFE at Shepparton* (Victoria) hosted by Shepparton Ethnic Communities Council, HREOC Website (www.hreoc.gov.au)
\(^4\) ABC TV, *Shepparton, Victoria and its connection to Iraq*, 7.30 report, reporter: Heather Ewart, 21/03/2003
# INFORMATION AVAILABLE TO THE ARABIC SPEAKING COMMUNITY

Following is a table of booklets and brochures related to HIV prevention in Arabic. Although we selected documents produced or revised since 2000, older materials of particular relevance have been included.

<table>
<thead>
<tr>
<th>MATERIAL</th>
<th>SOURCE</th>
<th>PUBLISHER</th>
<th>DATE (last update)</th>
<th>FORMAT</th>
<th>INCLUDES CONTACT DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS Your Questions Answered</td>
<td>Internet. Hard copy of English version. Other languages Internet only.</td>
<td>Victorian Department of Human Services (DHS)</td>
<td>2003</td>
<td>Q&amp;A format, responding to basic questions about HIV</td>
<td>YES</td>
</tr>
<tr>
<td>Safe Sex</td>
<td>Internet. Hard copy of English version. Other languages Internet only.</td>
<td>Victorian Department of Human Services (DHS)</td>
<td>2003</td>
<td>Q&amp;A format, responding to basic questions about safe sex</td>
<td>YES</td>
</tr>
<tr>
<td>Sexually Transmissible Infections</td>
<td>Internet. Hard copy of English version. Other languages Internet only.</td>
<td>Victorian Department of Human Services (DHS)</td>
<td>2003</td>
<td>Q&amp;A format, responding to basic questions about STIs</td>
<td>YES</td>
</tr>
<tr>
<td>HIV An Introduction – Fact Sheet 1</td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>Basic information - general</td>
<td>NO</td>
</tr>
<tr>
<td>The Effects of HIV/AIDS – Fact Sheet 4</td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>The Effects of HIV/AIDS</td>
<td>NO</td>
</tr>
<tr>
<td>The Health System in Australia – Fact Sheet 7</td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>The Health System in Australia</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Some common terms (glossary) – Fact Sheet 8</strong></td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>A glossary of terminology relevant to HIV prevention</td>
<td>NO</td>
</tr>
<tr>
<td><strong>HIV INFECTION A.I.D.S.</strong></td>
<td>Internet only - no hard copy. NSW specific</td>
<td>Sydney Sexual health Centre</td>
<td>2001</td>
<td>Basic information - general</td>
<td>YES</td>
</tr>
<tr>
<td><strong>STI’s</strong></td>
<td>Internet</td>
<td>Sexual Health Information Networking and Education SA (Shine SA) South Australian Department of Human Services</td>
<td>2000</td>
<td>STI information, including HIV</td>
<td>YES</td>
</tr>
<tr>
<td><strong>The Condom</strong></td>
<td>Internet</td>
<td>South Australian Department of Human Services</td>
<td>1996</td>
<td>STI information, including HIV</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Women Talk ... about Aids, Sex &amp; Sexual Health</strong></td>
<td>Booklet developed by the Islamic Women’s Welfare Council of Victoria</td>
<td>Commonwealth Department of Health &amp; Family Services</td>
<td>1996</td>
<td>Bilingual booklet written specifically for Arabic women about sexual health (including HIV)</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Women and HIV (Fact Sheet 1 - Testing)</strong></td>
<td>Internet</td>
<td>Family Planning Australia &amp; NSW Health</td>
<td>2002</td>
<td>Part of six fact sheets for women with HIV</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Healthy African Women</strong></td>
<td>Brochure (A6)</td>
<td>Women Health West</td>
<td></td>
<td>Brief health (including sexual health) information</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Everybody’s Business</strong></td>
<td>Video</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>1999</td>
<td>General HIV information</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>The Australian AIDS Tape</strong></td>
<td>Audio Tape</td>
<td>NSW Department of Health</td>
<td>2000</td>
<td>General HIV information</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Don’t be afraid to ask</strong></td>
<td>Booklet (A6). Bilingual English/Arabic and specifically for Injecting drug users (NSW only)</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>HEP C information, bilingual and with photos of people of different ethnic backgrounds</td>
<td>NO</td>
</tr>
</tbody>
</table>
FINDINGS FROM KEY INFORMANT INTERVIEWS

Key Informants interviewed for this research were primarily concerned with the risks taken by young people in their community, and the fact that information was not always provided in a way that was relevant to the specific needs of Arabic youth.

Reaching Young People
Like other young people whose parents migrated to Australia, young people of Arabic background need to negotiate both the Australian culture and the expectation that they will engage with their parents’ culture. Part of the pressure of living between two cultures is that young people must meet family expectations; for instance, getting married at a young age, while also responding to the expectations of their peers. This can create situations where they adopt risky behaviours without having the opportunity or resources to access relevant information. As described by the MENTORS (Middle East Natives Testing, Orientation and Referral Service) Program in the United States, prevention must take care to reach Arab Youth, who are at greater risk of HIV and, while more assimilated than many adults, are making life decisions amid conflicting cultural values and messages.5

It is very important to talk to them and give them information at this age … the ones who are a bit liberated they can do much harm to themselves because they are ignorant and they try to do everything before they get to marriage age. (Community Worker I)

All Key Informants agreed that there was a need to provide more information to young people, regardless of parental expectations of ‘good behaviour’.

In this country, the young boys (more than the girls) they have more chance to have sexual relationships. I think it is very important to teach them about sex the safe way. (CW II)

Part of our culture, our parents don’t give us sex education; It’s more ‘You’ll find out one day.’ (CW III)

According to one Key Informant who works with young people of Arabic background in schools, this dichotomy is present in the way young people associate the use of English language with a greater level of personal freedom.

_In English they can discuss anything, openly talk about sex, sexual health; they can do that, even the girls. When they are at home that’s different, they are very polite, conservative, they don’t even swear. I discovered that they feel that when they are using the English language they can talk freely because no one is correcting them, no one is hearing them like at home._ (CW 1)

Many young people of Arabic background were born in Australia and do not speak Arabic, or speak a broken Arabic, depending on how long they have lived in Australia. Many young Lebanese for instance, don’t speak the language, they don’t read it they can’t go into a deep conversation in Arabic. (CW 1)

At the same time, young people who have arrived more recently may give the impression that they are fluent in English, but may lack a level of language sophistication that results in a limited understanding of health related material.

_The Arabic kids when they are talking they have a very good Australian accent, but if you are talking with them they don’t really have enough English language, especially the medical terminology._ (CW II)

One way to address this is to provide bilingual information. Another way is to provide specific material for young people, or at least material that is presented in a way that takes into account the nuances of their cultural context.

_The thing that I feel is always missing is that I think this is Australian culture. I feel in their mind all the information in English is related to the Australian culture. So it needs to be linked with some cultural information or followed by sessions where a person from the same background leads the discussion … They would believe a person from the same background, they would trust him more than an Australian source. It is because of the ‘values thing’, they think that person would share the same values._ (CW I)

For many young people, religion is a part of their life, either because they are practising or because it defines their family’s culture.
There is an issue of trust and thinking that I have the same religious belief as them, they check with me whether I am Christian or Muslim, it’s the first thing they do. (CW)

Some of the young people are very conservative, very religious, connected to their Church. This Informant felt that for young Muslims it can be more a matter of acknowledging the role Islam plays in their life and the linking of information presented to the teachings of the Koran and its different interpretations (e.g. contraception or pre-marital sex).\(^6\)

**Involving Parents**

It is essential to obtain parental agreement in order to reach young people with information about sexual health, or, as youth workers working with school children under the ARAB (Anti-Racism Action Band) Program put it: *to have parents on-side.*

*Even to talk to [parents] we have to follow certain strategies, like calling them one by one to explain what the program is about, consult with them whether they can give permission.* (CW I)

Parents worry about what information their children are exposed to at school, particularly sexual education.

*When the mother or the father has enough information and know exactly what [the sessions] are about, they will allow their boys and girls to attend.* (CW I)

**Gender differences**

All Key Informants highlighted the importance of respecting gender differences in terms of information needs and delivery. One felt that girls were likely to be less sexually active.

*I am sure some of the [Arabic boys] are having sex, but there’s no way they’re having sex with Arabic girls.* (CW II)

Therefore the girls do not need the same access to sexual health information as the boys. Commenting on a diagram showing a condom and penis, this Community Worker explained;

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I am an educated woman but I would never let my daughter see this, because that means we would teach her something that is not necessary to teach her now. As we don’t allow girls to have sex before they get married I think it is not necessary to have this information at this stage. (CW II)

This Community Worker, who works mainly with women, also felt that many women of Arabic background had little understanding of their own body and were hungry for information.

They are very busy looking after their husbands and children, they are never thinking about themselves. (CW II)

This was confirmed by another Key Informant who provides education to parents and has found that some women had little knowledge of the sort of world in which their children were growing up.

This woman, she’s been having problems with her sons, she doesn’t know anything about HIV because she was involved in raising her children and she believes she gave them all the important teachings. (CW I)

It is essential to provide information separately for men and women; if you run information sessions together very few people will come. This includes ensuring that both the presenter and the interpreter are of the same gender as the target audience. This message from the Key Informants was clear: it is not possible to ask a question [about sexual health] in front of a person from the opposite sex. This can pose problems during sexual education classes at school, where young people can’t ask what they want because there’s an Arabic boy or girl in the same class. (CW II)

**FOCUS GROUP SELECTION**

Three Focus Groups were selected for this community. They are as follows:

**Arabic Women**

Women were identified by the Arabic co-worker and Key Informants as key to the collection and dissemination of information in their community, particularly to their children. Channels of Information need, where possible, to address men and women separately, particularly when dealing with issues that are considered to be sensitive.
The importance of conducting segregated education sessions for the community was emphasised by one Key Informant from the Iraqi Community when she commented: *the speaker will be female, the interpreter will be female, anybody who provides that information, and then there’s no problem!* Iraqi and Lebanese women were chosen firstly because they come from the two largest groups in Victoria and secondly for the differences in cultures and date of arrival.

The Focus Group with Arabic Women consisted of 10 women, mostly aged from 40 to 54 (with one participant aged 28). Six were born in Iraq and four in Lebanon. Four (Iraqi) were recent arrivals, living in Australia from 3 to 7 years. The others had lived in Australia between 17 and 24 years. All were married with children.

Below is the material presented to this Focus Group:

**Women Talk**
(Islamic Women Welfare Council of Victoria)

**HIV An Introduction (MHAHS)**

**Getting it Right!**
(MHAHS)

**Arabic Young People**

As is common for other communities, young people of Arabic-background straddle two cultures: that of their parents and that of the broader Australian culture. Negotiating these cultures can be challenging, leading them to adopt different positions to match changing circumstances.

The Focus Group was comprised of 5 females and 4 males, aged 18 to 26, of Lebanese and Egyptian background. All participants, excluding one, were Australian-born or arrived in Australia as small children. Five were students (university or TAFE)
and four were employed. Most were connected with the Victorian Arabic Social services.

Below is the material presented to this Focus Group:

Iraqi Men (Shepparton)

A Focus Group was run in Shepparton, Victoria, to allow for the inclusion of a large and recently formed community in a regional setting. It provided an opportunity to investigate the provision of information to one of the most disadvantaged groups in Australia, refugees under Temporary Protection Visas (TPV). The level of support received by refugees on TPV is markedly inferior to that received by Humanitarian Entrants and other refugees who are permanent residents. Access to information and people’s view of sexual health issues is also influenced by issues of trauma and the refugee experience, mental health, level of anxiety and depression, etc.

A group of 10 men of Iraqi and Kuwaiti backgrounds, aged 20 to 71 years old, participated in the Focus Group discussions. They had lived in Australia between 2 and 10 years (the majority around 5). They were representative of the diverse socio-economic backgrounds of the Shepparton Iraqi community, with professionals, employed and unemployed participants, retirees and students. Seven were married, one divorced, and two were single.
Below are the materials presented to this Focus Group:

**Sexually Transmitted Diseases (DHS)**

**Getting it Right! (MHAHS)**

**HIV/AIDS Your questions answered(DHS)**
KEY FINDINGS

WOMEN FROM ARABIC-SPEAKING BACKGROUND

There are varied levels of conservatism or openness about sexual issues between Arabic-speakers. A piece of material translated in Arabic may be received very differently depending on the level of sensitivity around sexual issues.

Women in the group seemed torn between the restrictions of their culture and their desire to have access to more information for themselves and for their family. This led to contradictory statements about appropriate language, presentation of material, ability to take information home, etc.

Health literacy was poor, and women admitted knowing little about their body and sexuality.

Generally speaking, HIV/AIDS in the Arabic community is treated with secrecy and shame. Sexual health is rarely discussed. The participants had never received any information about HIV/AIDS.

Women see themselves as key information providers to their children. They are aware of the gap between their children’s knowledge and sexual experience with their own. They are keen to bridge this gap.

Information that presented HIV/AIDS as a health issue was more readily accepted than that which presented it as a relationship issue. The participants were only interested in basic, factual information about prevention, presented in a medical/scientific manner.

Diagrams of condoms were seen as offensive, ‘men’s business’ and would deter women from sharing the material due to the stigma associated with carrying such information and ‘being seen’ with it.

HIV/AIDS is not seen to be a major problem in Australia thanks to a high level of awareness and education. Young people of Arabic background receive sexual education at school and men who may be unfaithful to their wives know how to protect themselves.
### Information Provision

Some preferred written information to take home, as long as it is in a moderate and culturally appropriate language.

A Question & Answer format with little terminology was preferred.

Terminology related to sexual health was better understood in English than in Arabic.

Bilingual material was seen as useful as it would address the different levels of fluency in English.

Internet provided the opportunity to seek out information in privacy, and Arabic sites are widely used.

Arabic-language media, particularly satellite television, are a primary source of information.
MEN FROM ARABIC-SPEAKING BACKGROUND (SHEPPARTON)

HIV/AIDS was highly stigmatised and associated with ‘unrestricted’ behaviour. Therefore, the men in the group did not see themselves as being at risk.

Participants believed that the ‘boundary-free culture’ of Australia presented a risk in terms of HIV infection, but that this was corrected by the high level of education and access to health information.

None of the participants has ever read any information about HIV/AIDS, either in Arabic or in English.

Knowledge of HIV/AIDS and modes of transmission was very limited and included erroneous beliefs. Health literacy and understanding of terminology varied widely between participants.

Specific terms (oral sex, anal sex), description of certain physical contacts and diagrams pertaining to condom use provoked very strong and negative reactions. They were seen as culturally inappropriate and reinforced the impression of irrelevance of this information for the Arabic-speaking community.

Participants clearly stated that the inclusion of such insensitive words and pictures would absolutely prevent them from using the material and from sharing it with family members. Only one participant (the youngest of the group) felt that he had an obligation to share information seen as useful with his family, however sensitive the information may be.

HIV could be discussed in a family setting if it was presented in scientific terms, but not if it was seen as an issue of sexual nature.

Information Provision
Arabic was the preferred and for many the only valid language for information provision for this group. English information was considered useless.

There was a desire to accommodate the diversity of the community and find ways to present information acceptable to families, young people, and for different levels of English proficiency.
GPs (preferably Arabic-speaking) and to a lesser extent specialists and Community Workers were the preferred and only sources of health information, including sexual health. However the small size of the community and the perceived lack of privacy may hinder the willingness to seek HIV/AIDS information from a GP.

As a newly arrived group in a regional area, these men felt at a disadvantage in terms of access to information. The lack of Arabic media and paucity of Arabic-speaking services in particular were mentioned.

In this context, the Internet was seen as the only media available, although its reliability was questioned. The participants had never used the Internet to access HIV/AIDS information.

Written information was generally supported as an effective and practical mean to provide sexual health information, as long as it is clear and sensitive. It was preferred over Internet-based information and over information sessions.
### YOUNG PEOPLE OF ARABIC BACKGROUND

Parents’ tacit or expressed permission was essential to the young people’s ability to take information home to read.

The material was not seen as sensitive by young people’s standards, but definitely too sensitive for older generations, in particular the inclusion of diagrams depicting the use of condoms.

Community stigma about HIV/AIDS and its perceived link with homosexuality and drug use limited young people’s ability to discuss HIV/AIDS-related information with their family.

Therefore raising the Arabic community awareness about HIV/AIDS and its relevance to the Australian population as a whole was seen as a pre-requisite to facilitating young people’s access to information.

The participants were Australia-educated and their health literacy was built on information available through the Australian school system. They had no difficulty understanding the material in English.

Some had come across information about HIV/AIDS (in English) through their schooling and studies but did not find the topic relevant as they were *not affected by the disease*. Their only discussions on this topic had been around political conspiracies.

### Information Provision

Most of the young people in the group did not speak Arabic well, and preferred material in English.

Participants strongly recommended bilingual information as a way to cross the language-divide between their generation and that of their parents and grandparents. It would also increase the usefulness of the material to young people who have more recently migrated to Australia.
Community Workers were the preferred information provider, as they were expected to be able to make the information relevant to the context of the young people’s life. GPS were seen as less flexible.

Young participants found written information of limited use, preferring to have the opportunity to ask questions and clarify issues with someone.

Contact details of relevant organisations and a toll-free number also offered means to obtain more specific information.

Use of colour, simplicity of information and a clear statement that HIV/AIDS information is relevant to everyone (therefore diffusing assumptions of sexual orientation or drug use) were key to the uptake of material.

The Internet (in English) was commonly used for health information, but trust in the medium was low. Government or international agencies’ websites were seen as the most reliable.
THE RELEVANCE OF HIV TO THE ARABIC COMMUNITY

Women
The women in the group felt that it was important for their community to be better informed about HIV and AIDS, even though this was a sensitive topic and was embarrassing to discuss. They felt under-informed and were eager to obtain more information for two reasons: [as mothers] our kids know more than us, and [as wives] men in our community are cheating on their wife, we want to know this information in a simple, easy and quick way.

The women valued education as a way to prevent HIV. They believed that the high level of education was the reason why HIV was rare in Australia. Some commented that selling condoms at schools and educating children also contributed to raising awareness.

Men
Most men in the group believed that HIV and sexually transmitted infections were confined to prostitution and ‘unrestricted’ sex. As long as these practices were avoided HIV was not of concern to them. There was a definite connection in their mind between what they understood as a ‘free culture’ and the risk of infection. They agreed that in Australia, as in any other western country, such risks exist.

The reason we are not very concerned about AIDS is that as far as we know, it can be caught either by blood transfusion, needles or sex. Regarding needles, we have no worry at all because we trust the health system in Australia, and when it comes to safe sex, we don’t have sex with people other than our partner.

Some participants believed that the lack of reported HIV in Iraq meant that there were no infections.

Back home, we knew how serious such diseases are, but we never cared much about it because it has never been a problem for Iraqi society.
One participant remarked on specific qualities of Iraqi culture that protected them from HIV;

*Why is HIV/AIDS not an issue in Iraq? Simple: the religious and cultural restrictions.*

Although HIV/AIDS was not seen as a problem in Iraq, all participants felt that they had had access to more information about HIV/AIDS in Iraq than in Australia. This was not a comment about the availability of HIV prevention information in Australia, but about the limited availability of HIV prevention information in their language.

*There were education campaigns through the media, and I watched some Arabic movies about AIDS and the seriousness of this illness.*

The risk of transmission was thought to be higher in Australia than in Iraq, based on the belief that HIV was linked to lack of cultural and religious restrictions. This was off-set by the level of education and medical care available. A participant stated that:

*The access to health information and the ongoing education campaigns increased people’s awareness about the measures that can be followed to eliminate the risk of these diseases.*

*High standards of living and good health services play a big role in limiting the seriousness of these illnesses in Australia.*

In general, the men’s interest in health information was limited.

**Young People**

HIV/AIDS was of little relevance to the young people participating in the Focus Group. While their understanding of modes of transmission was good, they felt unaffected by HIV/AIDS and consequently would neither seek information nor read it when it was made available to them. It was not a topic they had ever talked about to anyone (except for the participant who is a youth worker);

*It is not the type of subject that you discuss.*
The only time they had discussed it was for its news value, around what they themselves described as ‘conspiracy theories’. This belief that HIV is used for political means was also reflected in the Arabic women’s group.

The young people’s attitude towards HIV prevention information was coherent with their attitude to health information in general, in that they would only be curious when directly affected.

**HIV AWARENESS**

**Women**
The women’s understanding of HIV was limited. Sexual contact, saliva, mosquito bites, body piercing and needles were all potential modes of transmission mentioned. Most of the information the women had about HIV/AIDS was around ‘conspiracy theories’, such as a belief that the virus was used as a political weapon in the Middle-East to infect certain groups. Women also reported how infection in Kuwait was due to Kuwaiti men holidaying in Europe, and how a group of African men in Iraq were found to be HIV +.

The women had little knowledge of sexual health in general, and unanimously stated that no one had ever talked to them about HIV/AIDS prior to the Focus Group discussion. The health information sessions they had attended in the past did not mention this topic. They were eager to obtain information, and comfortable to discuss these issues in a small group. Their main concern was about the means of transmission, and whether the virus can be transmitted by using public toilets or by kissing.

**Men**
Awareness of HIV/AIDS and modes of transmission was low, with most participants admitting a lack of awareness about the difference between HIV and AIDS, resulting in the use of both terms indiscriminately. None of the participants had ever read a leaflet about HIV/AIDS in English or Arabic – although a young participant had seen some.

Only [now] I realise that there is a difference between HIV and AIDS, before I thought they were the same irrespective of the term.
All I know about it is that it is transmitted sexually, mainly when someone has casual sex.

Some feared that going to the dentist or the barber represented a risk of HIV transmission. Because of this, one admitted that;

*Neither I nor any of my children have been to the barber since we arrived in Australia, we cut each other’s hair.*

**Young People**

Almost all the participants had grown up in Australia and attended Australian schools and universities where they had been exposed to sexual health and HIV/AIDS information through the school curriculum or through events such as *Sexual Health Education Week*. This, and information sessions run by the Victorian Arabic Social Services, constituted the only times they had ever read information about HIV prevention.

Levels of awareness and understanding varied. None of the participants had any knowledge of the HIV/AIDS situation in their parents’ country – which may be a reflection of the fact that all bar one were Australian-born. They saw it as an increasing problem in Australia, although they had little information to support this. The two main barriers to a higher level of awareness were their own lack of interest in the issue and their perception that their families would block access to information, due to the high level of stigma associated with the virus.

**HEALTH LITERACY**

**Women**

Health literacy was low and was directly related to the difficulty of discussing sex-related issues. Some participants reported that they know little about sexual relationships in general and how uncomfortable they are about their body.

*We feel shy if we see some parts of our body.*
I never took my clothes off in front of my husband.

In addition, medical terminology was not well understood. Several women understood language for STIs and other sexually related terms better in English than in Arabic, primarily because such information had not been available to them before they came to Australia.

Men
The vocabulary used in the material made it difficult for some participants to understand the content and several men mentioned they would need a dictionary to understand some English words/terms. Some material, such as the DHS booklet, was categorically rejected as it was seen as too difficult.

Young People
As mentioned above, these are young people who attended Australian schools and as a result health literacy was not an issue. They had no difficulty understanding the material presented to them. The only term which was not widely understood – and which they said would not be understood in the community, even in Arabic - was ‘harm minimisation’.

SENSITIVITY

Women
The topic of HIV was sensitive among Arabic-speaking women, as was any topic relating to or discussing sex, sexual health or sexuality. The words shame and embarrassed were used repeatedly throughout the discussions.

It was difficult for women to reconcile their own desire to be better informed with both their sense of responsibility to provide information for their children and the high level of sensitivity of the material. There was a debate in the group about how open one could be when talking about sexual issues and what language was acceptable. This debate was not resolved and the ambiguity of some of the women’s positions resulted in statements such as the following which related to anal sex.

We don't like it, but it is in our community, we need to talk about it.
There was a strong belief amongst the women in the group that they were ‘different’ from Australian women in terms of their comfort around such topics. This was highlighted when some participants indicated that the written material was obviously for Australian women as it was quite graphic and detailed in its description of sexual practices.

Material presented in a health/scientific context was seen as less offensive. The sensitivity of the topic was exacerbated if it was presented within the context of relationships. One booklet was strongly criticised by a participant for its use of language to describe feelings and physical contact.

*What sort of language is this, touch and smell and sounds!*

The need to use appropriate and sensitive language was also brought up when the women discussed the sharing of information with their children.

**Using Diagrams**

Sensitivity was shown around the use of explicit diagrams. Diagrams created embarrassment and were a deterrent to reading information, taking it home and discussing it with younger generations. They were seen as *not adding any value* to the material and ultimately deterred people from reading the material.

The negative reaction to the use of diagrams was demonstrated when the women expressed their preference for a black and white fact sheet without illustrations, as opposed to more attractively presented brochures that contained diagrams explaining how to put on a condom. These diagrams were seen as shocking by eight out of the ten women who participated in the group discussion.

*If someone looked in my bag and found this brochure what would they think of my whereabouts?*

Most women felt that condoms and how to use them was a man’s area of responsibility and not appropriate for women to know or learn about. Some also saw condoms as a separate issue, unrelated to HIV/AIDS.

*We have nothing to do with this; it is a man’s business.*
Pictures of female genitals were easily accepted, as they are already found in medical Arabic magazines. Pictures are considered an integral part of information about sexual hygiene. Diagrams, as opposed to pictures, were not seen to add any value to the information and were not seen as a good way to attract potential readers.

**Men**

Details of sexual practices, such as oral sex or anal sex were seen as particularly offensive.

*I feel disgusted about the term ‘oral sex’. I don’t have any big objection about minor things like ‘deep kissing’ but I do about something as offensive as oral sex.*

*That specific description of sex acts is absolutely unnecessary!*

One participant was offended by the inclusion of examples of intimacy such as kissing.

*I don’t understand why someone should label everything with a name? Isn’t it enough to say saliva can’t transmit AIDS?*

It was clear that the inclusion of explicit terminology and diagrams created great embarrassment and would deter participants from using the material. They felt more comfortable reading a booklet that they found less informative and less interesting with no diagrams in comparison with a booklet that may be more informative but also included diagrams. Most men, as the following quote shows, felt strongly about not taking the material home.

*We can’t take it home, I can tell you right now. All of us will read it and leave it in this room before we walk off.*

Descriptions of particular practices, which were seen as culturally inappropriate by the men, reinforced their impression that the leaflet was intended for an Australian audience and not for their community. All men agreed that the document had been translated from English into other languages.
Young People
The young people did not find the material sensitive and did not note any inappropriate content. However, sensitivity was raised as an issue in terms of their parents’ reactions which would impact heavily on how comfortable they would be taking written material home.

It was difficult to fathom how the older generation’s sensitivity to the material translated into young people’s perception. While the terminology and diagrams used were seen as acceptable to them, the young people did not distance themselves from their parents’ positions, including comments such as:

[Parents] think you are not a good person if you have it … they associate AIDS with homosexuality.

There is certainly a sense that HIV is highly stigmatised in their community as it is associated with homosexuality and drug use. This perception has a direct impact on how comfortable young people are discussing HIV/AIDS with their family and with other members of their community as they fear being suspected of either ‘activity’. Looking at HIV prevention material and/or information about condoms was also seen as evidence of sexual activity. Their willingness to take material home was impeded by the conclusions their family would draw.

Most parents would jump to conclusions and start to stress, because they would think ‘Why are you reading about it if you’ve done nothing?'

[My parents] wouldn’t think I am reading about HIV they would think I am learning how to put [a condom] on.

INTERGENERATIONAL COMMUNICATION

Women
All the women saw themselves as key providers of information for their children and acknowledged their responsibility to provide such information. There was an acceptance that young people obtained information about sex (and condoms) at school which helped raise awareness of HIV. Some had reservations about what
age girls should learn about sexual health. Sixteen – 18 was seen as the appropriate age.

While some participants acknowledged it was their responsibility they still did not feel comfortable discussing sex with their children. The topic of taking home written information about HIV and sexual health raised a great deal of discussion in each Focus Group. While they were keen to take general health information home, the women were unsure about HIV/AIDS related information. Their worries were reflected in the following comments:

*Children can catch us reading about sexual health.*

*What would my children think of me if they see this with me?*

Half the participants said they would only read the brochure at the community health centre or clinic. One participant declared;

*I would feel shy taking it home. Not that I am not interested, I know that my kids would have learnt about AIDS and sex but I still feel uncomfortable taking [brochures] home.*

Others, as demonstrated in the following statement, were comfortable taking the information home to their children, especially if it was presented as a health issue and not sexual.

*We should give it to our kids, especially when the information is discussed in a scientific way.*

**Men**

There was no consensus amongst the men as to whether it was possible to discuss such information with their family and to share brochures about HIV prevention. While most were not opposed to discussing HIV/AIDS with their family, the presence of explicit diagrams and the mention of sexual practices were deterrents to passing on information.

*[The diagram] makes it difficult to take this home and share it with the rest of the family.*
Having a picture of the male penis makes me uncomfortable to take it home.

I would feel a bit embarrassed carrying leaflets with these pictures and some parents may want to educate their children with this information but having such images can stop them from doing so.

The youngest participant (high school student) did not share the group’s concerns.

If I have learnt something whether at school or somewhere else and I think it is beneficial to share it with my family I would not hesitate regardless of the topic.

The tension between presenting HIV as a health issue or a sexual/relationship issue was crucial to the ability to discuss such information in the family context.

Although discussion of religion or scientific facts is not embarrassing, I don’t think I can discuss any issue of a sexual nature with my family.

I would like it to be clear with, with some scientific facts and no offensive images.

Young People
The need for parents and other older family members to have a better understanding of HIV was at the forefront of the young participants’ mind when discussing information HIV/AIDS. There was no expectation of parents being willing to discuss the topic or to share the material with their children, but their tacit approval was essential to the young people’s ability and willingness to take the material home.

The idea of reading a HIV/AIDS brochure at home made the young participants slightly uneasy as they commented that their parents were not as liberal with their thoughts as their generation. Parents did not have enough awareness back in their country and their generation has not been educated enough on it. They felt that their parents viewed AIDS as something that is wrong rather than as a sickness and that HIV would not be contracted by a good person.

When the young participants were asked what would make it easier for them to take written information and HIV/AIDS home, they suggested that the priority was to make it clear that anyone could get it. They recommended community education, for instance through radio announcements, which would help to de-stigmatise the issue.
There was no need for parents to understand the information in detail, just to know enough to not be concerned about their children’s interest.

*Because the parents are probably not going to read all the details of the brochure it should therefore not cause the parent to question the kid’s activities.*

Eight out of the nine participants felt that their parents would not be opposed to their reading of the material if they had a chance to discuss their interest in this area. Another recommendation was to provide some information in Arabic, either by translating the whole leaflet or by including a paragraph explaining what the material is about.

*If a grandmother or parent picked it up and doesn’t understand English, all they’ll see is the picture [of a condom]. It would be good to have a message saying in different languages what it is about.*
Channels of Communication

Participants were asked to provide suggestions on what they saw as the most effective way to pass on HIV/AIDS prevention information. They were asked specific questions about Internet use, the value of written material and preferred information providers. They were also asked to provide suggestions on how to communicate to members of their community who were illiterate.

Preferred Channels

Women
The women expected to find information about HIV/AIDS in medical centres, community health centres and libraries. These places were also mentioned as sources of general health education. Arabic satellite channels were widely watched (news and nature documentaries mainly).

While these women had attended health information sessions before, no one had ever talked with them about HIV/AIDS.

When asked how they would prefer to receive information about HIV/AIDS, the women participants all agreed that they preferred a Community Worker to meet with their community group and explain about HIV/AIDS in their own language. Another suggestion was for someone to be available at the community centre with which they could discuss these issues. While some of the women were better informed than others, most were aware that there were gaps in their sexual health knowledge. They felt that the best way to improve their knowledge would be to discuss these issues face-to-face and have the opportunity to ask questions. This would also help women who were not literate as a Community Worker could explain the information in the booklets.

Internet use
Arabic websites were commonly used by participants and were seen as very useful to those with low English and low education level. The main advantage offered by the Internet was privacy. While they would feel uncomfortable accessing sexual health information from their family or strangers, the women felt that they could access the Internet in their own time and more importantly, in private. They generally
trusted the Internet, although some had reservations about unwittingly accessing pornographic sites.

**Written Information**
Brochures and leaflets could be read in the women’s own time and at their own pace, and could be kept for further reference. They did mention, however, that they had little time to read and therefore the information needed to be short and concise.

*We don’t have time to read long articles; I prefer well prepared material like [this brochure] and TV documentaries.*

The downside of written information was its inaccessibility for the illiterate women in the community (in Arabic and English).

**Men**
**The impact of migration and resettlement**
Recent migration and resettlement in a regional area had a strong impact on the men’s access to information. These two factors combined to limit their access to services and media in their language. The importance (and lack) of radio programs in Arabic was repeatedly mentioned.

*Radio was always my favourite tool for education programs, but there is no Arabic broadcasting in the region.*

*Our English skills are very limited, we don’t benefit from television and radio programs, there is nobody we can approach expect the GP.*

*We are not fortunate enough to receive such broadcasts like metropolitan regions. It’s very important.*

**Preferred sources of information**
The preferred source of information about health, including sexual health, was overwhelmingly the GP/family doctor. Consulting a specialist was also mentioned by two participants. Only one participant thought he would talk to friends and check the Internet first, but ultimately he would still turn to his GP.

*No doubt the family doctor, I can see a specialist if further information it needed.*
The family doctor can be the best person to explain things and direct me in the right direction.

One participant was keen to provide some correction to this almost unanimous response by stating that the importance of the GP may be related to the lack of Arabic services in Shepparton;

We are a conservative, small community and we don’t voluntary approach the GP just for the sake of knowledge.

The barriers presented by the lack of English language skills for this group was also evident. The reasons for relying on the family doctor were primarily because some GPs in Shepparton speak Arabic.

I’d rather go to a family doctor as there is no specialist who speaks my language.

Community Workers were also mentioned as a possible recourse, with one participant stating;

Some social workers especially those who work for health organisations are well trained and very efficient.

Another commented that;

Seeking the assistance of a Community Worker is a good idea, but we will not be able to communicate without the assistance of an interpreter.

When asked how they would like to receive information about HIV the men suggested television and radio in Arabic. The men thought that information sessions were also an effective way to provide information about sexual health and recommended them, particularly for women.

They are very much needed, by hosting women guest speakers on sexual issues, and distributing written material to participants during the session.

Another suggestion was to;
Invite an Arabic doctor to deliver information in Arabic to a group session.

It was also acknowledged that running information sessions was not easy. Although they thought it was the best way to disseminate information, in reality it was difficult to attract people to information sessions. One participant asked the facilitator, who is also a Community Worker for the local Arabic community;

*How many times have you invited people to information sessions, without much success?*

**Internet use**
The difficulties experienced by participants in accessing health information made the Internet a *handy tool* for several of the men. None had ever used the Internet to access information about HIV/AIDS. Participants seemed very Internet literate; however levels of trust in the Internet did vary.

**Written Information**
The men agreed that written material was a valuable source of information as it can be accessed at any time.

*Forums and meetings are set at specific times and locations, which are not always convenient, but with written information I know where it is and I can get it when I need it.*

*I think brochures and leaflets are very effective because they are simple and handy.* Another saw it as a good way to access more detailed information;

*In every brochure there is a website that can be accessed for those who want to seek out more details.*

Several of the men believed that written information should complement information sessions. Another participant commented;

*When I stressed the importance of information sessions, I didn’t mean they should be in place of information material.*
The men felt that written information about HIV should be available *in every venue that is used by the Arabic community*, including TAFE, the Ethnic Community Council, and mosques.

The men stated that they currently come across written information mainly in waiting room at the GPs, and this seems like a valuable opportunity to disseminate existing information about HIV in Arabic.

*I think pamphlets and brochures are good as they are accessible, you go to the medical centre and you find something that draws your attention, you read it quickly and if you like it you take it home.*

However the comment was also made that *most of the time when I am sitting in a medical clinic, I feel more attracted to magazines than brochures and leaflets.*

The men in the group were keen to suggest options that would be of benefit to everyone in the community, regardless of their level of literacy or their age.

*It would be better with some amendment to sensitive words … and no offensive images. It should be placed in accessible venues chosen by the community, and people have options: they can read while waiting, those who feel comfortable can take it home, and those who have different interpretations from the content can leave it where they found it.*

**Young People**

Overall the young participants get their health information, if they needed it, from their GP, the Internet and the Victorian Arabic Social Services. If they are concerned about their sexual health they would also turn to friends and siblings for advice. They read little about health issues – mainly leaflets available in the doctor’s waiting room. They had seen leaflets about HIV/AIDS at school or university, but did not feel they needed to read them.

The young participants stated that they would prefer to have the information explained to them by a Community Worker (not necessarily in Arabic). This was related to a desire to obtain information that was relevant to their life as they valued the ‘real-life’ examples that a Community Worker would provide. This ‘tailored
information’ was not expected from general practitioners, who were more likely to work by the rules and stick to what he had been taught.

Another way to address this need was to provide a toll free number. They occasionally watched Arabic satellite channels with their parents, but not of their own initiative.

Internet use
The participants were all Internet users but had never looked for HIV/AIDS information. They accessed websites in English, using standard search engines such as Google or Yahoo. They trusted websites from government departments or international agencies they recognised (UNICEF was mentioned). A doctor’s recommendation would also add considerable credibility to a website. They did not access websites in Arabic.

ILLITERACY
Recommended channels of communication to illiterate members of the community were through information sessions in Arabic, word-of-mouth and the presence of a Community Worker who could explain information contained in booklets. They also turn to relatives who can access information for them. Radio programs in Arabic were seen as particularly important in this context and their absence in regional Victoria was criticised by the male participants.
Participants in each group were shown three brochures and asked to provide feedback on the following points: level of language used, clarity of translation, sensitivity of material, diagrams, and general appearance.

The difference in terms of language preferences between young people and parents was stark: Arabic was clearly the preferred language for information provision for both the men’s and women’s group, but not for the young people’s group, where the majority of participants preferred English and felt their Arabic was limited.

**LANGUAGE**

**Women**
Arabic was clearly the preferred language of all participants.

*I will take home any information in Arabic.*

Classical Arabic was preferred, as regional dialects can differ markedly. An example given was the word ‘thrush’, which in another dialect means ‘acne’.

**Bilingual Information**
Bilingual information was seen as a good way to address different levels of literacy in the community, including the women who spoke good English.

Commenting on the *Women Talk* booklet, the women liked the fact that there was an English part for women who are capable of reading English.

**Men**
There was no question that Arabic was the preferred language for information provision for the men’s group.

*Brochures that are written in Arabic can draw my attention strongly and attract me to read their content.*

*I have never bothered looking at health information as long as it is written in English, simply because I can’t understand it.*
Bilingual Information

Bilingual information was mentioned as a good way to accommodate the different levels of English language competency within a family.

The elders who cannot read English will read the Arabic information, while younger people who have more competence in English can read the English part; and that all in one tool!

Young People

The value of written information

Overall, the young people were critical of written information, as it did not meet their needs for interaction. Comments included;

You can’t ask questions, you can’t really explore.

All criticised how written information did not provide an opportunity to ask questions and obtain answers to specific queries. One participant was concerned that this may lead to misunderstandings, such as;

If someone reads they are HIV negative they may freak out, they wouldn’t understand that it means they haven’t got it.

Language

The Focus Group with young people explored the issue around which is the most appropriate language. In regard to information provision, it was interesting to investigate whether information in Arabic or in English was most suitable for young people and whether it required a level of cultural appropriateness that differed from that intended to other young Australians. Most of the young participants could not read Arabic well. In the Focus Group discussion, all bar one picked material in English. This, along with the fact that they had little trust in information produced outside Australia, made them reluctant to use information in Arabic.
Bilingual Information
The inclusion in English language booklets of some Arabic information was recommended by this group, as a way to reduce the ‘communication gap’ between the participants and their parents and to alleviate parents’ concerns. This could take several forms: an acknowledgment in the material that it is available in other languages, a brief explanation in Arabic of the content of the brochure, or a heading in different languages on the cover page of the English material. One participant commented that this would make you more comfortable reading it in front of your parents. It could also take the form of a totally bilingual booklet such as the Multicultural HIV/AIDS and Hepatitis C Service ‘Don’t be afraid to ask’ (Hepatitis C information).

If the material is bilingual, it is important to show for instance by using similar presentation and illustrations in both languages.

CONTENT AND PRESENTATION

Women
Women requested clear and concise information. They wanted short and direct messages about means of protection.

This was requested for two reasons: lack of time and lack of understanding of medical terminology/general health literacy. Material needed to be unsophisticated and easy to understand, with few medical terms, and should only provide basic information: means of transmission and means of protection were sufficient. A Question and Answer (Q&A) format met these needs and gave the impression of a straight to the point medical approach.

I am asking myself a question and here it is answered directly!

Colours were appreciated, but not key. The women were interested in a black and white fact sheet printed off the Internet because it provided useful content and, importantly, had a conservative appearance. It was their preferred document out of the three pieces of material presented, despite the fact that another booklet had been written and designed specifically for Arabic women. The absence of diagrams in this document was also highly valued, to the point where one participant commented;
I will photocopy it and give it to my family members.

While explicit diagrams were rejected, watermarks or pictures of couples and a clear indication that the document was about HIV/AIDS were recommended.

Men
The men identified the clarity of information, a colourful presentation and the absence of sensitive facts and diagrams as key to their interest in material.

I would like it to be clear, with some scientific facts, and no offensive language.

Rewriting some sensitive words and messages would extend the benefit of the material to the more conservative people.

All rejected a document printed off the Internet as very poor quality material, despite the fact that it was in Arabic.

It is not attractive at all, I like nothing about it.

Several participants suggested that readers should be warned about the serious consequences of HIV/AIDS by using fear tactics [and] pictures of victims.

Young People
The young people appreciated clarity of writing, concise information and attractive colours. An Internet print-out was seen as targeting researchers and students, not the average young person. Although the content was exactly the same as that of one of the brochures, it was seen as containing too much information and needed to be cut down on the wording. This in turn made it a lot less attractive to participants.

A Question and Answer (Q&A) format received very positive responses. References to other sources of information and phone numbers that could be called for more information were also seen as very useful. Information needed to be broken into sections with different subheadings.

Although diagrams explaining how to use condoms were not considered offensive, they had a negative impact on the young people’s willingness to take pamphlets
home. They felt that it may arouse their parents’ suspicion before they had a chance to read the material. This was particularly the case with large pictures and diagrams, as it was felt that *the bigger the diagrams the bigger the slap may be!* 
PART TWO

COMMUNITY FINDINGS

HORN OF AFRICA

ARABIC-SPEAKING

VIETNAMESE

THAI
COMMUNITY FINDINGS

HORN OF AFRICA
COMMUNITY PROFILES

The information in this section is based on Australian Bureau of Statistics 2001 Census data, and data from the Department of Immigration and Multicultural Affairs. As such, it gives a broad picture of the main trends but does not reflect the diversity within each community in terms of language, educational and employment levels, or literacy. The diversity between and within communities from the Horn of Africa is highlighted in our research findings.

In a nutshell
- Horn of Africa communities are ‘emerging’ communities, and rapidly growing
- The majority are refugees accepted under the Australian Humanitarian Program
- Many have spent long periods in refugee camps
- Many face complex barriers to resettlement
- They are generally young communities, with low levels of education and high levels of unemployment
- Communities from the Horn of Africa differ in languages, religions and cultural practices. This diversity is also seen within each community.

In the past ten years, there has been a significant increase in the number of people from the Horn of Africa (Ethiopia, Eritrea, Somalia, Sudan and Djibouti) settling in Victoria. The 2001 Census reported 6,264 Victorians from Sudan, Somalia, Ethiopia and Eritrea, but this figure has now changed dramatically. Between 2002 and 2004, 3,125 Humanitarian Entrants from Sudan, Eritrea and Ethiopia settled in Victoria. Informants from these communities estimate that there could be between 15,000 and 20,000 migrants from the Horn of Africa living in Victoria today.

The majority of African entrants are refugees accepted under the Australian Humanitarian Program, which is increasingly focused on Africa with 63% of people assisted under the Integrated Humanitarian Settlement Strategy in 2003-2004 coming from Africa.¹

In Victoria, Australians from the Horn of Africa have settled mainly in the local government areas of Brimbank, Maribyrnong, Springvale and Dandenong. There are also small Sudanese communities in regional areas such as Colac and Warrnambool.

According to the Department of Immigration and Multicultural Affairs (DIMA), ‘People from Africa tend to face more complex barriers to settlement than people from other source regions, such as higher level of poverty, larger families and lower levels of education and English proficiency. Many have spent long periods in refugee camps before coming to Australia’. Furthermore, the fact that ‘conflicts, instability and deprivation erode refugees’ traditional coping mechanisms, offering ground for the spread of HIV/AIDS’² has been well documented. The experiences described above have a strong impact on refugees’ educational level, literacy, and subsequently their ability to access information.

DIMA notes that ‘cultural difficulties may be encountered by many people from Africa who are unfamiliar with urban environments, Western cultural norms and the Australian way of life. Some Africa families may experience conflicts within the family, including clashes between parents and children, as a result of changing cultural roles’.³

**Somali**

There were 2,311 Somalia-born living in Victoria at the time of the 2001 Census, an increase of 65% compared to 1996. Melbourne has the largest Somali community in Australia, with most people living in the local government areas of Moonee Valley, Banyule, Darebin and Melbourne city.

This is an emerging community,⁴ which barely existed until 1985 (less than 1% of Somalia-born had reled before 1985). It was also the largest emerging birthplace group from the Horn of Africa in 2001, ahead of Ethiopia, Eritrea and Sudan.

The Somali in Victoria are young, with almost one in two Somali aged under 24 years. The median age is 25 years, compared with 36 for all Victorians.

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³ DIMA *Australia’s Support for Humanitarian Entrants 2003-2004*, op cit
⁴ The Victorian Office of Multicultural Affairs defines ‘emerging birthplace groups’ according to two criteria: a) those with between 400 and 10,000 persons at the 2001 Census, and b) their numbers have increased by at least 15 per cent between the 1996 and 2001 censuses.
It is also worth noting that about a third of Somali in Melbourne live in a one-parent family household. This can be explained by the fact that many single-parent families headed by females entered Australia on a ‘Women at Risk’ visa.\(^5\)

Almost all Somali in Victoria are Muslims.

**Language & Education**

This community is linguistically and culturally homogenous, with almost 9 in 10 speaking Somali at home (another 5% speak Arabic). Somali also show a high level of English proficiency (almost 75% assess themselves as speaking English ‘well’ or ‘very well’).

Educational level is low (only 6.4% hold Bachelor degrees) and 65.6 % have no post-school qualifications.

Unemployment is very high (typically for a recently arrived refugee community), with a rate of 47%.

**Internet use**

Computer use is as common as the Victorian rate of slightly over 40%.

**Ethiopian**

Ethiopians formed the second largest Horn of Africa community in 2001, with 1,970 people. Most were Melbourne-based, living mainly in Maribyrnong, Moonee Valley and Greater Dandenong. More than two thirds of those born in Ethiopia have arrived since 1991, including almost one in two since 1996. It is largely a young adult community, with 65% aged between 25 and 44 years old. The sex ratio is biased towards men, with 117 men for 100 women.

Ethiopians in Victoria follow a variety of religions: while 4 in 10 are Muslims, 16% are Oriental Christians, 12% Greek Orthodox and the remaining percentage Orthodox, Western Catholics or followers of other religions.

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\(^5\) DIMA *Australia’s Support for Humanitarian Entrants 2003-2004*, op cit
Language & Education
The Ethiopian community is linguistically diverse: Amharic is the most widely spoken language (one in three), but many speak Oromo at home (16.5%) or Arabic (9.2%). One in three Ethiopians speaks another language (including Tigrigna).

English-proficiency is high; with more than 78% stating they speak English ‘well’ or ‘very well’. Only 1.4% thought they did not speak English at all.

Post-school qualifications were relatively similar to the state average, with 57% of Ethiopia-born having none (53.7% for total Victoria). The unemployment rate is more than three times that of Victoria (22.3%).

Internet use
Internet use was average for a migrant community, with a third of Ethiopians accessing a computer at home and the same number using the Internet.

Eritrean
Eritrean-born represent a smaller emerging community in Victoria, with only 1,113 members in the 2001 census. More than 60% of Eritreans in Australia live in Victoria. Almost all live in metropolitan Melbourne, mainly in local government areas of Moonee Valley, Melbourne City, Maribyrnong and Greater Dandenong. This is also a new community, with more than three quarters of Eritreans arriving after 1991. The proportion of young adults is very high (57.5% between 25 and 44 years of age), with more females than males (100 to 90 respectively). More than one in four lives in a one-parent family household, which (as with the Somali) can be explained partly by a high number of widowed women migrating with their children. Three quarters of the Eritrean community in Victoria are Muslims, with the other 25% Orthodox (including Greek Orthodox) or Catholic.

Language & Education
The community speaks two main languages: Arabic (spoken at home by 62.9%) and Tigrigna (spoken at home by 25.6%). Three in four assessed themselves as speaking English ‘well’ or very ‘well’, and 3.8% speak no English at all.
Post-school qualifications were low, expect for Bachelor degrees (held by 12.6%). Two thirds of Eritrea-born have no post-school qualifications. Unemployment is high, at 32.9%.

**Internet use**
Home computer use is slightly lower than the state rate (34%) but Internet use is higher (40.3%).

**Sudanese**
It is difficult to obtain up-to-date information about the Sudanese community in Victoria, as the characteristics of this group change annually as the community grows. In 2003-2004, almost half the Humanitarian Entrants accepted in Australia were from Sudan (6,147 out of 11,802). They are the single largest refugee group processed from Africa. According to DIMA, ‘people of Sudanese … nationality most frequently settled in Victoria’ (1,667 people in 2003-2004).

The Sudanese community consists of South Sudanese (mostly Christians) and North Sudanese (mostly Muslim). The ‘intense war being waged against the south’ has caused a mass exodus in the last few years. Most Humanitarian Entrants from Sudan accepted in Australia are South Sudanese. Most Sudanese settling in Victoria identify as Dinka, Sudanese or Nuer, and speak Arabic as well as their community language. In Melbourne, most Dinka live in the Western Suburbs (Braybrook and Sunshine) whereas Chollo and Nuer live in the South East (predominately around Dandenong).

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7 DIMA *Africa Newsletter*, op. cit.
8 DIMA *Australia’s Support for Humanitarian Entrants 2003-2004*, op cit
INFORMATION AVAILABLE TO THESE COMMUNITIES

Following is a table of booklets and brochures related to HIV prevention in three languages spoken by the Horn of Africa communities: Amharic, Somali and Tigrigna. Information about HIV prevention was not available in Oromo, Nuer, Chollo or Dinka. Documents in Arabic are listed under the ‘Arabic-Speaking Communities chapter.
<table>
<thead>
<tr>
<th>MATERIAL</th>
<th>SOURCE</th>
<th>PUBLISHER</th>
<th>DATE (last update)</th>
<th>FORMAT</th>
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<tr>
<td>HIV/AIDS Your Questions Answered</td>
<td>Internet. Hard copy of English version. Other languages Internet only.</td>
<td>Victorian Department of Human Services (DHS)</td>
<td>2003</td>
<td>Q&amp;A format, responding to basic questions about HIV</td>
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<td>Safe Sex</td>
<td>Internet. Hard copy of English version. Other languages Internet only.</td>
<td>Victorian Department of Human Services (DHS)</td>
<td>2003</td>
<td>Q&amp;A format, responding to basic questions about safe sex</td>
<td>YES</td>
</tr>
<tr>
<td>Sexually Transmissible Infections</td>
<td>Internet. Hard copy of English version. Other languages Internet only.</td>
<td>Victorian Department of Human Services (DHS)</td>
<td>2003</td>
<td>Q&amp;A format, responding to basic questions about STIs</td>
<td>YES</td>
</tr>
<tr>
<td>HIV An Introduction – Fact Sheet 1</td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>Basic information - general</td>
<td>NO</td>
</tr>
<tr>
<td>Information about sexuality and sexual health</td>
<td>From Working Women’s Health newsletter</td>
<td>Working Women’s Health</td>
<td>2001</td>
<td>Includes information about HIV, STIs &amp; condoms</td>
<td>YES</td>
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<tr>
<td>Multilingual Fact Sheet</td>
<td>Internet only</td>
<td>Well Women Website</td>
<td>2004</td>
<td>Contraception fact sheet</td>
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<td>Healthy African</td>
<td>Brochure (A6)</td>
<td>Women Health West</td>
<td>2001</td>
<td>Brief health (including)</td>
<td>YES</td>
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### Part Two – Community Findings

#### Horn of Africa

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<thead>
<tr>
<th>Resource</th>
<th>Description</th>
<th>Provider</th>
<th>Year</th>
<th>Availability</th>
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<tr>
<td><strong>Women</strong></td>
<td>Video (Somali version)</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2004</td>
<td>Sexual health information</td>
</tr>
<tr>
<td><strong>AMHARIC</strong></td>
<td>Internet. Hard copy of English version. Other languages Internet only.</td>
<td>Victorian Department of Human Services (DHS)</td>
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<td>Q&amp;A format, responding to basic questions about STIs</td>
</tr>
<tr>
<td><strong>HIV/AIDS Getting it right!</strong></td>
<td>Internet only</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service (MHAHS) &amp; Australian National Council on AIDS and Related Diseases (ANCARD)</td>
<td>2003</td>
<td>Basic information about HIV transmission</td>
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<td><strong>HIV An Introduction – Fact Sheet 1</strong></td>
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<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
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<td>Brochure (A6)</td>
<td>Women Health West</td>
<td>2001</td>
<td>Brief health (including sexual health) information</td>
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<tr>
<td><strong>Everybody’s Business</strong></td>
<td>Video (English version with African presenter &amp;</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2004</td>
<td>General HIV information</td>
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<tr>
<td><strong>TIGRIGNA</strong></td>
<td>characters)</td>
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FINDINGS FROM KEY INFORMANT INTERVIEWS

New arrivals & resettlement issues
Resettlement needs have a great impact on Horn of Africa communities’ access to information about HIV prevention. Newly-arrived refugees’ priorities are to organise such things as income support, accommodation, English classes and schooling.

The main focus for them is resettlement. They need to get a comfortable home for them and their family. Then the next [focus] is to see the children settle at school. (Community Leader I)

HIV information may also be difficult to access and understand because refugees from the Horn of Africa may present with serious health issues that require more immediate attention by health professionals.

I tested people for malaria last week, and … the little boy had the worst kind of malaria, and I had to send him to the hospital in an ambulance. They had been in the country five days, you know. HIV was the last thing on their minds. (GP)

Refugees receive HIV prevention information in their first six months of arrival through information sessions delivered under the Integrated Humanitarian Settlement Strategy (IHSS).9 How important it is to provide HIV information to new arrivals was a topic of debate with most Community Workers. One Key Informant thought that for young people, the first year of arrival was a particularly high risk-taking time.

When you arrive you want to try everything. The first twelve months are a crucial period for boys and young men because it’s freedom, there are no cultural barriers here. (Community Worker I)

Another Settlement Worker had noticed that people coming from refugee camps felt saturated with HIV information.

Some of them say ‘We’re actually sick of hearing about it because this is all we heard in camps in Africa … There is UNHCR coming to camps delivering sessions, lots of

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9 Community-based organisations funded under the IHSS provide assessment and referral services to refugees and other humanitarian entrants during their initial settlement in Australia. (DIMA website: www.immi.gov.au)
people would come to camps and deliver information on how to prevent HIV’. It is not something they don’t know anything about, on the contrary. (Settlement Worker)

For other new arrivals from refugee camps, particularly those arriving with their partner and family, HIV was not seen as important.

*People didn’t see it as relevant to them as they were married with children.*

(Settlement Worker)

*They have come here as family units so it has not really come up as an issue.*

(Refugee Nurse)

This obviously does not apply for all communities from this region, as was shown in the Focus Groups where knowledge of HIV varied widely from one group and from one participant to another. A Community Leader commented about the lack of knowledge about HIV.

*In the community, the level of awareness is zero.*

In the first few months of their arrival in Australia, refugees are ‘bombarded’ with information, and there is often little room in their lives for information that is not of immediate need or that is presented in writing.

*Usually they’re not interested in lots of written information, it’s very confusing. Once they come, there are lots of registrations, lots of letters from the bank, from Medicare, Centrelink…. They are overwhelmed with it anyway, and if we started going ‘Read this, read this’, I don’t think they actually would.* (Settlement Worker)

*They won’t have time to read, you see? So they won’t read. But if information is passed on to them through seminars, they will really listen to it.* (Community Leader I)

**Young People**

Like many young people from migrant backgrounds, young people from the Horn of Africa must manage two vastly different cultures. They often find themselves straddling the culture of their parents and that of their peers, assuming different identities depending on the context.
There is a big gap between the parents and the young people… The kids live in this system. The parents don’t. Kids live between two cultures, when they go to school they want to behave like Australian kids. When they come home, they need to take their shoes off, change their clothes, the girls have to help their mum. (Community Leader I)

The young people in these communities, who are hearing the two stories, they are hearing the very strong story, perhaps from the older members of the community, or the people who are in power in the community, but they may also have partners who are not from the community, or maybe as they become more assimilated they do start engaging in those practices. How on earth do they know how to be safe? (Health Worker)

This ‘hearing of two stories’ is particularly acute for newly arrived groups, such as the South Sudanese, where the contrast between Sudanese culture and Australian is strong.

In an African context of living, they function completely differently, there's an understanding of freedom, a respect for the elderly... but once they come here, I think it becomes looser, and parents actually lose their grip. (Settlement Worker)

At home there is more of a sense of community. And everyone is responsible. But here there is no communal life, and people don’t have that respect. (Community Leader I)

Key informants working with African communities were particularly concerned about the cultural gap, and the impact of this cultural chasm on young people and their families.

The parents live in their own world. They don’t know how to access services. If they want to go to hospital they have to take their children to interpret for them. It's a big shame but they don’t have any choice. (Community Leader II)

This balancing of their own culture and the western culture can result in risk-taking, through a combination of freedom, lack of information as well as just being young.
[T]he spirit of being young, of wanting to try everything... It’s fun for them, it’s just fun, but after a couple of drinks they don’t remember anything. Whenever there is alcohol involved, people lose their sight... in some communities it’s out of control.

(Community Leader II)

**Going Home**

A Key Informant from the Horn of Africa communities raised the need for HIV prevention information related to ‘travelling home’. Key Informants reported anecdotal evidence that return trips to either country of origin or a refugee camp present risks for migrants from the Horn of Africa. These communities have been settled for some years now, long enough for patterns of travelling to emerge.

*The fluidity between the two countries is a big thing for certain groups.* (Health Worker)

**Channels of Communication**

Communities from the Horn of Africa present a challenge for information and Service Providers, due to their diversity and associated demands of a recently arrived community.

*We haven't developed different ways of working with the diversity within communities. For example, the Sudanese community [in NSW is] diverse in religions, diverse in regards to tribal cultures, diverse in regards to educational levels, to the mixture of family grouping either large families or smaller professional families with no kids.* (Community Worker II)

Traditional approaches such as media campaigns have little effect in these groups, partly because there is little or no media in their language, and partly because of their lack of time.

*I don’t think they listen to the radio, I don’t think they read the newspaper, I don’t think there is a really defined source of information for them on this, apart from what they get from the language school.* (Refugee Nurse)

The most effective ways to pass on information are through community advocates and word-of-mouth. This was confirmed by the Focus Group discussions, particularly with women.
Things are happening around kitchen tables, particularly for the more recently arrived communities. We think that if it’s not formal community consultation it’s not real, but the group of women that are meeting in someone’s kitchen and saying ‘I’ve got this little DVD, let’s put it on’, that is also valid. (Community Worker II)

When [community members] elect a management committee, they believe that they are going to be advocates, to pass on any information delivered by the Service Providers. (Community Leader II)

This face-to-face information delivery also addresses the lack of literacy in these communities (as shown through the Focus Group findings). The most effective setting to reach new arrivals, according to several Key Informants, was through English-language schools.

*English Language School is taken very seriously, they really want to learn, so if you go directly there it’s a very good way of reaching them.* (Settlement Worker)

**FOCUS GROUPS SELECTION**

The composition of the Focus Groups was determined after consultation with Key Informants and co-workers. Due to the number and diversity of communities, our objective was to reach and discuss these issues with as many communities as possible. It was essential that Focus Groups be gender-disaggregated. When appropriate, Focus Groups included participants from different countries of origin - here too we relied on advice collected through the consultation process.

Four Focus Groups were organised as follows:
- Women from the Horn of Africa
- Women from Somalia
- Men from South Sudan
- Young people from the Horn of Africa.

Focus Group findings were tested with a small group of FARREP (Family and Reproductive Rights Education Project) Workers. Workers from FARREP are key intermediaries for women from the Horn of Africa in sexual health information and
education. Originally set up to provide education on female genital mutilation, the group now promotes women’s reproductive health issues throughout Victoria.

Women
On the advice of co-workers and Key Informants, two Focus Groups were conducted with women to accommodate cultural differences. Focus Group findings from these two groups are presented under the same heading in the ‘Findings’ section.

Women from Eritrea, Ethiopia and North Sudan
The group comprised twelve women; from Ethiopia (7), Eritrea (3) and Northern Sudan (2). Participants were aged between 28 and 42 years old and were all mothers. Five were in paid employment or education. The majority had lived in Australia between 9 and 17 years, with two newly-arrived (2 and 4 years, both from North Sudan) and one who had migrated to Australia 20 years previously.

Below is the material presented to this Focus Group (material was presented in Amharic, Tigrinia and Arabic to accommodate the diversity of languages of the participants):

*Healthy African Women (Women Health West)*
Somali Women

The seven Somalia-born women were all mothers, and two were also in paid employment (a nurse and a Community Worker). Five women had lived in Australia between 10 and 15 years, while two had arrived 3 and 5 years ago.

The group was linguistically homogenous – all women spoke Somali – but levels of literacy differed greatly. Two participants spoke English fluently, while others spoke no English at all. One participant was illiterate in both languages, two were literate in Somali and others could read English but not Somali. The participant who was literate in both English and Somali read the material out loud for the group.
Below is the material presented to this Focus Group:

South Sudanese Men
A group of men from South Sudan living in the South East region (Dandenong) was conducted. The seven men in the group were of Chollo or Nuer background and came from different tribes and different parts of South Sudan. The majority had lived in Australia for more than five years, although two participants had arrived in the past two years.

Participants were recruited through community associations and were all actively involved as community leaders and advocates. As discussed in the Key Informant Interviews, they play a key role in providing information to community members. All bar one (studying English) were working.
Below is the material presented to this Focus Group:

**Safe Sex (Victorian DHS)**

**Getting it Right! (MHAHS)**

**Young people**

The young people group comprised 11 people: nine from Ethiopia and two from Somalia. There were six women and five men, aged between 18 and 25.

Ten participants had lived in Australia between 2 and 6 years, and one had been in Australia for ten years. Most of the participants arrived in Australia in their late teens. Two of the men were working, while all the others were students, including two who were at university. With the exception of the two who had been here for only two years, all spoke excellent English. They never used English however to communicate with each other, preferring Amharic or Somali.

Below is the material presented to this Focus Group.
Part Two – Community Findings
Horn of Africa

Safe Sex (DHS) – Amharic
(also shown: Somali version)

Safe Sex (DHS) – English

Getting it Right (MHAHS) – Somali
(also shown: English and Amharic)

Don’t be afraid to ask (MHAHS)
### WOMEN FROM THE HORN OF AFRICA

Discussion of sexual practices such as oral sex was highly sensitive. Material containing information that was seen as inappropriate was rejected outright, regardless of the level of interest in other information included.

Women reacted negatively to material that did not appear to take their cultural norms into account. This included level of health literacy, lack of literacy in the community, appropriateness of pictures and text.

Assumption of health literacy was criticised, as was material that was deemed unclear or poorly translated.

Participants were concerned about the risks their children may be taking (sexually and otherwise) growing up in Australia.

Women felt a high level of responsibility, as mothers, to protect their children’s health by ensuring they had access to HIV prevention information. This overrode some of the sensitivity regarding the material.

To meet this responsibility to be information providers to their children, the women in the groups were eager for information about sexual health.

#### Information provision

There was a strong discrepancy between where the participants expected to find information and where they preferred to find it, highlighting the fact that the current information provision does not meet their needs.

Diversity of languages and literacy levels amongst communities (even from the same country) creates particular challenges for written information.

Word-of-mouth and ‘kitchen table discussions’ were the most common ways to circulate information. Women relied on those in the community who were educated.
and either worked in the health sector or/and had access to the Internet to provide health information adapted to their needs.

Information sessions run by a woman from their cultural background were recommended.

Language was the key factor in material uptake – the women testifying they would pick up ‘anything’ in their language. An exception to this was if the material’s presentation clearly indicated if was targeting African women, in which case it would be picked up even if in English.
# MEN FROM SOUTH SUDAN

The men in this group were highly educated, with a high degree of awareness of themselves as an emerging community and a high level of health literacy.

They are not representative of their community’s educational level but are key to the provision of information.

Recent resettlement played an important part in their information needs. They attested to the sense of security felt by new migrants through being screened for HIV before migrating to Australia.

Any HIV-prevention information had been acquired prior to their arrival in Australia, in refugee camps or in countries of temporary residence. They felt that more information should be accessible about HIV incidence in Australia.

HIV was blamed on contacts with outsiders (non-Sudanese). This fuelled the belief that young people, mixing with different communities, were particularly at risk.

They had a strong sense of their responsibility to their community as information providers, to protect the community and to protect themselves.

South Sudanese men seemed comfortable around discussing HIV and sexual issues amongst themselves, with their community and with their family. They all claimed that they could take written material home.

## Information Provision

English and Arabic were the preferred languages, as other Sudanese languages were not available.

The preferred sources of information about HIV and sexual health were Community Workers, especially if they were from the Sudanese community itself.

While they valued written information for their own use, oral communication and face-to-face interaction in-language were preferred for the many illiterate members of their community. Written information could be used as a support for the information provider.
When running information sessions, it was important to keep men and women separate. Introducing HIV under the cover of a broader topic was also recommended.

Internet was seldom used. It was seen as not very accessible and did not offer information in community languages.
The level of interest in health (including HIV/AIDS) information was high.

Their level of general health literacy was higher than that of adults. All had received information about sexual health through attending school in Australia. Despite this, awareness and understanding of HIV/AIDS were limited.

They had no knowledge of HIV incidence in Australia. They believed that HIV/AIDS in Australia was ‘not an issue at all’.

It is rare for parents to discuss HIV and sexual health with their children as young people are expected to remain virgin until they marry.

All were comfortable taking written information home and discussing it with their family – as long as discussions remained general and did not touch on their own practices.

Young women felt concerned about younger people (15-18) immersed in the Australian culture and lacking understanding of their cultural background.

They saw themselves as intermediaries between their parents’ languages and cultures and that of Australia. They felt that they had a responsibility to share information that may benefit their community.

There was no particular sensitivity around diagrams nor material content, but the translation and choice of words provoked strong reactions.

**Information provision**

Friends and siblings were the first sources of information, followed by GPs/clinics and the Internet.

Internet was easily accessible and Internet use was high. They did not know of websites providing sexual health information.

Written material was seen as a useful way to provide information.
Language of origin was key to the uptake of material and they would pick up anything in their language. They were not aware that information about HIV existed in Amharic or Somali.

Bilingual material was preferred as it allowed them to navigate between their two main languages. Multilingual material was seen as ‘too busy’.

Material that ‘looked African’ had strong appeal.

Channels of communications mentioned by other groups, such as information sessions and ethnic media, did not appeal.

They had little to do with ethno-specific organisations, which they felt did not represent them.
CROSS CUTTING ISSUES

THE RELEVANCE OF HIV TO THE COMMUNITY

Women
Women from both groups showed a high level of interest in HIV prevention information. They felt that they had access to little information about this topic and that it was important for their community, particularly for the young people, to be informed.

*In our community, there is not much information about what HIV is; how huge it is.*
(Horn of Africa Women’s Group)

*I believe you need to educate your community about HIV and about the latest advances, particularly its social effect and the means of transmission. Also, educating our youth is very important.*
(Horn of Africa Women’s Group)

*So many people think they’re safe but then they get it another way, because they don’t know, they don’t have any knowledge.*
(Horn of Africa Women’s Group)

There was also an admission that cultural norms, such as virginity or fidelity, may not prevail.

*The women they’re not supposed to have sex but the men, they say ‘We are men so we can do whatever we want! We are men so we can have sex any time with any women we want’.*
(Somali Women’s Group)

*Some Somali boys, they just want to be in denial about it. Things like drugs, AIDS, they’re in denial.*
(Somali Women’s Group)

Women were also keen to obtain more information about other health issues they felt were relevant to their community, such as depression and suicide.

*A lot of people suffer from depression but are too scared to talk.*
(Horn of Africa Women’s Group)
South Sudanese Men

The men in this group have a strong awareness of their community as an ‘emerging community’ (a term they used) and of the vulnerability this implied. They were concerned that resettlement in Australia created a false sense of security around HIV. One participant admitted that since coming to Australia he had forgotten all about HIV.

I think the problem is that our community, when we came here, everybody goes through a medical screening, and everyone who is HIV positive will not be allowed to come to Australia. So everyone who comes to Australia, it means that they’re safe! So people got a sense of security, like ‘Why should I look for information?’

The concern associated with this false sense of security was voiced by a number of participants.

The community should be informed that AIDS is a concern here. People might think that now they are in Australia, there’s no more AIDS. We have to tell them that AIDS is a concern here, not just overseas.

Another migration-related factor that was seen as a risk of HIV infection is the fact that the South Sudanese community now has more opportunities for interaction with other communities in Australia. There was a sense that HIV came ‘from outside’ and that increased contact with outsiders was a source of concern.

Since migrants are now interacting with other communities socially, there is much fear that they might get infected.

A lot of young people have got friends from different communities so it is necessary to give awareness to our communities, to our sons. Sometimes young people get caught up with other people. It is good to have information about what’s going on, to be aware.

This concern was not dissimilar to that of women from the Horn of Africa Focus Group, who felt their children were growing up in a very different environment which they knew little about.
Concern was raised about why the Sudanese community, as an emerging community, was, in one participant’s words *particularly targeted by HIV awareness*. Most participants welcomed the opportunity to increase their knowledge and recognised the need for information for new communities.

*It is a duty by the mainstream society to educate and protect the new comers.*

*There is a worry that Sexually Transmitted Diseases may increase [in Australia]. So if the Australian communities who know better are not practising safe sex, what would it be like for the newly emerging communities!* 

**Young People**

The young people in the group, particularly the young women, showed great interest in any information related to health. They felt that all health issues were relevant to their community, as they and many community members had ‘missed out’ on education before coming to Australia. HIV was seen as a health issue like any other, and therefore one they should be better informed about.

*Anything that’s about health I’m interested.*

*It’s relevant because you can come in contact with it.*

*Not all of us are perfect; it’s good for the people who are not perfect to know.*

The relevance of the topic to their own life, and their own interest and curiosity about HIV were compounded by a strong sense of their responsibility as channels of information for their community. In particular, these young people (men and women) felt it was their responsibility to educate the ‘younger ones’, their siblings and siblings’ friends who were in their teens.

*If you know about it then you can teach other people.*

*A lot of young people don’t know anything about this.*

*The young are stuck to MTV.*
This was particularly true of the young women in the group, who although only in their early 20’s felt that they had a duty to use their maturity and position to protect the younger ones.

*We’ve got a responsibility to teach them as well.*

*Unless we don’t break that wall the young ones are going to suffer.*

This responsibility extended to sharing information with adults. The young women were very aware of their role as ‘intermediaries’, comfortable in both their parents’ language(s) and English, and able to navigate both cultures.

*The burden is on us, we’re stuck between our parents and the young people, we’re connecting them [to each other] as well.*

This special position in the community can be partly explained by their experience of migration: having lived in Africa as teenagers, they had an understanding of both cultures - whereas their parents are more comfortable in an Ethiopian or Somali culture and their younger siblings are immersed in the Australian culture.

The male participants (most of them soccer players in the same team) also showed a degree of this sense of responsibility. They run a monthly group open to all young people of African background (regardless of their country of origin) to get together and discuss issues of relevance to them. They agreed that these meetings would be a good forum to discuss HIV and sexual health.

*Anytime is good to talk about this, it’s a health issue.*

**HIV AWARENESS**

**Women**

While all women agreed that this was an important topic for their community, awareness about HIV prevention was low.

*I don’t know anything about this.* (Somali Women’s Group)
We really need to know a lot. (Horn of Africa Women’s Group)

All participants were primarily concerned about the risk of transmission through blood.

[Somali] people have a lot of fear about blood transfusion because of HIV. If they need blood, they want to get it from a cousin. (Somali Women’s Group)

The women had never seen leaflets about HIV in their language and were unaware that such material existed. They remembered seeing information about pap smear, breast cancer and asthma. A few had seen information about HIV in English, but none knew of information in their language.

**South Sudanese Men**

Participants’ knowledge of HIV had been acquired through their experience of migration, living abroad as students or while awaiting approval by a third country. Most had been exposed to information before migrating to Australia (in Kenya, Egypt, Uganda and Ethiopia).

*When we were students in Egypt, the authorities used to do random checks for HIV/AIDS and other sexually transmitted diseases to the foreign students, especially from Africa.*

*Before I came here, in Lebanon I was working for Caritas and I was given information. But here, nobody ever gave me information.*

*Before I came here, in Egypt, I was given some information but it was mainly about Africa, it had a focus on Africa.*

*I have known this disease before I came to Australia when I was in Kenya; it is talked about on the TV and people visiting one another talk about it.*

They had little information about HIV in Sudan itself. This was due to the effects of years of war on infrastructures (including in the health sector) and cultural barriers.

*HIV/AIDS is not very much known in Southern Sudan. In the last four decades the civil war that was mostly fought in the south has left the region without any*
infrastructure and no economic development and the area that is most affected by the civil war is the field of health. No equipment, no hospitals, no educational institutions to promote health education.

South Sudan is a war torn zone therefore so there are always’ malpractices’ [rape & sexual assault], from the military, and other groups, so it is spreading.

I just came back from home; HIV is going on but nobody identify it, as there is no instrument that can identify it…. People do not talk about it back home, because some people have got several wives so when they hear about HIV they think it is just a plot from those who come to introduce and talk about it. Some churches are trying to introduce condoms, but people react against that because it can prevent them from having children.

In comparison to other countries where they had resided, they found that HIV prevention information in Australia was scarce, and they knew little about HIV prevalence in their new country.

The problem also is they don’t advertise it on television. In Kenya, wherever you cross, you may see a photo of someone affected by HIV.

I would not know exactly the percentage of HIV in Australia but it is here. Australia is among the best countries within the developed world with the HIV infected people…. It is mostly spreading between the unconventional sex practices in the community.

To be honest … I do not have much knowledge about HIV/AIDS in Australia.

Since my arrival to Australia two years ago, I have not seen much writing on health issues.

Young People
As all young participants attended high school in Australia, they all had come across information about HIV/AIDS in school, from people coming to talk to us and giving us hand-outs.
This had been their only formal source of information about sexual health and had its limitations in terms of HIV/AIDS awareness as it had mainly targeted sexually transmitted infections.

_We didn’t talk very much about HIV._

There was considerable interest from both the young men and women with the material and the information, in particular the difference between HIV and AIDS, female condoms, modes of transmissions and the number of people with HIV in Australia. However, when probed, HIV/AIDS awareness was generally limited. Awareness was particularly limited amongst the young men. Contact with blood was seen as the main mode of transmission. The young people had little information about HIV/AIDS incidence in Australia. One participant said she knew ‘absolutely nothing’ about HIV in Australia, which others agreed with. Here it’s _not an issue at all_. Several participants believed that people with HIV were not allowed to live in the community and that people with HIV did not bleed when cutting themselves.

There were differences of opinion about the availability of awareness information in Australia.

_People in Australia don’t worry because they have all the medications, it’s not neglected like in Africa … Here people educate you about it, people help you out._

_I went back home last year so I heard a lot more about it than I did in Australia. In my country there is a lot of drama about this but here we don’t hear anything about HIV._

**HEALTH LITERACY**

Women
Assumptions of the reader’s health literacy by the agencies that produce the material, provoked strong criticism from both groups of women. While women in the Horn of Africa group had a higher level of formal education, all resented information that required, and assumed, a certain level of literacy in order to be understood.
I am from Amharic background and I used to be an interpreter, and I don’t even know what this is talking about. This is very difficult. It’s almost annoying. (Horn of Africa Women’s Group)

Even the literate people who could read or write they wouldn’t understand. (Horn of Africa Women’s Group)

Let me tell you one thing: in my country, we don’t understand what ‘immune system’ is. We believe that there are more important organs in our body: we believe the heart is the most important one, then liver, then lungs, you see? We don’t know what the immune system is, unless they can explain it in a way that everyone can understand! (Somali Women’s Group)

The women were very critical of what they perceived as a lack of effort to adapt the material to their level of knowledge.

They need to make it easier. Some people don’t even know what a condom is. (Somali Women’s Group)

It says here ‘immunity’ system (sic), but they should explain! They should specify in an easier language. (Somali Women’s Group)

Simplicity is the key. It has to be simplified for everybody to understand it. Not everybody is educated! I am not a doctor! (Horn of Africa Women’s Group)

The lack of health literacy extended to sources of information, and the perception that few women would know where to access information.

A very small number can get this information, because people just don’t know where to go for information… [Women] only go for information when they hear about something, that’s when they try to find where to go. (Somali Women’s Group)

South Sudanese Men

Participants were very well informed about health, and had a clear understanding of terms such as immuno-deficiency, opportunist infections, syndrome, and the difference between HIV and AIDS. They had no problem understanding the material presented to them (in Arabic and in English). While their level of education is not representative of everyone in their community, they play a key role in passing on
information and their understanding and acceptance of such material is crucial to their community’s access to information.

*We have got a culture of obtaining verbal information from those who are able to read and understand it.*

**Young People**
Health literacy (as opposed to awareness of HIV/AIDS) was not an issue with the Young People Group as they had all studied to High School level in Australia, and benefited from a similar curriculum to their Australian-born peers. All stated that they found the material presented easy to understand. They also felt confident that they were well-informed – although they had many questions about HIV/AIDS itself (particularly the young men).

*We know enough to protect ourselves.*

*I know what’s right and wrong, even if my parents tell me it’s wrong to have sex, if I choose to do it I will be responsible, I won’t go around sleeping with lots of guys.*

**SENSITIVITY**

**Women**
The material includes highly sensitive information which is predominately due to the relationship between HIV and sex. There was however different degrees of sensitivity and responses to the information, from outright rejection of the material to an acceptance of the need for compromises due to the importance of the topic. Information about sexual practices, particularly oral sex and anal sex, was seen as extremely offensive. The Horn of Africa group believed that to mention these practices in information material that can be accessed by women was totally inappropriate.

*If I get a group of women and I talk about oral sex, they will run away from it.* (Horn of Africa Women’s Group)

*It’s disgusting.* (Horn of Africa Women’s Group)
Part Two – Community Findings
Horn of Africa

No one has sex like this in our community; the only way we know sex, is just the normal way. Maybe the next generation does it this way. (Horn of Africa Women’s Group)

The sensitivity in the Horn of Africa Women’s Group was such that material that otherwise contained information of interest would be rejected outright if it included discussion of oral sex or anal sex. This was expressed clearly by a participant who works as a Community Educator.

I would not be a teacher; I would not explain this to people in my words, standing in front of people, talking about oral sex. (Horn of Africa Women’s Group)

This is of particular importance as some of the material presented to the groups mentions various sexual practices in its introductory section. The effect of this was that women rejected the entirety of the material without reading any further. Other ‘sensitive topics’ included condom use and the very act of discussing sex publicly. However, as the following quotes demonstrate, there appears to be some allowances in terms of presenting these topics in an acceptable manner. There were also different degrees of sensitivity.

That’s great, it shows you how to use a condom, it’s clear. (Somali Women’s Group)

They need to get comfortable, in the Somali community, to talk about this. Like today, at the beginning no one was comfortable but then the more you talk about it the more you become comfortable. (Somali Women’s Group)

We have been given information about female circumcision, we’ve seen videos and lots of information that is much worse that this. (Horn of Africa Women’s Group)

When you do this [education] are you going to do it for married people or unmarried people? It is going to be hard for the unmarried and the younger ones because if you show them the way [to use a condom] people will think you’re encouraging them. (Horn of Africa Women’s Group)

South Sudanese Men
How sensitive this topic is was difficult to ascertain in this group. On one hand, participants admitted that this could be a sensitive topic:
In terms of cultural issues HIV/AIDS is not addressed as a topic for discussion because it is seen to be a bit sensitive.

On the other hand participants seemed remarkably ‘unfazed’ by the material, one participant commenting that he didn’t see anything extraordinary about them. The men seemed relaxed in their discussion of sexual issues and open to sharing information and taking materials home to their family.

We have an open mind about how to approach these topics.

You love your wife, love your friends, and don’t mix things. This is why we get married, partly for the children and also to avoid the diseases. You should be concentrating only your sex on your wife. Sex is not a sin!

I think there is no fear about talking about these questions in our communities, even with children. Even though condoms have been rejected by the Catholic Church, wherever there are individuals we need to talk about it.

I am able to talk to my family members without fear.

Sexual issues were discussed and were the subject of jokes. One topic in particular that seemed to attract much attention was female condoms. Most participants had not heard about them and showed great curiosity, asking for pictures to be included in the written material.

We did a project in 2002 and we saw these condoms, it’s very nice! Some of the prostitutes they say ‘do you have condoms’ and if no, they have their own. I did not see them in Australia.

Women have their own condoms and this should be shown, because if they have their own condoms they have a choice.

Young People
Discussing HIV/AIDS as a sexual issue was not a sensitive topic with these young people, who felt they were just like Australian teenagers.
It’s cool with us, it’s around us.

They were all adamant that they could take written material home without any opposition from their parents, and that the material would be discussed with their families. Taking material home is also a way for the young people to pass on information to younger siblings, as discussed above.

The language in which the material was written played a significant role in how much young people reacted to the material content. While neither young men nor women felt that the mention of sexual practices, such as oral sex, was culturally insensitive when written in English, sensitivity was higher when using their first language. This included diagrams and pictures. For instance, having diagrams of condoms in an English pamphlet was fine, but *if I saw them in [a brochure] in Amharic I'd be shocked!*

**INTERGENERATIONAL COMMUNICATION**

**Women**
As mothers, women felt strongly responsible for the provision of health information to their community, particularly to their children, primarily because they saw this topic as serious.

*If you have the knowledge, if you get a chance you have to tell everyone.* (Horn of Africa Women’s Group)

*We need to have that information so that we can share it with our kids.* (Horn of Africa Women’s Group)

*I always talk to my son, asking him to be careful. He always says ‘What are you talking about?’ And I always say: ‘You have to be very careful young man!’* (Somali Women’s Group)

*If the mothers are well informed I am one hundred per cent sure they will tell their children because they don’t want them to die.* (Horn of Africa Women’s Group)
There was a general acknowledgement that the sensitive nature of the material created some challenges and that this needed to be overcome.

*In our culture [even] if it’s a bit difficult but if we know about it, it’s our duty to talk to our kids.* (Horn of Africa Women’s Group)

*You can’t talk about this with the girls because in my culture, the girls are not supposed to have sex before they get married. So you can’t say to your daughter to be careful.* (Somali Women’s Group)

*I don’t see any reason why not, because this is a health issue. Nobody’s afraid to talk about cancer, because it kills you! HIV is the same; it’s going to kill you. The only issue here is that it is different from cancer because it is a sexually transmitted disease.* (Horn of Africa Women’s Group)

**Women communicating with young people**

The very different environment in which the younger generation is growing up in was a source of concern for these mothers, and increased the need for information at the same time as it made communicating it more difficult.

*We have this ‘back home’ mentality. But our kids were born here or brought up here so they took the mentality of here. So you have to be very close to your own kids.* (Horn of Africa Women’s Group)

*If you talk to the kids you have to use a different language. The kids already know, from their friends, their education, even the mass media.* (Horn of Africa Women’s Group)

Evidence of this was in the women’s willingness to pass on to their children information that contained diagrams on condom use, even though they may find them offensive.

*It’s good for teenagers because it shows them.* (Somali Women’s Group)

*For us it is not acceptable but for our kids…. they belong here. It’s another culture.* (Horn of Africa Women’s Group)
South Sudanese Men
The men in this group did not express concern about the ‘cultural gap’ between adults and young people as strongly as the women did, although they did mention that HIV came from interaction with other communities and that this was a risk for young people in Australia.

Young People
Young people appreciate that their parents have become more flexible since moving to Australia.

We’re allowed to ask questions, we’re free to ask.

Times are changing; we’re going to the modern society now. We come from the countryside where the culture is very strict but we’re moving to a modern society where things are more flexible.

When parents talk about sex and about HIV they make you scared.

If you have sex before marriage you’re going to hell!

This did not mean however that any HIV/AIDS-related issue could be freely discussed. There were definite boundaries to discussing sexual activity. All young women participants felt that they could talk with their parents about HIV as long as it was in scientific terms or using statistics (for instance saying they learnt about the number of people with HIV in Australia). It was not possible to express an interest in HIV information if it related to sexual activity, especially one’s own. Because of the expectation that neither young men nor young women should have sex before marriage, adults in the community did not think this was a relevant topic for young people.

I’m the sort of person who’s not supposed to ‘do it’ until I’m married so our parents don’t stress very much about HIV/AIDS. Only once, I remember, we were walking down the beach and one of us stepped on a needle and that’s when they explained HIV to me.

It’s OK to talk about HIV in general, like how many people have it, but not to talk about oral sex.
This was also very strong for the boys ‘You just don’t do it’ – but this ‘principle’ was received with much laughter and debate.

*As far as I know, boys do anything they want, but girls are girls.*
The DHS-funded Family & Reproductive Rights Education Program (FARREP) aims to work with communities that are known to practice female genital mutilation (FGM) in their countries of origin to:

- minimise the health impact of FGM for circumcised women
- increase access to health services and
- enhance culturally responsive health services for these communities.

The program focuses on health promotion and health education. It collaborates with health and related professionals and agencies to deliver gendered and culturally sensitive services to the affected communities.\(^\text{10}\)

FARREP Workers are based in community health centres and hospitals around Melbourne.

**WHAT FARREP WORKERS SAID ABOUT …**

**Returning Home**

*When [we] hear that HIV numbers are increasing, our question is: ‘How?’ Because when we came to this country we were all screened for HIV... When we are here we still travel back home, our spouses sometimes travel alone and come back, and maybe they get infected. There are people who get infected in Australia but also travelling back home, and when they come for the second time they don’t get screened.*

*The women I have met who got infected were in refugee camps. Their husbands were already here and it took them time to organise and get their wives to come here. Whether we like it or not, women are being taken advantage of, in those camps. So those women got infected between the period when the husband left them and the time when they came.*

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**Literacy**

Speaking English doesn’t mean you understand. When we asked ‘What is safe sex’ some people said: ‘Being in a very hard bed – not to fall down’ or ‘Being in a safe place where no one can see you’… What does safe sex mean? Safe from outside things.

Many women are illiterate even in their language, so they wouldn’t pick up material. But what I would do with my session is put it (the material) all together, like a package, and explain ‘even if you cannot read, let your children read it for you’. Even if they don’t read their children can read it for them so they will have a good understanding.

**Sensitivity**

I think all this material I can use. In our group we talk about reproductive health, we talk about circumcision, the women in the group are very positive, they are comfortable to ask questions … and because of the curiosity that they have in wanting to talk about these things I think we can talk about it.

For me I would take some things out. I would just use my own tribe as an example. I would just want to discuss things that are relevant for them: I would not mention oral sex, I will take out things that I know are not practised in the community, because if you bring things that are not relevant for them … they will tune out, and some of them they will walk out. Some of them they would say: ‘What’s wrong with you? Why are you discussing oral sex with us? Are you assuming that’s the sort of people we are?’

Back in my country oral sex is not something that we talk about but being in a country like this one, we’ve got our children who may end up getting married and mix up… the second generation might end up getting married to people who do oral sex!

**Women as information providers**

One of the things we are trying to get the African women to do is to agree to be the first people to give the information to their children. So that when these kids go to sexual
education classes, and get the information, they already have the first information from the mums.

It is important to give women the brochures because women discuss this; they pass brochures to other people.

When I am holding a group for the women I am targeting the family. So when I talk to the mums about HIV, the mums are channels of information to their children. If my boys want to know something about sex they don’t go and ask their father, they come and ask me... Us, we are a bit conservative about sex, but our kids are out there.

I would just mention to them: look mums, I know this oral sex will not directly affect you, but you’ve got children who may get married here. For that reason, I would like you to know what oral sex is so that you can also mention it to your children.

If you don’t give information you want your children to know, they’ll get the wrong information from other people, from friends ... I say to mums ‘I may not agree with what [the children] get taught, but I want them to get the information! I would feel like a failure if my daughter came home and said ‘Mum, I’m pregnant’ because I had never given her the information.
Part Two – Community Findings
Horn of Africa

CHANNELS OF COMMUNICATION

Participants were asked to provide suggestions on what they saw as the most effective way to pass on HIV/AIDS prevention information. They were asked specific questions about Internet use, the value of written material and preferred information providers. They were also asked to provide suggestions on how to communicate to members of their community who were illiterate.

PREFERRED CHANNELS

Women
The main reason why women would seek health information was if it concerned their children. A typical instance would be hearing about meningitis or an immunisation campaign on television, and wanting to find out more. Their first port of call would be each other, particularly those with a health background, or a friend who accesses the Internet. Women who are not literate obtain information from their friends, children or husbands.

We’ll find someone in the community to tell us about this. (Somali Women’s Group)

Whenever we hear about a disease like that we’ll ring each other: ‘Hey, did you hear about this?’ (Somali Women’s Group)

Where the women expected to find information was not where they would prefer to find it. Participants unanimously agreed that the best way to provide information to them was through face-to-face interaction, and through information sessions preferably run by a woman from their community.

The best way is to do lots of information sessions, but that hardly happens. (Somali Women’s Group)

The best information you can give people is to have a discussion around a table. It would help a lot. (Horn of Africa Women’s Group)

Suggestions on how to run such sessions included: gender-segregation and separate sessions for young people and adults; involving community-specific organisations in
the process; addressing the topic as a health issue; introducing it gradually under the umbrella of broader health awareness.

*The first meeting should be about health and safety in general, and gradually talk about HIV and other diseases that affect the African communities.* (Horn of Africa Women’s Group)

Radio and television were not seen as useful, as participants were not familiar with ethnic media and had little time for television.

*Women are too busy with their children to watch television.* (Somali Women’s Group)

While they clearly expressed that information sessions were the most effective way to raise their awareness of HIV, women were keenly aware that this was not the way information was currently passed on to them. Currently, the main sources of information (outside each other) were community health centres, GPs or the Internet. A general complaint was the fact that they could only find information if they had an immediate need for it, and that it wasn’t offered to them as a matter of course.

*Information is passed on when somebody has [a problem], for instance you go to the GP or the hospital, or something happens to your child, and you get a bit of information, but it's very poor.* (Horn of Africa Women’s Group)

In these women’s experience, GP’s don’t have time to provide information, and ‘you only get very basic information.’ (Horn of Africa Women’s Group)

*You don’t go [to the GP] looking for information, I don’t anyway. Sometimes if I need something badly I will ask, but …* (Somali Women’s Group)

Some participants (in both groups) mentioned the Royal Women Hospital as a good source of information for African women.

**Internet use**

Internet use was common for the educated women in the community, and other women relied on them to collate information from websites and pass it on. Women in the Horn of Africa group accessed the Internet in English and Arabic. However, lack of time hindered how much they could use the resource. None knew about the
Health Translations website offered by the Department of Human Services. As with other groups, the privacy offered by the Internet made it an attractive tool.

You feel comfortable because no one can see you. (Horn of Africa Women’s Group)

South Sudanese Men
South Sudanese men recommended different channels of communication to meet the needs of the community. They identified three distinct groups:
- Community Advocates/information providers
- Community in general
- Women

The men in the group saw themselves as key information providers for their community. This responsibility extended to all community members who had the education and access to information to pass the information on.

It should be the work of everybody who is enlightened to help the people, and I have said this many times.

Those who have the trust of the community, let them have the leaflets so that they can read them to those who have no time or who cannot read, so that they can be able to get the knowledge.

It is everybody’s responsibility to create awareness. We, and others, should be able to talk to community groups, conferences, meetings to have publication of a booklet in people’s languages. These are the ways we should adopt to protect our people.

For themselves, the participants preferred to obtain information firstly from Community Workers, and secondly from GPs. There was a belief that GPs were less specialised but offered more privacy.

You can access information from a GP, if you feel that you want to keep your own privacy, but also from a Community Worker who is specialised.

Community Workers are especially good, because the GP won’t be specialised, they might not have all the information. But a community health worker, who specialises
in infectious diseases, they can be more practical and provide more information than a GP.

Other sources of information mentioned were the Southern Health Website, the Internet, schools and the mass media.

When information sessions were organised for community leaders such as themselves, participants often could not attend as they took place during work hours. The men in this group raised the need to organise information sessions for women through community gatherings and activities that bring women together to talk about how dangerous HIV/AIDS is and how they can protect themselves from it.

Such events would need to be for women-only.

The problem is the cultural background: when it comes to health or sex, women prefer to talk to other women and men prefer to talk to other men. So they will talk to each other or to Community Workers of the same sex.

For women-only sessions, it was important to take into account the sensitivity of the topic.

Women would not come if they know it is about HIV. For women, sexual health issues are not something to be discussed publicly. To call them at home to ask them to come and listen to sexual information…no, no, no! So when you are organising an information session you need to understand how to approach them.

Internet use
Few of the participants used the Internet, although most have access to the Internet. They doubted the usefulness of the medium for their community.

It is not an easy access by the majority of the community members especially the women. Also, it is not in many members’ languages.

Trusted sources included a known source, like a university or government website. If you get the information from a university, or a health centre that is an educated organisation you trust what you read there! But, if you just read it from some other
people, some researchers or some websites that are not official, then you can’t trust it.

Young People
The young participants relied heavily on the Internet and on personal contacts (friends and family members) for their health information. They access the Internet at school, at home or in the local library.

When you don’t understand something, and you don’t know where to start searching, you just jump on the net!

Both young men and women participants felt they could raise any topic with their friends without embarrassment – whereas they were more discerning about whom to raise it with in their family (see ‘Intergenerational communication’ section).

Probably an older brother, or parents, if I feel comfortable.

It depends how cool your parents are.

There was no such reluctance amongst friends.

We pretty much discuss anything.

If you’re embarrassed to talk about it, talk to you friends.

The local doctor and clinic were also cited as preferred sources of information about sexual health. The participants had great confidence that they would know where to get such information if required, and could get the information they needed from these mainstream sources.

Personally, if I had anything wrong I’d call the hospital and ask for someone to advise me, and then I’d ask my close friends if they know anything.

It’s easy for us; we can go to a walk-in clinic (reference to the Melbourne Sexual Health Centre).

There was no gender preference for medical practitioners.
It doesn’t matter as long at it’s a doctor.

All participants were adamant that they would not turn to ethno-specific organisations for information, for two reasons: they felt such organisations did not represent them, and doubted the quality of the advice they would get.

When it comes to health it’s better to go to professionals, because people can give you the wrong information.

Personally they’re not part of my life at all.

Not even our parents use them; it’s not a strong community. I would say they don’t represent me.

Channels of communications identified by other groups; such as information sessions and ethnic media, did not seem to appeal as much to this group. They had no interest in ethnic media, which they never listened to and found so boring. They complained that the radio programs were very news-focused and never discussed health issues.

They liked the idea of information sessions with a speaker but did not suggest this option. There appeared to be a lack of settings for such meetings. If such sessions were organised they suggested that the best way for advertising them would be by ‘spreading the word’ through friends.

Written Information
Written information such as brochures and leaflets was seen as very valuable, although some participants, particularly young men, felt overloaded by information in English to the point where they lost interest.

By contrast, information in their language would be highly valued. None of the young people had ever seen information in their language. They were very pleased to know such information existed. The young participants showed no discomfort around picking up brochures in public, in fact, the scarcity of in-language information made it attractive. While they would pick up information in English only if it was relevant to them, they would pick up anything, whatever the topic, if it was in their language.
ILLITERACY

Women
All participants agreed that there were many illiterate women in their communities. The Somali group estimated that around eight in ten Somali women are not literate in Somali. It is not uncommon for women illiterate in Somali to be literate in English, especially if they have been in Australia for several years (in the Somali group, some participants requested materials in English as they could not read Somali). This limits the value of written information in these communities.

*We’re used to having word-of-mouth information, instead of reading material.* (Horn of Africa Women’s Group)

*Eighty per cent of the women, they can’t read, so instead of funding these brochures, it’s better to get someone, arrange a talk and come and talk to them.* (Somali Women’s Group)

*In general, women who cannot read or write they have no clue what’s [at the GP or Health Centre]. Even in Tigrigna or Amharic, people who don’t know how to read, they’re not going to use [the leaflets].* (Horn of Africa Women’s Group)

However, written information was valued by those who act as intermediaries for their community.

*When you have such written material, if someone asks me to explain I would, because all the information is here.* (Horn of Africa Women’s Group)

South Sudanese Men
Illiteracy is high in the South Sudanese community, in great part due to disrupted education, resulting from conflict, displacement and long periods spent in refugee camps. This is one reason why information sessions were favoured. Another reason was the fact that this is an oral culture, where face-to-face interaction is the most common and valued channel of communication.

*We have traditional ways to pass on information that we have, not just focusing on leaflets.*
There is always lack of interest to reading; we do not have the culture of reading, so people would not actually go through a booklet from A to Z. The information could be there but they would not read it.

For those who are not able to read, the best way is to organise an information session on health promotion to be an open forum to deliver the information to the public in their own languages.

This high level of illiteracy and reliance on the spoken word limits the value of written information. It is however, valued if combined with face-to-face interaction.

You need both, to have it explained by experienced people and then you also read information at home. It’s good to have people and books.

Written material also presented the advantage of being accessible when needed – as opposed to spoken information which was delivered at a set time.

The best thing about written material is that it is an easily accessible reference when you need it.

A good thing is that you can have it in your hand and you can read it at any time.

It is good to have leaflets written properly that explain it, to be circulated to people who can read. Even if not all of them, some would be interested in reading and understanding in their own time, and it’s important.

Young People
This was not seen as relevant to young people, who felt that all their peers were literate.
WRITTEN INFORMATION

Participants in each group were shown three brochures and asked to provide feedback on the following points: level of language used, clarity of translation, sensitivity of material, diagrams, and general appearance.

LANGUAGE

Women
Language played a key role in the uptake of material for all participants.

*Anything in my language, I would pick it up.* (Horn of Africa Women’s Group)

*Just out of curiosity, just to see what they have written in my language, I would pick it up.* (Horn of Africa Women’s Group)

*If you’re walking somewhere and you see ‘Somali’ then you will wonder what it is and take it, without even knowing what it’s talking about.* (Somali Women’s Group)

This overrode other considerations, such as colours and the inclusion of pictures. Women would rather pick up a black and white text-based brochure in Amharic or Tigrigna than the more colourful and glossy English equivalent.

*It doesn't matter if it is less attractive, I will always pick up something in my language, just to see what is in it.* (Horn of Africa Women’s Group)

However, even the English version of *Healthy African Women* brochures was seen as highly attractive due to its distinctly African iconography. The women immediately identified with the material in the same way as they do when they see brochures in their language.

The diversity of languages spoken by women from this region and sometimes from the same country of origin highlights the complexity of producing written information for these communities. Two women from the same country, age group and living in Australia for the same length of time may speak and read different languages. Many women from Eritrea, Ethiopia and Sudan are multilingual. The Somali group was
more linguistically homogenous, but the diversity in levels of literacy presented its own challenges. There were particular issues around language for young people.

_They need to make [the document] clearer, especially for the young Somali who were born here, their Somali is not good, they wouldn’t understand this._ (Somali Women’s Group)

_The kids from Somali who left after the war, they never had a chance to learn Somali, so when they come here they learn English; there’s no way they would understand this._ (Somali Women’s Group)

**Quality of Translation**

Women’s critical approach to the material extended to the quality of the translation and the language used. The more educated members of the groups (nurses, Community Workers, and interpreters) who have a good understanding of the translation or adaptation process and are in a position to advocate for their community, were particularly critical of the fact that the in-language document seemed in most cases to be a direct translation of English.

_I don’t like the formality of the language, and copying it from a text without understanding the demand of the people they are sending it to._ (Somali Women’s Group)

_You know they interpret English to Somali just like that_ (miming the action of copying straight from one page to another). (Somali Women’s Group)

_The translator should read it and then interpret in their own way._ (Somali Women’s Group)

_It’s wrong because they are interpreters, they should know what their people’s level of understanding [of English] is._ (Somali Women’s Group)

The main need identified was to adapt the English text by including explanations of terminology, to explain exactly what it is.

_The way they translate sometimes they should explain what it means, to make people understand more easily._ (Somali Women’s Group)
It’s not us; we’re not talking about us, but about our community. The illiteracy rate is very high in our community, we can’t deny that. Simply, if we give them this document, I bet they won’t understand a word. So it needs to be in very simple Amharic and if they use any terminology, they can explain it and say exactly what it is. (Horn of Africa Women’s Group)

This was seen as more effective than attempting to translate English words that may not exist in other languages.

It doesn’t bother me that they don’t write [Chlamydia] in Amharic because there is not [a] word for it. But what they write in Amharic has to be simple! (Horn of Africa Women’s Group)

It should be written in English alphabet and translated in Amharic in brackets. (Horn of Africa Women’s Group)

South Sudanese Men
Chollo and Nuer were the languages spoken at home by all participants and were the men’s preferred spoken languages; however, two participants chose English and Arabic as their preferred written language. Three of the Chollo speakers also cited English or Arabic as their preferred spoken language. As in other Focus Groups from the Horn of Africa, this highlights the diversity of languages spoken and how difficult it is to address this through written material.

Information about HIV/AIDS is not available in Chollo or Nuer. Amongst the languages currently available, English and Arabic are the most relevant languages, although most Arabic material is translated into Lebanese Arabic, which, according to participants, differs from the Egyptian Arabic which they are most fluent in.

In the Focus Group, six out of the seven participants chose the English booklet over the Arabic translation. They also chose to conduct the discussions in English, which they spoke at a fluent level.

Young People
All participants spoke their parents’ language at home, but more than half preferred speaking or reading/writing in English, or in both languages. When presented with written information, almost all chose information in their language – only the
participant who lived in Australia for ten years did not. They all used their parents’ language when interacting with each other.

The Amharic-speakers took great offence at the translation of the *HIV/AIDS your question answered* document, to the point where some of them preferred the English brochure. Their reaction focused on the Amharic term used for ‘AIDS’. The words used have strong negative connotations in Amharic and its use has been abandoned to be replaced by the English term ‘AIDS’.

*They’re just using disgusting words.*

They commented that the negative connotations of the term (which meant something like ‘being worn out’) had contributed to the stigma affecting people with HIV in their home country.

*That’s why people have been neglected in Ethiopia.*

*This word is scary, what comes to your mind is a person who is very skinny. You don’t even want to sit next to them because people tell you that you will get infected.*

*People from the countryside may still use this word.*

Another word that attracted criticism was that used for sexual intercourse.

*It’s very old-fashioned.*

*It’s very strong. It’s so strong it pushes you away.*

*It gave the impression it had been translated by an old man.*

The general impression was that Amharic was a very strong language and one had to be careful with the choice of words as they could have negative connotations. They also admitted however, that they reacted to their language more than to English.
Bilingual material

All young people had a strong preference for information in Amharic, despite their fluency in English. A young woman explained this by saying: *we want to keep our language.* All said they would take both the Amharic and English version of a leaflet with them as they complement each other. They would go from one language to the other to make sure they understood. This was also a good way to improve our English.

*There are some words we may understand in our language but not in English, some we understand in English but not in our language, so it would be better.*

When asked, all participants thought bilingual material would be ideal. However, they rejected multilingual information as it is *too busy.*

**CONTENT AND PRESENTATION**

Women

Information needed to be presented in a concise manner, with contact details of services (this was emphasised by all women). Pictures were a key to addressing the high level of illiteracy, and helpful to reinforce the information. An A4 page in black and white and without illustration was rejected as *boring because it’s all letters.*

*Pictures will be best, to explain how the virus is transmitted for those who can’t read and write.* (Horn of Africa Women’s Group)

Material that was immediately identifiable as designed for this group, whether it is through the presentation or through a clear indication of the language used, would be picked up without hesitation, whatever the topic. For instance, the *Healthy African Women* brochures attracted high praise.

*If there is a picture like this [on the Healthy African Women brochure] I will always read it.* (Somali Women’s Group)
South Sudanese Men
Participants expressed a need for more illustrations to provide detailed explanation of means of transmission.

They should follow each means of transmission by an explanation and pictures of how to protect yourself against it. For example, one way of getting infection [is] contaminated needles so pictures of needles and how you could prevent that happening would be very helpful.

They say ‘mother to child during pregnancy’ is a means of infection, which means they should produce pictures of it, and also with blood transfusion.

In this leaflet there is one way of protection shown here which is using condom, but there are many ways of infection also there should be many ways of protection.

As mentioned above, the participants were curious about female condoms. This extended to wanting more illustrations to help satisfy this curiosity.

More information about the female body, like ‘female parts’ and pictures that shows female condoms.

Young People
Pictures and bright colours, clear and concise information, ‘punchy’ title: a more brightly coloured version of Getting it Right! would have been the ideal combination for the young people in the group.

The watermarks are good and people look African!

It was remarked upon that none of the material currently available about HIV is brightly coloured. Pictures representing people, especially families, were mentioned as particularly effective. A suggestion that was welcome with enthusiasm was to draw a picture of a family where they are happy but still living with HIV. This positive representation of people with HIV was seen as a way to address the stigma surrounding the virus in the Ethiopian community (a stigma reinforced by the use of the old Amharic term for AIDS).
Although pictures and colours were requested, language remained the primary factor of choice, and a black and white document in Amharic was more appealing than a coloured brochure in English. There was no sensitivity around diagrams of condoms.

*It’s cool; at least they [men] know how to use it.*

*It’s important to know because if the guy doesn’t know how to use a condom I will show him!*

The young men liked diagrams because they transcended language barriers.

*Some people for instance they won’t understand English, Arabic, any language, but if you show them the picture they will understand.*

Both young men and women commented positively on the directness of the message to ‘Get it Right!’ that they interpreted as a call to get the right information.

*It grabs you, the way they choose their word!*

Young men would pick up pamphlets because they are small and easy to read and easy to fit in your pocket.
COMMUNITY FINDINGS

THAI
BACKGROUND

COMMUNITY PROFILE

The information in this section is based on Australian Bureau of Statistics 2001 Census data, and on data from the Department of Immigration and Multicultural Affairs. As such, it gives a broad picture of the main trends but does not reflect the diversity within each community in terms of language, educational and employment levels, or literacy. The diversity within the Thai community is highlighted in our research findings.

In a nutshell

The Thai community in Victoria is:
- small
- new
- young
- highly educated
- not highly structured

The Thai community in Victoria is small (5,460 people). It comprises mainly business/restaurant owners and their families. In 2004 there were also 4,292 Thai students enrolled in Victoria. Almost all the Thais in Victoria (91.9%) live in metropolitan Melbourne, although they are not clustered in any particular area. There are few community groups and most community activities take place around the temple.

This is a new community with more than four in five Thailand-born people arriving in Australia after 1985 and more than a third (37.5%) arriving between 1996 and 2001. It is also a young population with a third of the population aged 15-24 years old, and another 25% between 25 and 34 years old. There are few people over 55 years of age (less than 4%, compared with 22.4% of the total Victorian population). The

3 Interview with Thai Key Informant
median age in 2001 was 25 years, compared with 36 for Victoria as a whole. It is an overwhelmingly female population (100 females for 62 males). The main religion is Buddhism.

Languages & Education

This is a highly educated population with strong English proficiency. While more than half speak Thai at home, 66.8% assess themselves as speaking English ‘well’ or ‘very well’ and only half a percent spoke English ‘not at all’.

Six per cent of Thailand-Born Melbournians hold post-graduate qualifications (against 1.8% of the Victorian total) and almost 20% have at least a Bachelor degree (10.6% of the Victorian total). This high level of education does not extend to all, as more than half the Thai population (55.8%) has no qualification at all. The level of unemployment in the Thailand-born population is high with 17.3% out of work.

Internet use

Computer use is high, with more than half (56.4%) of the Thailand-born having used a computer at home and 55.7% having accessed the Internet (a much higher percentage than the 38.4% of the total Victorian population).
## INFORMATION AVAILABLE TO THIS COMMUNITY

Following is a table of booklets and brochures related to HIV prevention in Thai. All material in Thai was translated or adapted from an English version.

<table>
<thead>
<tr>
<th>MATERIAL</th>
<th>SOURCE</th>
<th>PUBLISHER</th>
<th>DATE (last update)</th>
<th>FORMAT</th>
<th>INCLUDES CONTACT DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS Your Questions Answered</td>
<td>Internet. Hard copy of English version, other languages Internet only.</td>
<td>Victorian Department of Human Services (DHS)</td>
<td>2003</td>
<td>Q&amp;A format, responding to basic questions about HIV</td>
<td>YES</td>
</tr>
<tr>
<td>Safe Sex</td>
<td>Internet. Hard copy of English version, other languages Internet only.</td>
<td>Victorian Department of Human Services (DHS)</td>
<td>2003</td>
<td>Q&amp;A format, responding to basic questions about safe sex</td>
<td>YES</td>
</tr>
<tr>
<td>Sexually Transmissible Infections</td>
<td>Internet. Hard copy of English version, other languages Internet only.</td>
<td>Victorian Department of Human Services (DHS)</td>
<td>2003</td>
<td>Q&amp;A format, responding to basic questions about STIs</td>
<td>YES</td>
</tr>
<tr>
<td>HIV An Introduction – Fact Sheet 1</td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>Basic information - general</td>
<td>NO</td>
</tr>
<tr>
<td>HIV, STI and Travel – Fact Sheet 2</td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>Information about HIV and STI prevention when travelling</td>
<td>NO</td>
</tr>
<tr>
<td>The Effects of HIV/AIDS – Fact Sheet 4</td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>The Effects of HIV/AIDS</td>
<td>NO</td>
</tr>
<tr>
<td>The Health System in Australia – Fact Sheet 7</td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>The Health System in Australia</td>
<td>NO</td>
</tr>
<tr>
<td>Source of Information</td>
<td>Availability</td>
<td>Purpose</td>
<td>Notes</td>
<td></td>
<td></td>
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<tr>
<td><strong>Part Two – Community Findings</strong></td>
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<tr>
<td><strong>Some common terms (glossary) – Fact Sheet 8</strong></td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>A glossary of terminology relevant to HIV prevention</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Going Home Safe</strong></td>
<td>Booklet (A6), Available In NSW only</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2002</td>
<td>Advice on HIV prevention for people intending to travel to Asia</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Women and HIV (Fact Sheet 1 - Testing)</strong></td>
<td>Internet and hard copy</td>
<td>Family Planning Australia &amp; NSW Health</td>
<td>2002</td>
<td>One of six fact sheets for women with HIV</td>
<td>NO</td>
</tr>
<tr>
<td><strong>You are not alone</strong></td>
<td>Booklet (A5) Multilingual Information English, Thai, Cambodian, Vietnamese and Chinese</td>
<td>Australian Federation of AIDS Organisations</td>
<td>2000</td>
<td>General Information about HIV (some for people with HIV)</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Your Sexual Health</strong></td>
<td>Internet</td>
<td>Resourcing Health and Education in the Sex Industry (RhED) Project</td>
<td>2003</td>
<td>Information for Sex Workers</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Let’s Talk about HIV/AIDS</strong></td>
<td>Internet + RED Magazine</td>
<td>Resourcing Health and Education in the Sex Industry (RhED) Project</td>
<td>2004</td>
<td>HIV/AIDS prevention Information for Sex Workers</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Health and Safety Workshop for Sex Workers</strong></td>
<td>CD Rom</td>
<td>SQWISI</td>
<td>2005</td>
<td>HIV/AIDS prevention Information for Sex Workers</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Everybody’s Business</strong></td>
<td>Video.</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2004</td>
<td>General HIV information</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>The Australian AIDS Tape</strong></td>
<td>Audio Tape</td>
<td>NSW Department of Health</td>
<td>2000</td>
<td>General HIV information</td>
<td>N/A</td>
</tr>
</tbody>
</table>
FINDINGS FROM KEY INFORMANT INTERVIEWS

Two main groups of interest, in terms of HIV prevention, emerged from the Key Informant Interviews:

- Overseas students, and
- Sex workers

Thai Overseas Students

Amongst Thai students as with many of their peers (local or overseas students), casual sex, drugs and alcohol use are common.

*It’s fashion, kids start having sex from a very young age. Lots of casual sex cos’ they’re away from their parents, and it’s basically just fashion, because their friends do it so they see there’s nothing wrong with it.* (Student Leader)

Thai students in Australia may also feel safer than in Thailand, where the rate of HIV is higher.

*They’re pretty safe here; of course in Thailand they’re scared because the number of people with AIDS is quite high.* (Community Worker)

According to a Thai student leader, Thai students will generally not be interested in prevention and will only look for information if they are concerned about exposure to an STI or are at risk of pregnancy.

*I think they are aware of safe sex, but if they are looking for information it’s often afterwards, if they’re scared of being pregnant. It’s probably our attitude that we don’t approach anyone until a problem occurs.* (Student Leader)

Should they need information, they obtain it from their Thai friends, and mainly in Thai. They read English but would feel that the information *talks to them more* if it is in their language (see results from students’ Focus Group). Information that is written in an informal style and includes illustrations is also likely to be better received.

*It should sound like it is coming from a friend.*
The other main source of information is the Internet. Thai-language radio programs are popular with older community members.

Thai Sex Workers’ information needs
The term ‘Sex Worker’ covers a variety of situations, from legal to illegal brothels, street-based workers, trafficked women, etc. Thai women can be found in legal and illegal brothels, however they are rarely found in street-based settings.\(^5\) Research conducted by the Melbourne Sexual Health Centre (MSHC) and the Resourcing Health and Education (RhED) Program found that rates of STIs were lower amongst the workers in the legal sex industry than amongst street workers.\(^6\)

Access to information and levels of awareness vary widely depending on the legality of the worker’s activity. It is difficult for services that could provide such information to reach illegal brothel-based workers.

*If you think about it, if I knock on your door and say: ‘Hi, I’m just a free, anonymous service, would you like our information?’ Just by entertaining me, you’re already admitting that there is an illegal activity, so it would just not make sense to do that.*

(Support Worker)

In her Senate Standing Committee Submission on *Trafficking in Women Sexual Servitude*, Dr Elizabeth Hoban explained that women who are trafficked from South East Asia to work in the sex industry in Australia do not have access to reproductive health services or health practitioners because of their undocumented status and invisibility in the sex industry. The majority of trafficked women in the sex industry in Australia (licensed and unlicensed) do not receive prevention education and resources, STI and HIV/AIDS screening.\(^7\)

Hoban also comments that there is an urgent need for dedicated, free and confidential sexual and reproductive health and support services for trafficked women. *These services should be delivered through clinic-based and outreach activities and utilize the skills of ethnic health workers.*\(^8\)

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\(^5\) Key Informant Interview with RhED Project Worker  
\(^6\) Skelsey G et al (2003), *Legal vs Illegal Sex Workers*, Victoria, Australia, cited in Red Magazine #6  
\(^7\) Hoban, E (2003), *Trafficking in Women Sexual Servitude*, Senate Standing Committee Submission, Submission n 14, Sept 2003  
\(^8\) Ibid
By contrast, Key Informants reported that Thai sex workers based in legal brothels are generally well informed of their sexual health needs. The legislation in Victoria requires that workers in the legal sex industry undertake monthly checks for STIs and, at a minimum, quarterly HIV testing.⁹

Just the fact that they (the sex workers) are able to continue in a legal brothel suggests to me that they’ve negotiated STIs and Blood Borne Viruses to a degree. That’s not to say it’s going to be accurate … Two decades of involvement in the sex industry will not necessarily give you accurate information. (Support Worker)

While it is in the brothel owners’ and in the workers’ interest to maintain their sexual health in order to keep working, several Key Informants mentioned that a vulnerable area is the workers’ private life, where the ‘guards are down’ and the women may not use the same protective measures as in their professional life.

I think the few times a sex worker has appeared on the blip on the radar of the surveillance data has probably been because she or he picked it up from her private partner as opposed to a client. (Support Worker)

Information Provision
Sources of information for workers in the legal industry include brothel owners themselves, and clinics such as the Melbourne Sexual Health Centre’s Thai Sex Worker clinic. However, the main source of information for sex workers is each other.

It’s a known fact that it’s among one another that they share information.’ (Support Worker)

Information provision can be difficult in a brothel environment, where time is money. It is essential to be well-informed ‘and to the point’.

Some of the women would be very unhappy with management if management start letting in people that are of no use to the women, who are just wasting their time. They’ll be really angry with that and find that unsatisfying. (Support Worker)

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Information needs to be provided individually, as it is impossible for all workers to be available at once. A more opportune time is when workers go to a sexual health clinic for their health check. At the Melbourne Sexual Health Centre and in the drop-in STI clinic at the RhED premises, information is systematically provided on syphilis, HIV and other STIs.

To communicate with Thai Sex Workers, *nothing beats a translated resource* (Support Worker). The RhED project includes a Thai insert in every issue of its *Red* magazine and has translated information in Thai on its website. SQWISI (Self Health for Queensland Workers in the Sex Industry), a community-based organization funded by of Queensland Health, has produced a CD-Rom in English and in Thai to use in workshops run by peer educators.

**FOCUS GROUP SELECTION**

It was our original intention to investigate the information needs of sex workers regarding HIV/AIDS and how these needs were currently met, however through discussion with Key Informants it was realised that doing so could put the sex workers at risk. As explained above, sex workers, whether they operate in the legal or illegal sex industry, are difficult to approach and often distrusting of outsiders. It was decided that a focus on Thai Sex Workers was beyond the scope of the study. Should the specific information needs of Thai Sex Workers be investigated, we recommend that this be done as a separate project, and not as a part of research in the Thai community. The information material required by sex workers, due to the nature of their profession, is different from the material required by other members of the Thai community.

**Thai Overseas Students**

When asked which group they saw as most at risk in the Thai community, Key Informants raised the issue of lack of access to information and services for overseas students from Thailand. The combination of youth, freedom from parental discipline and cultural obligations, and a tendency to live in a close-knit group, preferring ‘the comfort of speaking their native tongue and the safety of being cocooned by a shared

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*Part Two – Community Findings
Thai*
Part Two – Community Findings
Thai

culture’\(^{10}\) make Thai students studying in Australia particularly vulnerable to sexually transmissible diseases such as HIV.

Participants were all overseas students at undergraduate and postgraduate level, aged 24 to 27. They had lived in Australia between four months and six years. They attended social activities organised by Thai associations such as the Thai Association of Victoria or the Thai Student Association of Victoria. All participants were born in Thailand and although they studied English at a tertiary level, all nominated Thai as their preferred written and spoken language. The facilitator was a student of Thai background.

Below is the material presented to this Focus Group:

Getting it Right! (MHAHS) Safe Sex (DHS) Going Home Safe

\(^{10}\) The Age newspaper (2005), Hello Stranger, Melbourne 19/09/2005
### KEY FINDINGS

#### THAI OVERSEAS STUDENTS

Overseas students of Thai background have grown up in a society where media is very present. They are distrustful of the motives behind health promotion campaigns, including campaigns about HIV/AIDS. This critical approach makes them different from other groups.

While HIV/AIDS is not a sensitive topic amongst their peers, it remains sensitive in their community and seldom discussed.

Health literacy and knowledge of HIV/AIDS were high.

They had seen little or none information about HIV/AIDS in Australia and felt information was more freely available in Thailand.

Young men and women in this group were comfortable discussing sexual health together – there was no need for gender separation.

Communication between parents and children varied in each family and was not set by cultural and societal rules.

They have access to quality health care in Thailand and are critical of the health system in Australia. They have little faith in GPs. Some chose to return to Thailand if in need of health care.

For these young people, being in Australia - in contrast with returning home – is a time of risk-taking. Whether they return home on holiday or at the end of their studies, they are more conservative than in Australia. Therefore they did not see the relevance of written material targeting travellers.

#### Information Provision

Thai was the preferred language for information provision.

The Internet was widely used (in Thai and in English) and its privacy was valued.
Participants requested the inclusion of English-language terminology in Thai material in order to communicate with local doctors and services.

Bilingual information is a good way to meet their information and language needs. Multilingual information was seen as *too much*.

They value materials’ content more than presentation.

Material needed to be ‘straight to the point’, informative and presented in simple terms. There was no sensitivity around diagrams.
CROSS CUTTING ISSUES

THE RELEVANCE OF HIV TO THIS COMMUNITY

The students in this group did not feel that, as young Thai people living in Australia, they were at risk of HIV.

The majority of Thai don’t engage in casual sex – it doesn’t apply to us.

I think it is far from us, unless we have unsafe sexual activities or associate with someone with HIV – our family members, friends or anyone. Then we would be concerned and would start looking for information as we would need to learn how to live safely with them.

The male students were more curious and concerned about HIV and STIs than their female counterparts. Some had looked for information about HIV on the Internet, while none of the female students had done this. Both sexes believed that it is a man’s responsibility to use condoms. Using condoms was also seen more as a form of contraception than as a protection against STI.

I use condoms with women, partly because it is a protection against AIDS, but a major reason is that I don’t want to get a girl pregnant – it means ‘end of life’ for me.

I only found out after I slept with this girl that she has had many unprotected sex with other men. And my friends all said it could be quite unsafe. So I got frightened and decided I had to have a blood test. Just the thought of AIDS gave me a big fright – it’s not a normal sickness … I’m terrified of its consequences – how I’m going to tell my parents, how I’m going to live a life till I die, what if people find out I have HIV. It’s just scary. Since then I’ve never ever had sex without condom again.

The students were suspicious of health campaigns driven by commercial interests, and were somehow cynical towards the media. This could explain why they were only interested in information if it was of direct relevance to their life.

I think media [follows] the trend at that particular period of time. It’s partially commercialised I think. Let’s say, if they’re running a national campaign on cancer...
prevention, then we’ll see a whole heap of TV programs or reality shows raising money and awareness for cancer. It doesn’t stay for very long. And we as audience know that it’s commercial. It stays because it’s being sponsored to be there. But once it’s over, hardly anyone ever talks about the issue again.

For instance, I think the Thai government only pays attention to AIDS prevention campaign when the country is at risk or when statistics show that more people have AIDS. If private pharmaceutical companies pay them enough money to sponsor the campaign, they’ll definitely do it. More for money, not for the benefit of community.

Thais use media the wrong way. Most of the time it is too commercialised, forgetting it’s a very sensitive issue that takes a long time to sink in.

**HIV AWARENESS**

This is an educated and wealthy group of young people who have grown-up in an environment where HIV prevention information was prominently displayed. Since the early 1990’s Thailand has been running intensive public information [campaigns] on HIV/AIDS prevention … through the mass media,\(^\text{11}\) with messages emphasizing prevention, behaviour change, condom use, and AIDS as not just a health problem but a social problem.\(^\text{12}\)

By contrast, the students had seen little or no information about HIV in Australia. They felt that it was easier to access information in Thailand, in part because it was in Thai but also because there were more advertisements in the media, along highways, etc. Despite this, students admitted to gaps in their understanding of HIV/AIDS, and were concerned about how these gaps affected their attitude towards people living with HIV/AIDS.

We haven’t got clear knowledge of how AIDS is transmitted from one person to another. So we need to protect ourselves as well as looking after people with HIV the right way.

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\(^{12}\) Ibid
When we talk about AIDS, we usually directly link it to sexual intercourse and simply forget that there are other ways it can be transmitted. Because we do not have the right information of how those people caught HIV and how it’s transmitted, we have wrong impressions of those who have it although they could have been diseased (sic) via other ways apart from sex. We exclude them and this leads to even bigger social problem.

**SENSITIVITY**

Despite their familiarity with health information and media campaigns, students felt that HIV remained a sensitive topic as it was related to sexual intercourse.

*I think the Thai culture remains conservative. When [parents] think of AIDS, they only think of sexual intercourse and that’s a very risky area to talk about, because they would prefer us not to be sexually active and open-minded about it.*

*Because of our culture, to have sex before marriage is bad.*

Whether material should explicitly indicate that it contains HIV/AIDS related information could not be ascertained (there was no consensus), but the majority of participants felt uncomfortable picking up material that clearly ‘spelt out’ the topic.

*HIV/AIDS on the front would be appropriate for content inside but then again, people would feel reluctant to pick up a copy.*

*If it is too explicit and if it is in public, I would be reluctant to pick it up.*

*It looks like there is something wrong with you if you pick it up.*

*I would be embarrassed to pick up materials in public. So a better alternative would be for someone to hand them out in the street. You pick it up from them and put it straight in your bag to read later when you get home.*
INTERGENERATIONAL COMMUNICATION

Communication between parents and children did not follow set societal rules around young people’s respect for elders. There is an assumed naivety about sex or acute cultural sensitivity around sexual activity outside wedlock (as in the Arabic and Horn of Africa communities, see Focus Group discussions). Students identified different degrees of difficulty in bringing up HIV/AIDS as a topic of discussion.

*It really depends on families and how you grow up …. For some families with conservative and old-fashioned parents, children are afraid to talk to their parents... These kids end up turning to their friends for advice – which aren’t always right as they don’t have the same experience and knowledge as their parents. I think attitude towards sex is a real problem there. We need open communication between parents and their children.*

*Parents of our generation are still very conservative and they’re too embarrassed to talk openly to us about these things.*

*My parents would not talk to me directly, they would pretend to accidentally forget books or materials in my bedroom and would leave it to me to read them.*

*It depends on your family background and how you’ve been brought up. I am very close to my dad and I’m sure my family would support me.*

RETURRING HOME

Discussions around the *Going Home Safe* booklet, aimed at Thai-speakers travelling back to Thailand, highlighted a somewhat puzzling interpretation of the information. The students could not see the connection between travelling and risk-taking.

*I’m confused if it is travel material or they want to talk about AIDS.*

*We’re not sure what it means.*

*Does that mean I should carry condoms while I travel or what?*
I don’t see how HIV/AIDS could be related to travelling. If you’re going to get AIDS, it could happen anytime, anywhere because you’re careless.

I still don’t get what the leaflet is trying to say. What’s the main message? It doesn’t have a focus.

They interpreted the target audience as being tourists going to Thailand; the illustrations showed activities that give us a feeling of leisure or taking a holiday. As the material was in Thai, they found that the material had a very limited audience.

One explanation for the confusion about the content is the fact that students do not travel back to Thailand for holidays, but rather to visit their family or to return at the end of their studies. Therefore, their time in Australia, away from their family and environment, is where possible risk-taking takes place – not when they return home. This was clearly expressed by a female student:

Going Home Safe – I might be already going home and do not need to know anything about AIDS anymore.
CHANNELS OF COMMUNICATION

Participants were asked to provide suggestions on what they saw as the most effective way to pass on HIV/AIDS prevention information. They were asked specific questions about Internet use, value of written material and preferred information providers. They were also asked to provide suggestions on how to communicate to the illiterate members of their community.

PREFERRED CHANNELS

The preferred sources of information for this group differed markedly from those suggested by other CALD groups during this research, who relied on community health centres and ethno-specific organisations as the first port of call. Instead, the Thai students learnt about health in newspapers and magazines (Thai or English-language editions of women’s magazines), from pharmacists, the Internet and close friends.

If faced with an HIV + diagnosis, typical reactions were:

*I would go to friends first, seek information to read, and then see a doctor.*

*I would search from books, then doctors, then friends.*

Few would turn to their parents.

*I don’t want my parents to worry about me, once I know there’s a major issue to worry about, then I’ll let them know.*

Pharmacists and instructions in medication boxes were seen as reliable sources of information by some.

*Chemist is a safe place. I usually talk to pharmacists on medicines and read from materials given in the box to find out more.*
When asked what would be the best way to provide HIV/AIDS information, students recommended the Internet and specific programs on radio (in Thai), such as Q&A with a doctor.

**Internet Use**
The Internet was widely used. The students would go to Thai-language websites as a first preference, as they found them easier to understand. Some participants preferred English-language websites as it gave them the terminology to communicate with doctors when needed. As with other groups, the privacy offered by the Internet was seen as a bonus.

*Most people access the Internet at home in their private room these days so they shouldn’t be embarrassed searching these sites in their own time.*

They trusted sites supported by government bodies and educational institutions. An on-line diary or pocket book written by people with HIV and Internet sites on sex education (rather than just HIV/AIDS) were suggested as popular ways to provide HIV prevention information.

All the participants agreed that a website about health issues, specifically for overseas students, would be a great resource. The site could be promoted through student agencies, the Australian Embassy in Thailand, student unions and flyers distributed in Thai restaurants (heavily frequented by students).

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**PERCEPTIONS OF AUSTRALIAN HEALTH CARE**

Students in the groups showed strong dissatisfaction with the Australian health system, particularly GPs. This was based on their own experience of health care in Australia, and comparison with the level of care they were used to receiving in Thailand.

*Once a doctor thought I had some serious illness. I had to go through several painful blood tests and other tests. In the end, I decided to go back to Thailand. It turned out that I had a urinary track infection – nothing more serious. So I was quite disappointed and had a rather unimpressive memory of doctors here.*
Receiving health care was criticised by one student as not accessible enough.

To me, it's a big hassle with Medicare. Not everywhere does bulk-billing and payment doesn’t come through till many weeks later. It’s just not a convenient enough system.

The level of dissatisfaction is so great that some students opt to return to Thailand if they are concerned about their health.

I think they ignore Asian patients. They treat us differently without tolerance which makes us scared and left stuck in the middle. In the end, it makes us feel like we want to go back to Thailand.

If my illness got really severe I would choose to go back to Thailand straight away. Definitely not see a doctor here.

Should they fall ill in Australia and need to see a GP, then the preference was for a practitioner of Thai background.

I suggest a clinic with [a] Thai doctor. I would also like to see Thai translators in large hospitals who understand the system and can help me with difficult medical terms and language barrier, medical problems and everything else. Illness is a very sensitive issue that needs private consultation with someone they can trust and rely on emotionally.

Maybe these services should be provided through the embassy. A doctor from Thailand maybe.
WRITTEN INFORMATION

Participants in each group were shown three brochures and asked to provide feedback on the following points: level of language used, clarity of translation, sensitivity of material, diagrams, and general appearance.

LANGUAGE

Thai students were comfortable in both Thai and English, but preferred communicating and receiving information in Thai. They felt however that they needed to understand English medical terminology in order to communicate effectively with Australian doctors.

*I prefer websites with information in English so that I know exactly the right medical terms.*

This could be addressed by bilingual information – or at least, if the information is in Thai, an index with the English translation of key terms. Despite this, reaction to multilingual material presented to the group was not positive. Participants found the booklet *You Are Not Alone* (presented in English and translated in four Asian languages) too busy and confusing.

*English is transferred into so many languages on each page, they run out of space and the message ends up meaning nothing.*

*The lay out with multi-language (sic) is too much.*

CONTENT AND PRESENTATION

Students’ astuteness regarding information provision also showed when asked to reflect on the way HIV prevention information is presented. They rejected jargon and statistics.

*We don’t need to know the full medical terms as we wouldn’t understand them anyway.*
We just want simple words that allow us to communicate precisely with doctors about our symptoms. We don’t need lots of numbers. Sure, we want to know if there are any significant trends but not full statistics; just not necessary and not interested.

They welcomed information presented in a direct and ‘straight to the point’ manner.

I need something that just says it.

The heading is ‘in your face’ and you know straight away what to expect. I like that it’s clear.

It should get straight to the point and one pamphlet for each disease so we are able to screen and only choose to obtain information related to us.

This means that given the choice between several brochures, they preferred the most informative even if they lacked illustrations.

Although (other) material looks pretty, this has more information. It is more formal, with more useful information too, because it is information I have never come across before.

Brochures with pictures sometimes lead us to believe that it is selling something to us. Materials without pictures look more serious and we know they try to inform us.

There was no sensitivity around ‘condom diagrams’
COMMUNITY FINDINGS

VIETNAMESE
BACKGROUND

COMMUNITY PROFILE

The information in this section is based on Australian Bureau of Statistics 2001 Census data, and on data from the Department of Immigration and Multicultural Affairs. As such, it gives a broad picture of the main trends but does not reflect the diversity within each community in terms of language, educational and employment levels, or literacy. The diversity within the Vietnamese community is highlighted in our research findings.

In a nutshell
The Vietnamese community in Victoria is:
- one of the largest migrant communities
- urban (clustered around key areas)
- young
- a recently established refugee community
- some members have low English proficiency and low educational levels

In 2001, Victoria had a Vietnam-born population of 56,664 people (36.6% of the overall Vietnam-born population in Australia).\(^1\) Another 1,900 Vietnamese settled in Victoria between 2002 and 2004.\(^2\)

The Vietnam-born population in Victoria is essentially urban, with 98.6% living in metropolitan Melbourne. More than half the population lives in the Local Government Areas (LGA) of Brimbank, Greater Dandenong and Maribyrnong. This refugee community settled in Victoria in the past twenty-five years, with 75% of Vietnam-born Victorians arriving between 1981 and 1995. The Vietnamese population in Victoria is predominantly young, with more than 40% of all Vietnam-born aged between 15 and 34 years, and another 25% aged 35 and 44 years old. More than half live in a ‘couple with children’ setting. The two main religions are Buddhism and Catholicism (58.5% Buddhist and 21.5% Catholic).

Language & Education
Vietnamese is the main language spoken by Vietnamese Australians (80% speak Vietnamese at home). This community is characterized by a high number of non-English speakers (more than 40% estimate that they speak English ‘not very well’ or ‘not at all’). This is a significantly larger proportion of the population than in other CALD groups and has direct implications for communication campaigns. Only one in five assess themselves as speaking English ‘very well’.

Also of note is the low level of post-school qualifications for this community: almost three-quarters (72%) have no qualification higher than school (53.7% for total Victoria). Only 12.6% held university qualifications (undergraduate and post graduate). This can be attributed in part to the low English proficiency of this group and to disrupted education in Vietnam due to conflict and displacement.

This is also a community with a high level of unemployment: 20.4% (compared with 6.8% of total Victoria) and overall lower income levels.

Internet Use
In 2001, computer use in this population was low, with less than 30% having the use of a computer at home and only a quarter (26.5%) having accessed the Internet (compared to 43.1% and 38.4% respectively in the total Victorian population).
### INFORMATION AVAILABLE TO THIS COMMUNITY

Following is a table of booklets and brochures related to HIV prevention in Vietnamese. Although we selected documents produced or revised since 2000, older materials of particular relevance have been included.

<table>
<thead>
<tr>
<th>MATERIAL</th>
<th>SOURCE</th>
<th>PUBLISHER</th>
<th>DATE (last update)</th>
<th>FORMAT</th>
<th>INCLUDES CONTACT DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS Your Questions Answered</td>
<td>Internet. Hard copy of English version other languages Internet only.</td>
<td>Victorian Department of Human Services (DHS)</td>
<td>2003</td>
<td>Q&amp;A format, responding to basic questions about HIV</td>
<td>YES</td>
</tr>
<tr>
<td>Safe Sex</td>
<td>Internet. Hard copy of English version other languages Internet only.</td>
<td>Victorian Department of Human Services (DHS)</td>
<td>2003</td>
<td>Q&amp;A format, responding to basic questions about safe sex</td>
<td>YES</td>
</tr>
<tr>
<td>Sexually Transmissible Infections</td>
<td>Internet. Hard copy of English version other languages Internet only.</td>
<td>Victorian Department of Human Services (DHS)</td>
<td>2003</td>
<td>Q&amp;A format, responding to basic questions about STIs</td>
<td>YES</td>
</tr>
<tr>
<td>HIV An Introduction – Fact Sheet 1</td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>Basic information - general</td>
<td>NO</td>
</tr>
<tr>
<td>HIV, STI and Travel – Fact Sheet 2</td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>Information about HIV and STI prevention when travelling</td>
<td>NO</td>
</tr>
<tr>
<td>The Effects of HIV/AIDS – Fact Sheet 4</td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>The Effects of HIV/AIDS</td>
<td>NO</td>
</tr>
<tr>
<td>Publication</td>
<td>Format</td>
<td>Publisher</td>
<td>Year</td>
<td>Description</td>
<td></td>
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<tr>
<td>The Health System in Australia – Fact Sheet 7</td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>The Health System in Australia</td>
<td></td>
</tr>
<tr>
<td>Some common terms (glossary) – Fact Sheet 8</td>
<td>Internet only - no hard copy</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>A glossary of terminology relevant to HIV prevention</td>
<td></td>
</tr>
<tr>
<td>Going Home Safe</td>
<td>Booklet (A6) – only available in NSW</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2002</td>
<td>Advice on HIV prevention for people intending to travel to Asia</td>
<td></td>
</tr>
<tr>
<td>STI's</td>
<td>Internet</td>
<td>SHINE SA (South Australian Department of Human Services)</td>
<td>2000</td>
<td>STI info, including HIV</td>
<td></td>
</tr>
<tr>
<td>The Condom</td>
<td>Internet</td>
<td>SHINE SA (South Australian Department of Human Services)</td>
<td>1996</td>
<td>STI info, including HIV</td>
<td></td>
</tr>
<tr>
<td>Women and HIV (Fact Sheet 1 - Testing)</td>
<td>Internet and hard copy</td>
<td>Family Planning Australia &amp; NSW Health</td>
<td>2002</td>
<td>One of six fact sheets for women with HIV</td>
<td></td>
</tr>
<tr>
<td>Multilingual fact Sheet</td>
<td>Internet</td>
<td>Well Women Website</td>
<td>2004</td>
<td>Contraception fact sheet</td>
<td></td>
</tr>
<tr>
<td>Everybody’s Business</td>
<td>Video</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service (MHAHS)</td>
<td>1999</td>
<td>General HIV information</td>
<td></td>
</tr>
<tr>
<td>The Australian AIDS Tape</td>
<td>Audio Tape</td>
<td>NSW Department of Health</td>
<td>2000</td>
<td>General HIV information</td>
<td></td>
</tr>
<tr>
<td>You are not alone</td>
<td>Booklet (A5). Multilingual Information English, Thai, Cambodian, Vietnamese and Chinese</td>
<td>Australian Federation of AIDS Organisations</td>
<td>2000</td>
<td>General Information about HIV (some for people with HIV)</td>
<td></td>
</tr>
<tr>
<td>HIV prevention information (Various)</td>
<td>Booklet (A5) &amp; brochures</td>
<td>Health Works</td>
<td>2004</td>
<td>IDU – specific information</td>
<td></td>
</tr>
<tr>
<td>Don't be afraid to ask</td>
<td>Booklet (A6) – Bilingual Information (Available in NSW only)</td>
<td>Multicultural HIV/AIDS and Hepatitis C Service</td>
<td>2003</td>
<td>HEP C ONLY</td>
<td></td>
</tr>
</tbody>
</table>
FINDINGS FROM KEY INFORMANT INTERVIEWS

Returning Home
The risk-taking behaviour associated with return trips to Vietnam were a concern for Vietnamese Key Informants.

You need to run a campaign with older and mature Vietnamese males, because they visit Vietnam frequently and we know there is an alarming increase in HIV infection there. (Community Worker I)

For the Key Informants interviewed (who were all women), there was no doubt that some men, when in Vietnam, behaved in ways that could lead to HIV infection.

The problem is when people go back to Vietnam, it is our culture and tradition that men get together to drink, then many of them can't control what they do and they forget to use condoms. (CW I)

The Key Informants were concerned about the risk of infection for women as a result of the risks taken by their male partners.

The husband goes back to Vietnam and goes to the sex workers, then comes back to Australia and has a relationship with his wife. The woman goes to hospital and has a test and the doctor recognizes that she has HIV. (CW II)

In the Vietnamese community however the concern was not restricted to men and their wives. The Burnet Institute reports that ‘the issue of well-meaning families dispatching their sons and daughters back to Vietnam, as a method of rehabilitation in response to their drug use and to get them away from the drug scene in Australia, remains an area of major concern.3 This was confirmed by a Key Informant.

Quite a lot of Vietnamese get HIV in Vietnam, drugs and needles are so cheap and it is easy to use. If you’ve got friends they can share it and they take the risk because they don’t know about [Hepatitis C and HIV]. (CW III)

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Effective Communication

Key Informants in the Vietnamese community worked mainly with women (young mothers, older women). They reported that women’s understanding of health information, including HIV, was very low, and the time they could dedicate to information gathering was very limited. Communication needs to be in Vietnamese for the adults, although for young people Key Informants felt that English was the common language.

In my community when we talk to young people we can use a mixture of English and Vietnamese, but for written information I prefer it to be in English because if they grow up here or are born here I don’t believe that they can read Vietnamese. They are more comfortable in English, but with the parents definitely in Vietnamese. (CW IV)

Effective channels of communication included Vietnamese Community Workers, in-language radio programs and information sessions.

The Vietnamese community, if they have any problem they usually don’t go to the mainstream service, they come and see the Vietnamese worker first. (CW IV)

People know by word of mouth, if you organise (an information session) with an experienced worker and a good interpreter I think that’s a good way to reach people. I organised the Fire Brigade to come and talk, hundreds of them turned up and some of them even said ‘You should have let me know earlier so I can bring my friend or my neighbour’. (CW IV)

One Key Informant thought that written material was not seen as the most effective way to communicate information of any kind.

Sometimes pamphlets are too much like junk mail so if they receive it they just throw it away. Sometimes they are too busy, there’s too much information floating around. (CW IV)

When producing written material, illustrations were welcome and could be explicit if necessary – as long as they were seen as educational. When asked to react to a
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Diagram of a penis and condom a Key Informant commented; *It’s OK because all the Vietnamese women, they know that all the brochures here are for education purposes.* (CW I)

**FOCUS GROUPS SELECTION**

**Vietnamese Men**
The Vietnamese co-worker and Key Informants highlighted that the time spent visiting friends and relatives or on business in Vietnam is a time of high risk-taking for men. It was therefore decided to investigate how men who travel back to Vietnam receive information about HIV prevention.

Participants were selected by the facilitator according to the following criteria:
- Men
- Married
- Over 30 years old.

All nine participants were of middle- to high-income socio-economic background, working in IT, customer service, or running their own small business. All were born in Vietnam, but had lived in Australia for many years ranging from 17 to 27 years. They were aged 35 to 55 years old.

**Language:**
Participants had arrived in Australia as teenagers or young adults. Some undertook a tertiary or vocational education. They have at least a functional (at best fluent) level of English to communicate and understand basic information. Despite this, seven out of nine participants preferred to use the Vietnamese language in all their communication channels. Two were comfortable with both Vietnamese and English for verbal and written communication.
Below is the material presented to this Focus Group:

*Going Home safe (MHAHS)*  *Safe Sex (DHS)*  *Getting it Right!*

**Vietnamese IDU**

Injecting Drug Users (IDU) are a high-risk group for HIV transmission in the Vietnamese community.

Participants were selected by the facilitator according to the following criteria:

- Drug Users currently injecting
- Minimum of 18 years old

All participants were male. The youngest was 18 years old and all others were aged between 25 and 37. Education level was low with one studying at TAFE, one completing his VCE and the remaining participants leaving school in Year 10 or 11. All participants were unemployed. Seven out of eight participants lived with family members (parents or older sibling’s family).

**Language:**

Vietnamese was the preferred language and the language spoken at home of all participants bar two, who were born in Australia. The two Australian-born participants spoke Vietnamese at home but selected English as their preferred written and spoken language. All participants had studied Vietnamese at school or in ‘ethnic
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schools'. Those who left high school in Year 10 or 11 did so due to their lack of English proficiency.

Below is the material presented to the first Focus Group:

Health Works  Don’t be Afraid to ask

Below is the material presented to the second Focus Group:

Getting it Right! (MHAHS)  Going Home Safe (MHAHS)

4 ‘Community languages schools, previously referred to as ‘after hours ethnic schools’, provide language study to approximately 34,000 Victorian primary and secondary school students in over 50 languages.’ Review of the Commonwealth Languages Other than English (LOTE) Programme, Commonwealth Department of Education, Science and Training, 2002
KEY FINDINGS

VIETNAMESE MEN

Participants’ awareness of HIV and understanding of modes of transmission were low.

The little information they had came from mainstream campaigns or was acquired when travelling to Vietnam.

As with most communities, HIV carries a stigma within the Vietnamese community. HIV/AIDS was associated with drug use and sexual promiscuity, and seen as morally reprehensible.

The men in the group considered themselves ‘too busy’ to think about any health issues, including HIV/AIDS. They did not see themselves at risk.

Because of this they did not think that HIV/AIDS was relevant to their lives and it was rarely discussed.

There was no sensitivity around the material’s presentation and content, although they felt that it may offend some women and older people.

They had never seen pamphlets about HIV in Vietnamese and were not aware that such information was available.

Information Provision

English language proficiency was low. It is essential that information is presented in Vietnamese for this group. Illustrations were highly valued, particularly for the illiterate members of the community.

Preferred information providers were community health centres and ethno-specific agencies.

They were consumers of ethnic media and saw it as an effective channel of information.
Religious leaders were seen by some participants as able to play a part in HIV prevention due to the trust that is placed on them by the community.

Participants were uncritical of all the HIV prevention material which they were shown during the group discussion.

Illustrations were highly valued as they transcended language difficulties and lack of literacy.

They used the Internet on a regular basis, but would not seek information in English.
Participants had rarely or never read HIV/AIDS prevention information in Vietnamese or in English. What little material they had seen they had not understood.

They had never asked anyone about their sexual health, Hep C or HIV/AIDS.

Participants had some awareness of HIV in Vietnam, but little of the Australian situation. Knowledge of HIV/AIDS incidence in Australia was very limited, and related to the level of support received by those living with the virus.

The main known modes of transmission cited were blood and using unclean injecting equipment, followed by unprotected sex (particularly male to male sex).

Privacy and secrecy were highly valued by this group. Drug use was highly stigmatised in the community and their own use surrounded with secrecy.

English-language proficiency was very limited, and Vietnamese was the preferred language for all interactions.

Participants were not linked to mainstream or community-specific organisations, and all their interactions with Service Providers were related to their drug use.

**Information provision**
Because it can be taken home and read in private, written information, in the form of leaflets and brochures, was the preferred way of obtaining information about HIV. However they do not want material which is easily identified as relating to drug use.

Preferred information providers were those who provided drug-related support: Needle Exchange Agencies, blood/urine testing facilities, General Practitioners providing heroin substitutes.

GPs were seen as the most trustworthy and knowledgeable source of information. There was little confidence in Community Workers’ ability to provide information about sexual health. Most participants had never discussed their sexual health with Service Providers.
Internet use was low.
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Vietnamese

CROSS CUTTING ISSUES

THE RELEVANCE OF HIV TO THE COMMUNITY

Married Men
The men considered themselves too busy to think about any health issues, including HIV.

*All our energy is spent on earning an income for our family; we do not have time for this sort of topic.*

They did not consider themselves at risk of HIV and in fact HIV was seen not to be relevant to them. These men saw HIV as the disease of drug users and of those who have money to practice their sexual activities promiscuously. Therefore HIV was not seen to be a risk to them. They did not explicitly link HIV risk to their trips back to Vietnam and the sort of behaviours mentioned by Key Informants in the Vietnamese community.

Participants felt that HIV was an issue for all communities, not particularly for the Vietnamese. It seemed logical to them that a pamphlet would be written in English and then translated for different language groups, instead of being written specifically for a Vietnamese audience.

*HIV/AIDS is everyone’s problem since there is no cure, so this type of information is for all communities, not just for our community. Therefore it is not a surprise if it is written and translated from a reliable source.*

All participants stated that they would use the pamphlets to learn about particular issues and pass it on to their relatives, friends and community members. Six out of the nine participants indicated that they would not mind taking a pamphlet home for their family.

*These pamphlets help me understand the disease to allow me to share it with other people.*
Injecting Drug Users

The notion of ‘community’ for Injecting Drug Users is a complex one, and they ‘need to be approached and understood in multiple cultural contexts (e.g. Vietnamese families and communities, contemporary youth cultures, street drug market, education institutions and custodial settings)’. Vietnamese users have been described as ‘a relatively isolated group whose social worlds often related only to other Vietnamese-speaking drug users’. This may be a result of ‘the degree of alienation experienced by (...) Vietnamese IDUs in general, and the degree of shame and stigma associated with IDU in the Vietnamese community’.

Participants felt that all communities (not just the Vietnamese) needed HIV information, but disagreed on whether drug users needed it more than other groups. While some participants felt that IDUs were at higher risk of HIV as they may be infected by HIV/AIDS due to sharing needles, others thought that HIV information was necessary for everyone in the community, whether they inject drugs or not.

After the subject was debated, there was agreement that IDUs were a ‘high risk group’ for HIV. Another reason why HIV was relevant to this group was the increasing rate of HIV in Vietnam, and in other Asian countries. The participants were more aware and informed about the prevalence of HIV in Vietnam than in Australia. One remarked that:

In particular Thai and Vietnamese have got high number of HIV/AIDS patients.

The relevance of HIV information extended to Australians travelling to Vietnam. Commenting on the Going Home Safe booklet, participants recommended it for Australians who are likely travel to Thailand and Vietnam and should be concerned about the safe sex to prevent the disease (HIV/AIDS).

5 Higgs P, Maher L, Jordens J, Dunlop A and Sargent P (2001), Harm reduction and drug users of Vietnamese ethnicity, Drug and Alcohol Review, 20; 239-245
7 Kelsall J, Higgs P and Crofts, N (1999), The Vietnamese IDU & Harm Reduction Study, Macfarlane Burnet Centre for Medical Research, Melbourne.


**HIV AWARENESS**

**Married Men**
Understandings about modes of transmission were very low for this group. Blood transfusion and mosquito bites were mentioned as means of transmission – although comments on the immorality associated with drugs and promiscuous sex indicated an awareness of transmission through IDU and unsafe sex. One participant commented; *once you are sick you won’t last long.*

Several participants admitted that they knew very little about HIV/AIDS. HIV was rarely discussed, not because of the topic’s sensitivity but because there was little place in their life for topics related to health and sickness. The little knowledge participants had was gleaned from mainstream media or from information they were exposed to during trips to Vietnam.

*I have just returned from Vietnam, I did not see any advertisement about HIV/AIDS on television but there was information on billboards along the highways.*

*I can vaguely recall about ten years ago there was an ad that used a scare tactic. But it did not show as much details as these pamphlets.*

Participants had never seen pamphlets in Vietnamese before and were not aware that such information was available in Australia. They all, repeatedly, welcomed the fact that information was now available in their language as this makes it accessible to their community – particularly those with low English.

*It is our first time reading such pamphlets… There are a lot of details which I never knew.*

*Often what we see and hear about HIV/AIDS is not in detail. By reading these materials we can understand it clearly.*

*I think this pamphlet is very useful. By reading it, I have a clear view about HIV/AIDS and more importantly how it is transmitted.*
Injecting Drug Users
The level of awareness was low. The main mode of transmission cited was blood to blood. Sharing unclean needles was seen as the main risk activity.

*If users use ‘sword’ (needles) and share them then they get the disease.*

Only two of the men cited unsafe sex as a mode of transmission. Unsafe sex was linked to homosexuality or promiscuity, with comments such as:

*It is particularly transmitted through gay and lesbians sexual relationships.*

*In particular for Thai and Vietnamese people they have high number of patients due to sexual affairs.*

Regarding HIV infection in Australia, participants suspected that it may be prevalent but *many people don’t know that they have the disease* and others may fear disclosing due to the *stereotype for gay and lesbians*. They were aware that Australians living with HIV receive substantial support and have access to medication.

The participants in the group have never asked anyone about sexual health or health issues related to their drug use. They had rarely or never read information about HIV/AIDS.

*I read though some HIV/AIDS information in the past but did not understand it in depth.*

*I read through information but forgot a lot of its content.*

SENSITIVITY

Married Men
As in most communities, there is stigma associated with HIV in the Vietnamese community.
If someone was a carrier of such disease it would mean; be careful when you come near me as I am an outlaw. Therefore no one would want to be in such situation and deprived of all protection and rights.

There was however little or no expressed sensitivity around the material itself, including terminology (e.g. oral sex, anal sex), and diagrams. Although participants read the material very thoroughly, they did not bring this up as an issue.

We’re all adults; it’s OK to talk about sexual health.

When pressed on this, comments included:

Some female members of the community may feel uncomfortable and embarrassed.

From a cultural perspective, our older generations may not be happy as our traditional values have been thrown out the window by the younger generations.

The focus of participants’ attention was on how clearly expressed the message was, in words or in pictures. This overrode possible cultural sensitivity.

With the illustrations, the message stands clearly and will help people with low literacy skills to understand. For example, the Getting It Right pamphlet shows clearly how to use a condom. In this pamphlet (Going Home Safe) it would be clearer to have more illustrations.

Similarly, the fact that the Going Home Safe booklet did not make any reference to HIV/AIDS on its cover was seen as a flaw. The name of the pamphlet was too vague and does not have a direct target.

How acceptable illustrations were was directly related to their ‘usefulness’. Pictures and instructions about condoms were seen as reasonable as they provided useful information, while something that doesn’t need to be there was seen as unreasonable.

Injecting Drug Users
All participants felt that HIV/AIDS was a sensitive issue in the Vietnamese community.
Vietnamese do not talk about this.

One participant commented that it was only talked about when one of their family members gets the disease.

Compounding this, and of more direct relevance to users, drug use is also a sensitive issue. In a study of Vietnamese Injecting Drug Users in Melbourne, researchers from the Burnet Institute found that 'the degree of stigma associated with injecting drug use in this community can not be underestimated; nor can the way in which it impacts on patterns of behaviour.'

Although they lived at home, most participants hid their drug use from their parents. The ‘fear of disclosure or discovery by family or friends’ was clearly expressed when discussing the materials’ presentation, with comments such as:

The drug users are likely to hide their drug use from others therefore they will hesitate to pick up a leaflet with the pictures of a needle, syringe or spoon on the cover.

Parents may think that their child uses drugs if they take home a leaflet.

However, if material did not outwardly indicate that it contained drug-related information, then taking written material home was not seen as problematic. On the contrary, it was participants’ preferred way of accessing information, as it allowed for privacy. Material that indicated HIV/AIDS information could be interpreted as being of general interest and not as evidence of drug use.

If someone asks you why you are reading this information, you can answer that you would like to know about it.

Anyone can read about health information, no one would oppose that.

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8 Kelsall J et al (2001) op cit
9 Ibid
RETURNING HOME

Married Men
The participants in this group were middle to high income professionals who return to Vietnam regularly, sometimes stopping in Thailand or Malaysia on the way. There was no discussion in the Focus Group of their personal behaviour when travelling – only of the material presented.

The booklet Going Home Safe generated some discussion about the risks associated with going back to Vietnam. Participants related such risks to the value of the Australian dollar in other countries, and the opportunities available. For instance, they discussed the fact that commercial sex is much more affordable.\(^\text{10}\)

\textit{Five or ten dollars give you ‘Heaven’!}

\textit{In Australia, it could cost you one working day!}

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CHANNELS OF COMMUNICATION

Participants were asked to provide suggestions on what they saw as the most effective way to pass on HIV/AIDS prevention information. They were asked specific questions about Internet use, value of written material and preferred information providers. They were also asked to provide suggestions on how to communicate to the illiterate members of their community.

PREFERRED CHANNELS

Married Men
Community Health Centres, Family GPs, ethno-specific organisations and the Internet were expected sources of HIV/AIDS information. However, as the men had never sought HIV/AIDS information these suggestions regarding where they expected this information to be available were theoretical. When asked what would be the best way to provide HIV/AIDS information, they added travel agents, a hot line and Vietnamese-language radio programs as other possible sources.

*It is very effective to use community language media such as newspapers, SBS and other radio programs to raise awareness. It is important to broadcast regularly, perhaps on a weekly basis to ensure that the message is well understood.*

The role of religious leaders in HIV/AIDS awareness was a hotly debated topic in this group, as was whether to distribute pamphlets at places of worship (such as churches and temples). Some men supported this, arguing that Vietnamese people place great trust in their clergy, priests and monks. Others rejected the idea, on the basis that the role of the clergy was religious and spiritual and that there was no place for education about HIV/AIDS.

*In our contemporary society religion has changed to adapt to the social changes. Therefore priest and clergymen and women are required to have considerable knowledge to lead their community. I am therefore hoping that HIV/AIDS information can be at either churches or temples to allow easy access for the general community.*

There was consensus about the role the clergy can play in alleviating the suffering of people with HIV and their families, and in directing them to where they could seek
help. Monks, nuns and priests were seen as having knowledge and understanding of health issues and could provide support (if not information) to people affected by HIV.

Internet
Participants were comfortable using the Internet – several mentioned that they do so regularly. However they assumed that all HIV information produced in Australia would be in English and therefore not easily understood.

Although I can find information on HIV/AIDS on the Internet, it is hard for me to fully understand the message.

Injecting Drug Users
The participants gave the impression of a group whose lifestyle is very focused on their drug use, and when they do turn to Service Providers it is solely for services related to drug use. None of the participants in the group used Community Health Centres or other mainstream services. Health information, when communicated, came from Vietnamese-specific agencies or drug-users specific services: Needle Exchange Venues, testing facilities and GPs known to provide heroin substitution treatment.

Their health appeared to be of little concern (which was also expressed by a Key Informant working in this area). They had never asked anyone about sexual health or health issues related to their drug use. Only one had ever talked about hepatitis C with a friend. The few times they had read information about HIV/AIDS (which was rare), the information had been provided in the street by outreach workers or through Needle Exchange Venues (picking up leaflets or reading advice on posters depicting how to inject safely). As far as they remembered, they had never been handed HIV information by a Community Worker or social worker.

Should they wish to obtain information about HIV/AIDS, the most trusted sources would be GPs and workers at the Needle Exchange Venues. Workers at Needle Exchange Venues were seen as people that can help us find any information if we don’t know where it is. There was little confidence however in their ability to know the answers to the clients’ questions: Instead of asking a Community Worker about a disease that they may not understand, we should ask the doctor directly.
Trusted GPs (the few who provide heroin alternatives) were the preferred source of sexual health information for all participants, although one participant's experience was that they would only provide information if specifically requested.

Asking parents was not an option due to their perceived lack of knowledge about sexual health and the sensitivity of the issue.

Written Information
Brochures were the preferred method of communication of HIV information for this group, as it can be taken home and read in one’s own time and in private. They preferred this to having someone explain the information to them. Should they need further explanation, they would ask a doctor (preferred choice) or a worker at the Needle Exchange Venue.

Internet
This was not a tool commonly used by this group: less than half the participants had ever used the Internet, and only one used the Internet to access health related information (Hepatitis C, in English). Trust in the medium was low, although government agencies and hospital websites were regarded as more reliable than private sources.

ILLITERACY

Married Men
The fact that some community members were not literate (in either language) was mentioned repeatedly through the group discussions.

Illustrations were seen as a good way to address lack of literacy.

With the illustrations, the message stands clearly in each section and will help people with low literacy skills to understand it. For example, the ‘Getting it Right’ pamphlet shows clearly how to use a condom.

An A4 Internet print-out without illustration was described as not accessible to those who could not read:
Some illiterate and most vulnerable members of the community might be excluded by the format and the presentation of this pamphlet, because if you cannot read you will not be able to grasp the general idea about what the pamphlet is for.

Injecting Drug Users
While illiteracy was not directly mentioned, the low level of English literacy is well documented in Census statistics and demonstrated by this group’s preferred language. The experience of migrating to Australia as children has had a strong impact on these men’s English language skills and consequently their lack of understanding of messages addressed to the mainstream. As a result they are extremely reliant on Vietnamese language information.
Participants in each group were shown three brochures and asked to provide feedback on the following points: level of language used, clarity of translation, sensitivity of material, diagrams, and general appearance.

**LANGUAGE**

**Married Men**

Only two of the participants cited English (with Vietnamese) as a language they were comfortable reading and writing in. Participants in the group clearly valued the fact that the pamphlets were written in their first language.

*As I am reading these pamphlets in Vietnamese I can understand the details more clearly than when reading them in English.*

Bi-lingual information was not mentioned as an option.

All pamphlets were praised for the quality of translation and clarity of information.

*Language is clear and easy to understand.*

There was a presumption that young people could understand information in English\(^\text{11}\) and that the translated material was necessary only for adults.

*For us, the translation is clear and easy to read. For the younger generations, I don’t think they will need to read this information in Vietnamese as they can understand English much more easily.*

**Injecting Drug Users**

It is essential to communicate in Vietnamese with this marginalised group. Throughout the discussions, participants noted how language was what made them relate to the material and how they appreciated that it made it easier for them to understand the information.

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\(^{11}\) 2001 Census statistics show that out of the 42.8% of Vietnam Born in Victoria who self-assess as speaking English not well or not at all, only 5.3% are 24 years old or younger. Nineteen per cent are aged 25 to 34.
Reading this only once, I immediately understand because it is in Vietnamese.

The only participant who struggled with the Vietnamese language was the youngest member of the group (who was 18 years old and Australian born), but the illustrations in the Vietnamese material also helped him understand the message;

When I look at the condom pictures I can understand.

There was concern about the use of terms in Vietnamese which could not be understood by all, such as the Vietnamese translation for HIV/AIDS. Such terminology should be translated or included in English.

**CONTENT AND PRESENTATION**

**Married Men**

Participants were uncritical of all the HIV prevention material which they were shown during the group discussion. Clear and easy-to-understand illustrations were key to participants’ appreciation of the booklets. The clearer and more direct the more accessible they would be for people with low literacy skills. This included diagrams on how to use a condom.

*Such illustrations are important, particularly for those who have a low level of education and are illiterate, to understand what the message is all about.*

*It is important that the pamphlet has a user-friendly design. Its content needs to be clear, concise and with reasonable illustrations to ensure the message is getting through to the target group.*

The fact that Going Home Safe had many illustrations attracted several positive comments, such as:

*Those who are illiterate can possibly understand the general message of the pamphlet.*

Lack of illustrations in the A4 Internet print-out reduced its perceived relevance.
Some illiterate members might be excluded by the format and the presentation because, if you cannot read, you will not be able to grasp the general idea about what the pamphlet means.

Participants liked the size of the Going Home Safe and Getting It Right booklets, as opposed to the A4 Internet print-out, which they found inconvenient and hard to display.

The preferred written material out of the three shown was Getting it Right. Participants commented on the fact that the information is clear and concise, divided into sections with clear sub-headings and has clear illustrations.

Even a person with limited education can understand it.

Injecting Drug Users
Clarity of content and presentation was the most important factor for the participants’ reaction to the material. Comparing the materials presented to them, they liked brochures that were easy for everybody to read and understand as opposed to those that were messy.

An A4 page with dense text and no illustrations was not likely to be picked up and read; It has no specific thing to make a good impression – no one would want to read it!, while a brochure with many illustrations and clearly spaced text received appreciative feedback. Amongst the positive features were: large font, clear presentation, ‘catchy’ title (‘Don’t be afraid to ask’) and numerous and clear illustrations.

The pictures show clearly the message of the transmission of the disease.

The Going Home Safe brochure was warmly received because it has several pictures for easy reading.

There were no remarks regarding possible inappropriate content or illustrations /diagrams. As noted above, written information is valued as it can be taken home and read in private. The size of brochures was therefore seen as important, with small brochures/booklets easier to take home.
The small size is easy to put into my pocket.

There were some suggestions that illustrations should be scarier, such as bodies in hospital to make people aware. When people look at the pictures they will be afraid. This also included writing HIV/AIDS in large red font on the front cover of brochures.\textsuperscript{12}

\textsuperscript{12} There is considerable amount research in HIV/AIDS education and health promotion to support the position that a fear approach does not work.
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APPENDIX 1 - KEY INFORMANTS

- Tadgh Mc Mahon  
  Multicultural HIV/AIDS and Hepatitis C Service
- Sonam Paljor  
  Multicultural HIV/AIDS and Hepatitis C Service
- Wa’el Sabri  
  Multicultural HIV/AIDS and Hepatitis C Service
- Peter Todaro  
  NSW Multicultural Health Communication Service
- Antigone Coustonicas  
  Education Centre Against Violence, NSW
- Maureen Johnston  
  Royal Women’s Hospital
- Rosey Cumming  
  Melbourne Sexual Health Centre
- Kofi Osei  
  Western Region Health Network
- Grozdana Lukic  
  Migrant Resource Centre of the North East
- Dr Joanne Gardiner  
  Darebin Community Health Centre
- Rachanee Naksuk  
  Multicultural Health & Support Service
- Julie Futol  
  RhEd Project (Inner South Community Health Service)
- Linda Phan-Araya  
  Thai Student Association
- Dam Tran  
  HealthWorks
- Lao Vong  
  North Richmond Community Health Centre
- Huong Ngo  
  Multicultural Health & Support Service
- Binh Do  
  Vietnamese Community in Australia – Vic Chapter
- Jacqui Brown  
  HealthWorks
- Iman Allaf  
  Victorian Arabic Social Services
- Michael Farah, Kate Gillick and Adel Younis  
  Victorian Arabic Social Services (Anti Racism Action Band Project)
- Muhamnad Bunni  
  Multicultural Health & Support Service
- Fatima Al-Qarakchy  
  Cutting Edge (Shepparton)
- Halima Mohammed  
  Multicultural Health & Support Service
- Elleni Bereded-Samuel  
  Horn of Africa Communities Network
- Shroug Mohamed  
  Sudanese Community Association of Victoria
- Samia Baho  
  Family and Reproductive Rights Education Program
APPENDIX 2 - FOCUS GROUP LINE OF ENQUIRY

General questions (30mn)

Where do you find information about health and sickness?

Lead on question: How often do you read leaflets about health issues?

Lead on question: Have you ever read a leaflet about HIV/AIDS?

Prompt: Have you ever been given a leaflet about HIV/AIDS?

Prompt: By whom?

What sort of things do you know about HIV/AIDS?

What do you know about HIV/AIDS in Australia?

What do you know about HIV/AIDS in your home country?

Who do you talk to about HIV/AIDS? (friends, family members)

At the end of this session the facilitator will have a good idea about all participants’ level of knowledge on HIV/AIDS and everyone’s attitudes towards HIV/AIDS.

Questions about the material (60 mn)

Where would you expect to find this leaflet?

What is your overall impression of the leaflet?

Prompt: Who do you think this leaflet is written for? Why do you think that?

Prompt: What do you like and dislike about the leaflet? Why do you think that?

Prompt: Do you think this leaflet has been written specifically for Vietnamese/Thai?

What makes you think that?

How clear and easy to understand is this leaflet? Why do you think that?

What is the main message?

Some of the leaflets/brochures are large. If this is the case think about breaking up the Focus Group into small groups (i.e.: 3 groups of 3-4 people). Ask the participants to spend 5 minutes reading and looking through one or two specific sections.

Then ask the following questions:
Are there words or sentences that you don’t understand?
Prompt: How easy or difficult are these words and sentences to understand?

Are there words or pictures which you think might be inappropriate, strange or might offend people?
Prompt: If so, in what ways are they inappropriate?

What do you think is missing from the leaflet?
Prompt: pictures, cartoons, more colour

Have you seen anything in this leaflet that you haven’t seen in other material?
What was it?

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Can you tell me what other ways you might find information about HIV/AIDS?
Prompt: radio programs/Plays/TV programs/Internet
Prompt: Do you ever use the internet to access information about HIV/AIDS?

How much do you trust the internet?

Would you trust information in your own language?

What about more generally with sexual health; who do you go to when you need to find out about sexual health issues?
GPs/Community workers/friends/family

Do you prefer to have information explained to you by a: community worker/GP/Take information home and read it yourself

Lead on question: What is the best way?

Is written information the best way to get information across to people?
What are good and bad things about written materials?

Where do people from your community who can not read get information from?

Lead on question: Do you have any ideas about how people who can not read can get access to information?
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