

# **The National Indigenous Gay and Transgender Project**



## **Consultation Report and Sexual Health Strategy**



**Australian Federation of AIDS Organisations**

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The *National Indigenous Gay and Transgender Consultation Report* was written by Gary Lee. The *National Indigenous Gay and Transgender Sexual Health Strategy* was written by Gary Lee and Timothy Moore in association with the AFAO Indigenous Gay and Transgender Steering Committee. Thank you to all those who assisted this process with their generosity in time, knowledge and experience.

AFAO can be contacted at:

PO Box 876  
Darlinghurst  
NSW 2010  
Phone: (02) 9281 1999  
Fax: (02) 9281 1044  
E-mail: [afao@rainbow.net.au](mailto:afao@rainbow.net.au)  
Internet: <http://www.afao.org.au>

# Foreword

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The Australian Federation of AIDS Organisations (AFAO) is delighted to present this *National Indigenous Gay and Transgender Consultation Report* and *National Indigenous Gay and Transgender Sexual Health Strategy*, produced by the AFAO Indigenous Gay and Transgender Project.

As the peak non-government organisation representing Australia's community response to HIV, AFAO has long been concerned about the possible impact of the epidemic on Indigenous communities. It is becoming apparent that the HIV threat to Indigenous Australians is a real one, and this Report and Strategy will be important weapons in our struggle to overcome the problem.

For AFAO, 1997 was characterised by a number of significant achievements in our effort to be part of addressing the HIV-related needs of Indigenous Australians. In addition to establishing our first Indigenous project and producing this Report, it was also the year we moved to formalise a cooperative arrangement with the National Aboriginal Community Controlled Health Organisation (NACCHO), to ensure our movements work together to address HIV-related needs within the Indigenous community.

AFAO and its constituent AIDS Councils and peak bodies face significant challenges in meeting the health needs of Indigenous Australians, and must make greater efforts to work with Aboriginal Medical Services and other Indigenous community organisations and to learn more about the needs of our Indigenous constituents. We believe that as a movement, the HIV sector is keen to meet these challenges and we are confident that with NACCHO's assistance, we will be able to do so.

With this Report and Strategy, we at last have documentation of the reality of HIV for Indigenous gay men and transgender persons, and we would like to thank and commend the Indigenous Australians who generously shared their concerns and experiences so that this Report could be written and the Strategy developed. We ask all readers to respect the trust demonstrated by those who shared their experiences, and to recognise the obligation on all Australians to work with Indigenous people to improve Indigenous health.

The Report and Strategy will shape AFAO's ongoing response to the needs of Indigenous Australians. We also hope that these resources will be utilised by other key stakeholders, including governments, to help ensure that the general health care needs of Indigenous Australians are all addressed and are not exacerbated by the emergence of HIV epidemics within Indigenous communities.

The Commonwealth government's third *National HIV/AIDS Strategy 1996-97 to 1998-99* identifies gay men and Indigenous Australians as groups deserving of priority in the HIV response, in all areas of HIV servicing including prevention education, treatments access and care and support. AFAO is committed to heeding the Strategy's call for greater attention to Indigenous HIV issues, while maintaining our services and commitment to gay men and other groups at risk.

AFAO would like to thank project worker Gary Lee for his hard work in the preparation of this Report. AFAO would also like to thank the members of the Indigenous Gay and Transgender Steering Committee, formerly Aboriginal and Torres Strait Islander Gay and Transgender Working Party, for their ongoing and unpaid work for AFAO, for their dedication to the project and for enabling AFAO to better understand and respond to the needs of Indigenous gay men and transgender persons.

The individual members of the group are named in the Report, and AFAO thanks each and every one of them for their important contribution.

While the Strategy has been devised primarily for AFAO and AIDS Councils, we hope that it will be considered and implemented by all service organisations with a commitment to addressing the HIV-related needs of Indigenous Australians. While some readers may think it inappropriate for AFAO to be making recommendations relating to the work of other organisations, we could not in good conscience forgo the opportunity to present a broad, multi-faceted strategy to address the needs so clearly articulated during the consultations.

Prior to publishing this Report, we have consulted with NACCHO about its contents and the process for affecting change in AIDS Councils and in Aboriginal Medical Services.

The Report contains strong messages for AIDS Councils and equally strong messages for Aboriginal Medical Services and other policy makers responsible for the delivery of health care. All three groups need to accept and respond to the information contained in this Report. We hope that these messages are recognised for what they are, the collective views of over 130 Indigenous gay men, transgender persons, HIV positive people and HIV and Indigenous health care service providers. These voices, so long unheard and never before recorded, now deserve a response.

As always, the best responses to the HIV epidemic require honest and often difficult dialogue, and clever, courageous policy and community responses.

We commend the Report and Strategy to you.

Peter Grogan  
National President  
AFAO

Colin Ross  
Convenor  
AFAO Indigenous Gay and Transgender  
Steering Committee

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# **Consultation Report**

# Acknowledgments

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I would like to give thanks to the many people who contributed to this Report either directly or indirectly.

Firstly I would like to acknowledge the work of the Australian Federation of AIDS Organisations (AFAO) Indigenous Steering Committee - previously the AFAO Indigenous Working Party. Their enthusiasm for, and monitoring of the Project and the Project Officer went a long way towards keeping things on track.

Special thanks goes to all the Indigenous and non-Indigenous communities, community organisations - particularly indigenous health centres, AIDS Councils and staff - and other organisations and individuals who participated in this Report. There were many individual acts of kindness and gestures of community generosity extended to me which made my hard task all the more easy.

Thanks to Bill O'Loughlin, past president of AFAO, who was and is a staunch supporter of the Project and Indigenous gay and transgender issues.

I would like to thank the staff of AFAO, especially Lou McCallum, Executive Director, for continual support throughout the Project. In particular, I want to thank Tim Leach, Deputy Director, for his tireless efforts in managing the Project, his good humour, and his extremely good patience in keeping the Project, the Indigenous Steering Committee and this Project Officer moving forward as smoothly as possible.

A very special acknowledgment to the partners, friends and relatives of the Indigenous gay and transgender people who are the focus of this Report and, in particular, to the gay and transgender individuals whose 'voices' have been depicted throughout. Without you there would be no Report.

And last but certainly not least, I wish to acknowledge my life-partner, Maurice O'Riordan, for his unqualified love, understanding and unselfish support, particularly during my long absences away on the national consultations and while I was writing up this Report.

**This Report is dedicated to all Indigenous gay and transgender people.**

Gary Lee  
Project Officer  
AFAO National Indigenous Gay and Transgender Project



# Chapter One

## About the consultations

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### 1.1 The Indigenous gay and transgender steering committee

The Indigenous Gay and Transgender Steering Committee was established in response to one of the major recommendations of the 1994 Anwernekenhe Report (Anwernekenhe means ‘us mob’ in the Arrernte language and is used with full permission).

This Report was the primary document to come out of the first and historic Indigenous Gay Men and Transgender Sexual Health Conference held in late 1994 on Arrernte country at Hamilton Downs in the Northern Territory, 75 kilometres north-west of Alice Springs.

This Conference took place because of the dedicated efforts and lobbying skills of a number of committed Aboriginal and Torres Strait Islander gay men, many of whom were members of the first national conference steering committee:

- (the late) John Cross;
- (the late) Matthew Cooke;
- Colin Ross;
- Allen Cohen;
- Tommy Pearce;
- Jo’Deanne Bebe Mohamad-Gleeson;
- Shane Burgess;
- Neville Fazulla; and
- Rodney Junga-Williams.

A full listing of primary sponsors can be found in the Anwernekenhe Report (1994: 16).

Conference participants collectively drew up the important recommendations contained within the Anwernekenhe Report, and formed a national Working Group which they hoped would ‘lead to the establishment of a National Aboriginal & Torres Strait Islander Gay Men’s & Transgenders’ Committee empowered to act on the issues raised in this document’ (ibid: 3).

The national Working Group set itself a very clear objective:

That the Aboriginal and Torres Strait Islander Gay Men and Transgender Working Group formed at this conference be a national advisory group in assessing the delivery of HIV/AIDS and Sexual Health care services to Aboriginal and Torres Strait Islander communities and individuals and in particular to gay and transgender persons. This should pay attention to isolated communities (ibid: 5.4).

The Working Group members were nominated by consensus to reflect individual areas of experience and expertise rather than geographical location. The original members, with proxy in brackets, were:

- Colin Ross, Convenor, Queensland (QLD), (Stafford Alley);
- Jo'Deanne Mohamad-Gleeson, Transgender Representative, (Kooncha Brown);
- John Cross, Northern Territory (NT), (Gary Lee);
- David Kelly, Western Australia (WA), (Ralph Johnson);
- Rex Murray, Australian Capital Territory (ACT);
- Neville Fazulla, South Australia (SA), (Russell Reid);
- Rodney Junga-Williams, HIV Positive Representative; and
- Michael McLeod, New South Wales (NSW), (Bruce Forrest).

After the Anwernekenhe Conference the membership of the Working Group, which was renamed the Working Party, consisted of the following representatives:

- Colin Ross, Convenor, Qld;
- Jo'Deanne Mohamad-Gleeson/Kooncha Brown, Transgender Representatives;
- Gary Lee, NT;
- Peter Pinnington, ACT;
- Neville Fazulla, SA;
- Bruce Forrest, NSW;
- Ralph Johnson, WA; and
- Rodney Junga-Williams, HIV Positive Representative.

With the assistance and support of the Australian Federation of AIDS Organisations (AFAO), the new Working Party set out to develop the scope and parameters of a national project which would be consistent with Recommendation 33 of the Anwernekenhe Report:

On-going recurrent funding and opportunities be provided for Aboriginal and Torres Strait Islander gay and transgender people to develop and implement a national strategy to ensure that the complex and neglected issues of these groups are fulfilled (ibid: 10).

The Working Party fine tuned the Anwernekenhe Report and worked with AFAO on the preparation of a submission to the Commonwealth for the funding of the national project.

Over a twelve month period, and after much concentrated effort on behalf of all parties, the submission was completed and submitted in late 1995. In mid-1996, the Commonwealth, under the National Priorities Program, approved funding for the submission with virtually no amendments. This is testament to the amount of hard work and careful thought that went into the submission's preparation and planning.

AFAO was commissioned to conduct the National Indigenous Gay and Transgender Project. I resigned my position as NT representative on the Working Party, nominated Phillip McGuinness as my proxy and declared my interest in applying for the position of Project Officer. After being appointed Project Officer, I relocated from Darwin and commenced the project at the AFAO offices in Sydney in January 1997.

For the duration of the consultations and the writing of this Report, the members of the Indigenous Gay and Transgender Project Working Party were:

- Colin Ross, Convenor;
- Neville Fazulla;
- Rodney Junga-Williams;
- Jo'Deanne Mohamad-Gleeson;
- Ralph Johnson;
- Bruce Forrest;
- Phillip McGuinness;
- Peter Pinnington;
- Tim Leach, AFAO; and
- Eamonn Murphy, the Commonwealth, ex-officio.

The Working Party met four times a year to monitor the Project and to provide other related advice and assistance to AFAO and myself.

In the next section I will detail the Project itself and outline the 'doing' of the consultations. I will look at the issue of confidentiality, which was a major consideration for conducting consultations and writing this Report, and will describe how I 'indigenised' the project methodology. Some of the problems encountered during the consultations will be outlined.

The consultations took place over a period of seven months and entailed extensive travel across the country with visits to each capital city as well as some very remote communities and regions. In a number of communities I was used as an outlet for some general homophobic feelings. In one case, I was 'called out' in front of a small assembly, in a men's group meeting, to receive a dressing down about 'government people' and the perceived 'waste of money' in sending people around the country to 'talk about AIDS'.

Thankfully, these situations were in the small minority and do not reflect the generally overwhelming support I received around the country for the Project and for myself.

## **1.2 The national Indigenous gay and transgender project**

The National Indigenous Gay and Transgender Project was established to address the major Recommendations of the Anwernekenhe Report.

The Project has four main objectives:

- to address the needs that exist within gay and transgender communities around Australia, particularly in relation to sexual health delivery;
- to identify and build on existing networks, particularly in HIV/AIDS education;
- to encourage the establishment of support networks and foster liaison between the target group and the broader community, particularly in relation to the promotion of positive sexuality; and
- to formulate, co-ordinate and write a National Indigenous Gay And Transgender Strategy for the period 1996-2000.

The Project originally had a twelve-month timeframe - January to December 1997 - which was later extended by a further three months - January 1997 to March 1998.

As identified in the submission to the Commonwealth, it was considered appropriate and essential to the success of the Project to obtain a truly national perspective by conducting an intensive consultation schedule.

Moreover, Indigenous and non-Indigenous service providers in the areas of community and sexual health and in HIV/AIDS prevention, care and support and education needed to be contacted on as broad a level as possible.

Given the diversity and remote localities of many Aboriginal and Torres Strait Islander communities, it was decided to visit each State and Territory, including the Torres Strait Islands, at least once. Communities to be visited were identified following advice from the Working Party, pinpointing Indigenous communities with larger populations and/or specifying known areas with significant gay and transgender populations.

Queensland, the Torres Strait Islands, Western Australia and the Northern Territory were visited for approximately four to six weeks each, while South Australia, Victoria, Tasmania and the Australian Capital Territory were visited from between one to four weeks each.

The Working Party recognised the need for not only Indigenous gay and transgender issues to be highlighted and assessed, but also those of people living with HIV/AIDS, particularly in relation to the demystification of and education about positive sexuality and identity within the broader Indigenous community.

### **1.3 Consultations**

To ensure that the target group in particular were able to contribute to a national Indigenous gay and transgender strategy, an extensive program of consultations was undertaken across Australia between April and November 1997.

Initial consultations were conducted by telephone and letter, with follow-up telephone and fax calls made where necessary. Working Party members provided invaluable advice and suggestions in relation to State and Territory contacts within Indigenous communities as well as direct links to individual gay and transgender members, health educators and other valuable contacts. The expertise and experience of Working Party members facilitated liaison with Indigenous and non-Indigenous service providers.

Approximately 112 consultations were undertaken between April and November 1997. Those who contributed were community health workers, sexual health workers, HIV/AIDS peer educators, researchers, doctors, nurses, health care workers, tertiary and secondary school students, representatives from community councils, Land Councils, AIDS Councils, Aboriginal community controlled and Aboriginal health organisations, members of State and Territory government departments, people living with HIV/AIDS and their families, teachers and last but not least, the Aboriginal and Torres Strait Islander gay men and transgender participants.

## 1.4 Confidentiality

The Working Party members were very concerned with the question of confidentiality, particularly in relation to individuals and to the identity of individual communities. This was reflected throughout the consultation process.

It was my task to assure all individuals and community groups that their confidentiality would be strictly observed; and to ensure that any recorded or written information obtained by or given to me would remain with me.

Confidentiality has been maintained throughout this Report. No community, region, groups or individuals are directly identified by name or by inference except where permission has been first obtained to do so, such as in the case where local language terms have been quoted. In these instances a geographical area might be recognisable but individuals or communities are not. Some individual people gave me permission to use their names but this might have identified a specific community so no personal names have been used.

## 1.5 'Indigenising' the methodology

I approached the consultations from the perspective of co-authorship: I wanted to allow the voices of people to inform parts of the Report. Therefore, I chose the method of oral history recording to collect stories, experiences and statements.

Patience and flexibility were necessary to successfully 'Indigenise' the methodological approaches for conducting consultations. That is, consultations were conducted in culturally and socially acceptable ways, in accordance with Indigenous protocols, and in deference to local, social and cultural rules and processes, as determined by the participants and/or communities themselves.

The majority of group meetings were conducted according to community schedules and cultural protocols and were encouraged at all times to be as informal and affirming as possible for all in attendance. Communities themselves dictated where and when meetings would take place and for how long.

With solely women's groups, I would adapt my language and way of speaking in order to put the Project into an Indigenous context. I would be introduced to the group by a prominent female community member according to Indigenous women's protocols. The meeting was conducted away from the men, in a separate place and at a time that they decided on.

This 'Indigenisation' of consultations occurred with the large and small groups, with separate men's, women's and youth groups, mixed gender groups, with groups of elders, and also in the 'closed' forums.

In all but a few cases, gay men and youth, transgender people and homosexually active men were consulted individually and/or in face to face meetings. While wider community consultations were conducted out in the open in public spaces, talks with gay and transgender individuals generally occurred in private or in groups of two or threes. In the case of both groups and individuals, free expression and maximum participation was actively encouraged at all times.

Consultations were also carried out well in advance of community visits to establish my contact or contacts in a particular community, to allow an appropriate introduction for myself and to gather an idea of local politics and other important background information.

Although recording equipment in the form of a discreet hand held tape recorder was used, in most cases this was inappropriate and a pen and notebook was used instead. Permission was first sought and granted before proceeding with the recording of any information.

## **1.6 Some problems encountered**

From time to time, various problems arose during the course of the national visits but none were so insurmountable that they threatened the progress of the actual project itself. However, there were issues that could have affected the way certain information was given by or withheld from me.

My identity as a gay man only became an issue when people seeking that information turned out to be homophobic. Homophobic tendencies were evident in their responses to my enquiries and to my gay identity. I never felt that my sexuality has ever impinged upon my ability to conduct sound, objective research so, unless I was directly asked, I never thought to mention my sexual identity.

There were minor logistical problems such as people not showing up for appointments and waiting for long periods for scheduled meetings that never started. One community cancelled my visit at the last minute because of the perceived sensitivity and nature of my research enquiries.

The very sensitive nature of much of the information I received meant that I made some decisions and choices regarding its inclusion or non-inclusion within the Report. However, no information directly relating to the issues discussed in this Report has been withheld unless I was directed to do so by the individuals and/or communities involved or where it could be deemed libellous or even culturally inappropriate. It was my aim to gather as wide a range and diversity of opinions, experiences and statements as possible, particularly from the group for whom these consultations are for and about.

Perhaps one of the biggest challenges to the success of the consultations was finding a balance between not offending community sensibilities while at the same time giving a voice to the people being interviewed. However, my task was greatly facilitated by prior liaison and making appropriate Indigenous contacts such as male and female community and sexual health workers, STD/HIV/AIDS educators and certain elders. Thus, information on community sensibilities was obtained before each visit. This allowed me to introduce and discuss the Project in ways that were appropriate to each community.

Community sensibilities were finally ascertained during the initial process of the actual meetings and/or interviews themselves. In some situations I needed to use my cultural instinct and be adaptable as cultural sensibilities quickly changed during the process of the gathering and/or interview itself. At these times, and as with all other situations, the group or individual would influence the direction and boundaries of the discussion. I would take my lead from them.

On a personal level, I encountered specific problems of my own in relation to the issue of 'moral' confidentiality. I was sometimes given information from HIV positive individuals who were knowingly putting others in the community at a very high risk, and whose HIV status was unknown to the local health team. This placed me in an insidious position: knowing incriminating HIV information of such severity that I was tempted to pass it on to an appropriate person or persons.

What are the 'moral' boundaries of confidentiality? There are none. I have broken no confidentiality at any time, yet this serious predicament – where to draw the moral line? - needs to be addressed urgently, especially since the level of social research into Indigenous Australians' sexual health and HIV/AIDS issues is increasing each year.

# Chapter Two

## Major themes and issues to emerge

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### 2.1 Major Themes

During the seven months of national consultations, participants were encouraged to identify and discuss concerns and issues that were important to them. The most significant contribution in this respect came from Indigenous gay men and transgender participants whose ‘voices’ provide the human dimension to this section.

The following themes were determined by the participants and are in no particular order.

- **Alcohol abuse and sexual assault**
  - adult male to youth male rape
  - low self esteem
  - incest
  - violence
  - suicide
  - HIV/AIDS
  
- **Youth gay identity formation**
  - internalisation of ‘culture of violence’
  - sexual assault/lack of positive gay role models
  - unemployment
  - gay community exclusion
  - racism
  - alcohol and substance abuse
  - HIV/AIDS prevention education
  - Aboriginal Medical Services (AMSs) and AIDS Councils
  - suicide
  
- **Men who have sex with men/Homosexually active men**
  - HIV transmission
  - adult male to youth male rape
  - alcohol and substance abuse
  - powerlessness of female partners and children
  
- **Transgender acceptance**
  - Victimisation
  - lack of community awareness
  - lack of positive role models
  - prostitution-HIV/AIDS
  - poverty
  - alcohol and substance abuse



- **People living with HIV/AIDS (PLWHA)**
  - treatment and care options
  - poverty
  - access and equity
  - cultural confidentiality
  - community education about HIV positive people
  - ostracism
  - community rejection
  - family rejection
  - training for Indigenous carers of PLWHAs
  - AMSs and AIDS Councils
  
- **HIV/AIDS treatment, care and support**
  - unpreparedness for, and the inability of communities to deal with HIV positive people who wish to move back to their home community
  - lack of visible signs of HIV/AIDS in communities
  - lack of knowledge about PLWHA treatments
  - lack of support services
  - poverty
  - access and equity
  - fear of PLWHAs
  - AMSs and AIDS Councils
  
- **Aboriginal Medical Services and AIDS Councils**
  - community politics
  - lack of confidentiality
  - Indigenous, local politics
  - perceived nepotism at AMSs
  - AMSs viewed with suspicion
  - access and equity
  - AMS staff and community homophobia/memorandums of understanding
  - AIDS Councils viewed more favourably in general

Predominant issues arising from these major themes will now be outlined.

## **2.2 Alcohol Abuse and sexual assault**

One of the major issues that has arisen from the consultations with Indigenous gays and transgenders is the link between alcohol abuse and sexual assaults.

I listened to many stories from Indigenous gay men who recounted experiences of sexual abuse from an early age. In nearly all cases alcohol was a major factor in the behaviour of the perpetrators of the abuse.

The most significant group of people perpetuating this adult male to youth male sexual violence is alcohol-affected homosexually active men, also commonly referred to as 'men who have sex with men' (MSM). These are the men who do not identify as being gay and who live a heterosexual lifestyle. Female partners, wives and/or lovers are usually unaware of their extracurricular activities. Many of these men are older male relatives of victims - uncles, cousins - or family friends or acquaintances. Many are married and often have families of their own.

In all the communities I visited, knowledge and awareness of this group of men and their activities was more widespread and tolerated than I expected. One female sexual health worker who is working with male youths explained:

*There's a hell of a lot of men walkin' 'round our communities who're gettin' their cake and eatin' it too. Ought to be shot! They gettin' sex from the women and sex from those young boys too - takin' it I should say. It's always been around... these men... I feel sorry for the boys but nobody cares about them and nobody's game to say who those men are, even though we all know who (they are) anyways.*

The personal experiences of younger gay males repeatedly illustrated the prevalence of this activity.

Although many of the gay-identifying youths in remote and/or rural regions had never or rarely been outside their home community, there was nothing naive about their responses or statements. At times, many of them seemed to be quite world-weary in their general demeanour. To a larger degree, the same could be said of a number of gay-identifying youths based in the more urbanised areas, particularly in southern and south eastern Australia.

One thirteen year old youth from a remote north Australian community related his experience to me with an air of sad resignation. This young man's self esteem was so low as to appear practically non-existent and he seemed grateful to have someone to even listen to his story:

*He [older Aboriginal married man] always is no good one that one. [He] only come 'round when he's charged up and that when we frightened... Always he bin jump us and make me do that thing with him... no good, no good. All the time he hurt me, sometime blood be there... what I do? I'm only [a] kid, can't do nothing. He jump me plenty times, other one [boys] too. Drunken mens no good. If we try get away, no good, he bash us.*

This particular youth went on to describe being similarly assaulted by two other married men in his community over a period of two years, and how he has attempted suicide on three occasions in that time. He sees no future for himself and has lost interest in school. His self-esteem is almost non-existent and he has no access to peer educators or counsellors.

In south east Australia a youth of a similar age, 14 years, has a very similar experience even though he was born and raised in a large city:

*That [X] yeah he's my cousin - married an' he does [sexually abuses] us boys...he did me, first time now, when I was only little one [8 years of age] an' he drunk an' he grabs me... you know, it really hurts. If we don't do what he says... one time he was really really drunk, you know, he was scary... [He] caught me, I went to my friend's place, after I was going home and he followed me an' that's when he caught me. He pushed me on [to] the ground you know... I had blood 'n' all comin' out... I cried an' cried but who gonna listen to me?*

Wherever their location, there is no doubt that there are high numbers of youths being subjected to, and internalising sexual abuse and equating it with 'normal' behaviour.

For some gay-identifying men and youths, alcohol abuse by homosexually active men is having

a devastating affect on their perceptions of what it means to 'be gay'. Alcohol or drunkenness is accepted as normal behaviour when associated with male to male sexual intercourse which, in many cases, is expressed in the forms of sexual abuse, sexual violence and rape.

In particular, gay youths who have not yet experienced life outside rural or remote communities are growing up in a culture of male-to-male violence, a culture of misapprehension and fear of 'being gay' because they can only associate it with pain, violence, self-loathing and being the 'receptacles' for alcohol-affected males who constantly seek some quick relief. As one male in his mid-twenties put it:

*They only got the guts to fuck ya when they[re] pissed, yeah the grog makes 'em game and that's when they come sniffin' alright. It's like we [the gay boys] are only there for them to stick their bunja [penis] in you and with the grog oh it makes 'em like they big men, you know. If you don't [give in], they just bash you up and do it anyways. I hate it because of that. Bet if there's no grog they wouldn't be game like that, the grog brings out the true colours aye? No matter [they're] married, they get pissed an' what happens? It's a terrible thing what they [are] doing to us young ones. Better to stay away from [being] gay, its too hard, ugly for us. That's all I know.*

Having never lived anywhere else, a nineteen year old male living in an isolated community stated his perception of what being a gay man meant for him:

*When[ever] I have to have sex with [X] I don't worry for get hurt no more. It don't matter [he's] always drunk but he don't hit me no more - I do what he say. He don't touch myself I mean my thing. Never do that - why? What [he do] that for? They only know how to climb on the back and... too rough-way you know. Condom? Nah, they never for use that one -why? I got no AIDS. They always finish up quick-way, come onetime, finish up, that's it. Jus' up an' fuck off home to their wife anyway. It's hard bein' like me [gay]... no good.*

Even in those communities where there is a level of acceptance and/or awareness of gay identity, the situation is not necessarily any easier for the younger gay men growing up there. One eighteen year old said:

*I like men you know an' I'm not shame 'bout that. But I think it's no good [to be gay]... I dunno... [I] don't like grog. When I have that kajak [intercourse] I like to do that, but... ah, you know it hurts and... oh them mans don't give a shit - only do it when they are pissed. Hey! They only push their dick in you... in-out, in-out... always hurting. No good to be this way [gay], what for? If we don't give 'em what we gonna do? Nothin'. I think, better for not liking men you know...*

In a small remote area community which has a large alcohol 'problem' and a number of known homosexually active men, a significant number of gay- identifying men in their mid to late twenties were still coming to terms with their own adolescent and teenage histories of male-to-male experiences. One twenty eight year old said:

*Since I was a young boy I think I liked men... my uncle now. Supposed to be mindin' me and he started that now...but when he put his thing in me... you know, his buddu [penis]. I didn't know which way. But it's only pain[ful] oh I didn't like him to*

*do that, I couldn't get [away] from him. He[s] charged up an' when he's like that, I know what's comin'. He's always doin' bad things to me. I like him but... nah, no good no good. I do it with other ones [males] now but that way [sex] it's no good. They never touch me, not my thing [penis], nothing. Kissing? Wah! [laughs] What for kiss? No kiss! They only want to get drunk and to root you, [it's] alright for them, but, ah I dunno. Not nice for me - only nice for them.*

With all the males I spoke to, not one said that their sexual experiences with other men, whether forced or not, included condom use. In the case of sexual assaults, younger men and boys were in no position to negotiate safe activity with aggressive, highly intoxicated males. Alcohol abuse by homosexually active Indigenous men can and does lead to rapes and sexual assaults upon young boys and other males who are perceived as easy targets.

For men and youths identifying as gay, such assaults can be the only male-to-male experience they will ever know. The low self esteem exhibited by many of these men and youths reflects their misconceptions about what it means to be gay; which have been formed by their individual life experiences of sexual interaction with other males. For some, suicide attempts have been one of the ways to cope with the situation.

Irrespective of location, environment or even gender, the link between alcohol abuse and sexual assault is not an uncommon one in many Australian Indigenous communities, or at least for the majority of those visited for this Report. Sadly, for a whole new generation of young Indigenous gay men around the country, the only conception and understanding of what it 'means' to be gay is being formed through personal experience of alcohol-induced sexual violence, perpetrated by other males, some of whom are themselves HIV positive.

HIV positive Indigenous gay and transgender people who participated in this Report face, what many of them suggested, was the triple affliction of being Indigenous, gay and HIV positive. I will now outline the issues for this group as they arose out of the consultations.

## **2.3 HIV positive Indigenous gay and transgender people**

HIV was present in every community I visited. Not all the HIV positive men in these communities would necessarily have identified as gay nor would they have necessarily contracted HIV through homosexual activity. All the gay and transgender people I consulted have engaged or are actively participating in sex with other men.

Community awareness of the HIV positive men remained fairly low and in some places was completely absent. For those who are HIV positive there is still a strong fear of community and or family rejection. While Indigenous HIV positive men have been brought back to their home communities for burial, I was not made aware of any who had returned during the final stages of their illness.

I interviewed sixteen HIV positive gay and transgender participants during my consultations. Of this group nine were living in capital cities with the remaining seven located in remote and or rural communities. As expected, issues for the two groups differed although there were similar concerns.

The priorities of urban positive people include issues such as the availability of new HIV/AIDS

treatments and access and equity. In some places, injecting drug use (IDU) problems are a major worry along with general poverty, employment and housing issues and, to a certain extent, racism and prejudice issues.

For those HIV positive gay and transgender people who are living in very remote or isolated communities, many priorities centre on issues of disclosure and fear of family or community rejection. All but a few of these men's HIV status was unknown to the wider community or indeed, even to their own families. Around half were travelling away from the community to receive treatments; the remainder were on no special medications.

HIV was not physically visible within these remote communities: the people have no experience of 'seeing AIDS', and very few HIV positive people have returned to live in their home communities so there is no wider community understanding of this situation.

Levels of community awareness about HIV positive people were also very low, especially in remote communities, and even where the health team members were otherwise quite knowledgeable. For example, one female sexual health worker in a small community observed:

*We know there's plenty of mothop [gay] thing go on at [X community]. Them married men now. There's two, three here. Nobody can talk to them about that. There's one mothop man, well, that's the one they all go to now when they've been drinkin'. No condom - nothin'... Where they gonna be carrying condom charged up and frisky like that? But there's no AIDS here so that's something. I'm worried for that though. I don't know if those men had their AIDS test or not - I hope so you know. We heard there's someone got AIDS at [X ] but [it's] not here.*

A HIV positive man from the same community told me that he intended to keep his HIV status to himself and not even tell his immediate family. He travels to a major centre many miles away for his treatment and check ups and has been HIV positive for four and a half years. He stated that when he started getting 'really sick' or 'those sores', he would leave the community rather than face the 'shame of everybody findin' out.' He summed up his feelings this way:

*Nobody knows [about me]. I found out I got AIDS in [X-another community]. I'm not a mothop [gay] man but... oh I just use 'em.... for relief, that's all... Sure I been there... No, I don't like condoms much but I've used 'em. Other blokes don't use 'em 'round here. But... it's easy to go with them mothop ones [laughs].*

In a high number of the communities where knowledge of the existence of HIV positive people was virtually unknown, unprotected sex involving HIV positive homosexually active men was taking place. Tolerance of such homosexual activity among men was generally found to be quite high in the majority of communities. That many of these men are also having sexual relations with women partners causes grave concerns about possible increases in HIV transmission rates throughout Aboriginal and Torres Strait Islander communities.

Gay and transgender HIV positive people are increasingly wishing to spend their time with family back in their home communities. HIV positive people already in communities who're yet to exhibit physical signs of HIV/AIDS may soon choose to remain rather than relocate for treatment, often many miles away or even interstate.

Treatment, care and support for HIV positive people was found to be a major concern around the country for both infected and affected Indigenous people. This concern had more urgency in remote areas where levels of formal education of and about access to treatments, care and support are not as high as they are in the larger cities and towns.

For many communities, particularly those away from the large cities in remote locations, a long way away from major services, there is a distinctive fear of HIV positive people. This fear is based on a perceived lack of understanding and knowledge about how to 'look after' people living with HIV/AIDS, coupled with the fact that in many rural or remote communities the people have not yet 'seen' HIV/AIDS. One sexual health worker offered a compelling statement when asked about HIV/AIDS in his remote community:

*We're not too sure if there's any HIV positive people here yet but we wouldn't rule it out. It's just that if they are here they must have got their test done on the mainland.. I don't know what we'll do if anyone comes back here [HIV] positive. The people are scared because we don't know what to do. When AIDS comes here... there's nothing here for them. Families wouldn't know what to do. I guess we'll worry about that when somebody [HIV positive] turns up.*

The Anwernekenhe Report (1994: 5) stressed that particular attention should be paid to isolated communities in relation to delivery of HIV/AIDS and sexual health care services. It was in such communities in the north, centre and west of this country that concerns about awareness and understanding of HIV positive people and their treatment, care and support was strongest.

Many HIV positive participants expressed similar concerns relating to the perceived lack of commitment to them by some Aboriginal Medical Services (AMSs). In places where there is no AMS many of these communities are ill equipped to deal with HIV positive people, let alone gay and transgender ones.

## 2.4 Transgender issues

There are still Indigenous gay men and transgender people dying in the cities away from families and communities. Some do so by choice and others through no choice of their own.

Being nearer to treatments and to substantial care and support programs is a big advantage, but there is a growing tendency for HIV positive people to want to receive the same benefit back with their families in home communities. In talking about a close transgender friend, one gay Torres Strait Islander man put it this way:

*G was sick [HIV positive] for a long time in Sydney but all he wanted was to go back to [X island]. But his family said they couldn't look after him if he got sick and so he went back to Sydney. He was broken after that... and that's what finished him up sooner I reckon. Poor thing. I went and saw him in Saint Vincents [hospital] and he was really... really sad you know. Not even any of his own family came to see him or visit here. True! If he had been able to be back in his home, you know, he'd be here talkin' and laughin' up big like he used to, I reckon.*

This particular friend was a sex worker who had lived away from his home community for over twelve years. He had not returned due to his family's rejection of his identity and lifestyle as a

transgender and as a sex worker. He was an injecting drug user and was given his diagnosis around five years before. Despite growing up in a community with a cultural and social history of transgenderism, he was compelled to leave at sixteen and had been living in Sydney ever since that time.

Of the twelve transgender participants who I spoke with, five were HIV positive and all were based in Sydney, Melbourne or Adelaide.

In a number of rural areas there are several communities where transgenderism is not only tolerated but also is supported openly, such as one where the local Aboriginal Council offices have two or three long-time transgender employees. As described by the local council director:

*They [transgenders] fit in well here, there's no bother from anybody. My secretary is one... we're all one here in this community, all together, all kinds of people. As far as I know there's always been 'the girls'... they're the best workers you know.*

A twenty-eight year old post-operative transgender from the same place summed up this particular community's cultural history and acceptance:

*Before I had my operation [gender re-assignment] I dressed as a girl here from when I was about fourteen or fifteen. I never really had any hassles. Then I went away [to a large city] and worked and saved... cracked it for awhile too for the money. Then I got fixed up and I was really happy, really really happy. I came home two years ago and my mum was great from the start. There's some [people] here who have problems with it but I don't care about them. I don't go out much anyway, just to work and back home again. I've got a man now [laughs]... mum thinks he's nice too. But we're keeping things quiet for now. Everyone knows that [X] is going with me but nobody's said anything to him. No, it's always been good for all us ones [transgenders] here.*

Not all transgender experience was the same but for many of the younger transgender men and youths it was. In three communities at opposite ends of the country, with significant transgender histories and populations, youths - those between the ages of sixteen and twenty-six - faced similar problems. The important issues for them are experiences of sexual abuse by older men, lack of community activities to be involved in, HIV/AIDS awareness education and low self esteem, all despite living in reasonably tolerant, although remote, communities.

In the large capital cities, transgender issues reflect a more urbanised existence. Among the most prominent issues are poverty, prostitution, alcohol and substance abuse, IDU issues, HIV positive sexuality, social isolation, unemployment and racism.

A pre-operative transgender male and part time sex worker from north Australia who has lived in Sydney for the past twelve years articulated her experience:

*It was hard getting acceptance here at first. We all heard about how racist the Sydney gay scene could be but you never really find out until you live here. Still, I wouldn't really live anywhere else, not now anyway. I couldn't get a job so I worked the streets picking up captains [laughs], there was a few of us black [Aboriginal] girls there then, we'd look out for each other. Most of us got into smack but I was one of the lucky ones who went to rehab and stuck with it. Been*

*clean for near on five years now and I'm gonna stay that way. A lot of the sisters are dead now, either AIDS got 'em or smack - or both. Sydney's alright once you get settled and make friends. I guess I've been lucky but there's still a lot of prejudice around... gays are some of the most racist cunts around.. but you know that [laughs], we all do aye?*

In keeping with the evaluation of the Anwernekenhe Report (1994: 14), the consultation process aimed at establishing transgender priorities. These include prostitution, sexual assault and alcohol and substance abuse. Adoption and fostering issues are issues to be considered but were not a priority for the majority of communities I consulted.

## **2.5 Aboriginal Medical Services and AIDS Councils**

Aboriginal community health control first began in Redfern in the early 1970s. The Redfern AMS was established as a response to the inadequacy of mainstream services in dealing with the particular health needs of Indigenous Australians.

Aboriginal community controlled health services approach the delivery of primary health care from a holistic viewpoint, within a framework of self-determination. AMSs are also involved in community activities depending on the needs of the local community and the available funding. Today, there are AMSs established in all parts of the country and they each approach the delivery of health services individually, which is indicative of the AMSs' ability and willingness to respond according to the needs and circumstances of their area.

The National Aboriginal Community Controlled Health Organisation (NACCHO) is the peak body representing Aboriginal community controlled primary health care services. NACCHO is affiliated with Indigenous health care services around the country. Any development and implementation of national, State and Territory and regional policies, programs and services for Indigenous Australians cannot be successful without the involvement of NACCHO and the Aboriginal community controlled health services.

It is acknowledged that AMSs are not adequately resourced in terms of funding or expertise to conduct HIV/AIDS programs. While individual AMSs have responded and are responding to the Indigenous HIV/AIDS situation, and there have been many successes to date, some people interviewed during the consultations had not been satisfied in their dealings with AMSs.

In general, the Indigenous gay and transgender people I consulted have different experiences depending on their locality and the Indigenous politics at work there. This is true also of their experiences with AMSs. Variables in this scenario can and often do revolve around such matters as individual clan or family dominance over the particular AMS, perceived nepotism at AMSs, local black-white relations, the existence or not of an AIDS Council, confidentiality issues and Aboriginal community homophobia.

AMSs are widely perceived as being places for many Indigenous positive people, gays and transgenders to avoid. Reasons given mainly concern the perceived lack of confidentiality especially in smaller towns and communities. There were many comments surrounding this important issue. They are perhaps best summed up by one female community HIV/AIDS educator from a remote community health service that also meets the needs of outlying tradition-oriented outstations:



*The AMS here is not really for the gays because the health workers there are very homophobic. Not only that, the [X] family runs the whole show and we can't see where all the money's going. They not worried about HIV or AIDS because they haven't done any programs or nothing for the last three, four years. We're [Community Health Service] the only ones doing programs for the men and the women and that's for the gays and the [HIV] positive ones here too. There's no way they'd go to [AMS] because they wouldn't get their confidentiality kept or anything. It's a cryin' shame how that AMS is so bad like that.*

Indigenous gay and transgender experiences in virtually every State and Territory also reflected an overall concern with perceived shortcomings of AMSs. One HIV positive gay HIV/AIDS educator working in a major capital city provided another urban perspective that shows similar concerns:

*I think the AMS here is indicative of a lot of the big AMSs, and they're the ones with all the money and power, in that they're not really addressing our [People Living With HIV/AIDS] issues properly. And you can forget about the carers and the support and treatment stuff too. It's a pity they [AMS] don't do something about the IDU [Injecting Drug User] mob as well... There's no real acknowledgment that any of us really exist, well that's how you should look at it. People infected and affected by HIV/AIDS have special needs that are being largely ignored by the one place [where] you'd think it would be the opposite... but, no.*

While criticisms of AMSs were not uncommon, some people interviewed had enjoyed positive experiences with their local AMS. Alleged breaches of confidentiality were reported, but NACCHO has found that previous allegations, when investigated, have actually shown that information about positive status was not disclosed by the particular AMS but through other sources. However, perceptions of confidentiality are extremely important and AMSs may need to address these perceptions.

During the national consultations, AIDS Councils fared better overall than the AMSs. A higher proportion of the gay and transgender people preferred to access an AIDS Council, where available, rather than the AMS. Care and support issues for both infected and affected people and their families were generally perceived as more adequately provided for by AIDS Councils.

Although not true for all States or Territories, the majority of AIDS Councils are now taking steps to work with AMSs or are at least beginning to think about ways that cross-partnerships can commence. This will benefit not just gay and transgender people but also, in the short term, the broader Indigenous community as a whole.

With the release of the *National Indigenous Australians' Sexual Health Strategy* (1997), AMSs and AIDS Councils have a particular role to play in the delivery of health care to Indigenous gay and transgender people, including PLWHAs and affected communities. Effective partnership building (ibid: 47-48), must include direct participation by Indigenous gay and transgender people although, as has emerged during the consultations for this Report, this can only happen when both the AMS and AIDS Council start from common ground.

## 2.6 Older gay men

Generally, older Indigenous gay men are not considered in the wider scheme of things. During the national consultations I was fortunate to have had the opportunity to speak with eleven men who ranged in age from fifty to seventy years, and who offered some interesting and alternative perspectives.

Five of the men were living in large cities while the remaining six lived in small remote communities. Two of the men had lived as transgenders from their teenage years up until their early forties and now were living quite comfortably as men. All but one of these men described themselves as sexually active with two being in long-term relationships.

These gay men expressed experiences that reflected a different outlook to the younger generations. As told by a sixty-six year old:

*I came to Sydney when I was a young bloke oh, I must have been eighteen, nineteen - something like that. We weren't gay then, we were camp you know. It was just after the War [WW2] and there was plenty of opportunities to have sex... lots of those Negro [sic] soldiers there were... about all you had [to] do was look at their bulge [crotch] and they'd near jump you then and there. It was good times for sure, no AIDS then... There were plenty of places around the city to meet men if you wanted to. We had to be so careful them days too. I was working at Telecom later... nobody knew [about me being gay], not even my family. I only told them a long time later.*

Older Indigenous gay men growing up in a different era, nevertheless faced problems similar to the ones experienced today by many of their younger contemporaries. In an age of assimilation and well before the 1967 Referendum, one man in his late sixties had this to say:

*At [X] mission my uncle used to take me for walks to chop wood when I was only a young lad [seven years of age]. One day when we stopped for a bit by the creek he pulled his prick out of his trousers and made me suck it. I didn't want to... it seemed strange, but then he started to pull me of while I was suckin' him and that felt good. One day I didn't want to do it anymore and he got wild with me, he'd been drinking and he pulled my pants down and before I knew it he was fucking me. It hurt so bad - I still remember that pain. You know he kept doing it for three or four more years and it only stopped when he went to [X community] for work. I was about oh, ten or eleven I think. That's why I never liked doing it [anal intercourse] later on.*

Four older men from four different States discussed spiritual issues. Each described a sexual experience with an older man that was influential in the formation of a connection between their present gay identity and the spiritual experience itself. The following was articulated by one senior Aboriginal gay man who is not only held in high esteem by his community but who was also one of the custodians of Men's Business for his people:

*This bloke who was foolin' around with me when I was a kid, he used to always only do it to me at the back of the mission at this one spot. He would always put me on his lap facing his chest like... I'd straddle him and he would take his penis and mine in his hand and masturbate us together. But do you know what? He'd always sort of sing this song facing this one direction every time. We did this for nearly a*

*year but then he was killed in a car accident. After that, whenever I'd go to our special place, I used to feel some sort of spiritual sense there, like it would come over me. I couldn't explain what it was but I knew it definitely affected me each time.*

*Years after I left the mission I returned there for a bit of a look. You know, I went back to that special spot and that same spiritual feeling came over me only this time it was the strongest it's ever been. Then next thing I felt as though I was being drawn to the rock outcrop that sloped down to the river. I just went there and I looked under this old bush and there was a kind of small cave there. When I put my hand in there I pulled out an old bundle and when I opened it up there were these Churingas [secret/sacredboards] there.*

*I believe that that older man was teaching me or passing on a spiritual responsibility to me to take care of these boards. I think that it's men's business way what he did with me... you know, the singing and the masturbating together, always at that spot now, facing where I found those Churingas. I take care of them now, only I know where they are. Young blokes aren't interested these days. Looks like I'll take this secret to my grave.*

Another perspective was offered by the most senior male that I consulted. At sixty-nine years of age, he was still sexually active:

*My boy, I still appreciate a handsome lad... I do alright you know, here and there. Nowadays [of] course things are not the same. AIDS is everywhere but at my age, dear, I don't think I'll worry too much about that. Blackfellas have got it easy now. I've had a good life you might say... no complaints. It's the younger ones I feel sorry for. They['ve] got to worry about a lot of things... the culture's dyin' coz' it's all about money, money and everybody['s] out for himself. I see them young gay ones when I go to [X city] every now and then to stay with my niece. They think they know what it's all about... nobody cares about us old queens. Out of sight is out of mind. There's a lot of us around an' we still got feelings. We still get horny too ya know! [laughs].*

## **2.7 Female partners of homosexually active men**

The position of Indigenous women was found to be inextricably linked to gay and transgender issues, particularly through male partners who are also homosexually active. While there was a certain level of tolerance and awareness by women about gay male-to-male sex, it was generally found that their understanding that heterosexual-identified males can and do participate in same-sex encounters was unexpectedly low.

Female partners of homosexually active men are placed in an insidious position which becomes increasingly worse the longer they are kept unaware of their men's participation in unprotected male-to-male intercourse. That there are numbers of homosexually active men in many Indigenous communities around the country is without doubt. There was not one community I visited where such men were not active or where their existence within the community was totally unheard of.

Most of the women's groups I spoke with, were generally aware of this particular male sexual activity, however all expressed the opinion that it wouldn't or couldn't be their partners because they would somehow 'know'. Such assumptions were fairly widespread.

Some women expressed concern that 'those men' who were homosexually active 'could be spreading AIDS', but it was mainly younger women who did so. Months after I'd visited her remote community where I had a meeting with a mixed gender high school group, one teenager told me:

*You know, after you talked to us, us girls made sure we got condoms off [sexual health worker]. We told those boys we don't trust 'em no more. Don't know where they been, aye? We thought only gay ones [males] did that thing [male-to-male sex]. It's good to know about things like that you know.*

Generally, women were appreciative that I was raising the issue of homosexually active men in relation to them as partners, wives, girlfriends or casual acquaintances.

It was women who raised the issue of some sons or spouses returning from long or short prison sentences somehow 'changed'. This change was attributed to the perceived possibility that the men may have 'done that thing' or that 'something like that happened to them' in prison. There was certainly an awareness by women that men in prison can and sometimes do have sex with other men 'even though they themselves mightn't be gay or anything like that'.

The potential for an HIV epidemic to sweep through Aboriginal and Torres Strait Islander communities has already been remarked on in this Report but can never be reiterated too often. The vulnerable position of women, and by association children, in relation to the possible increase in infection rates through homosexually active men, has serious implications not just for Indigenous gay men and transgender people but for all Indigenous communities as well.

# Chapter Three

## Current context and future directions

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Indigenous gay and transgender sexual health concerns encompass a wide range of HIV/AIDS and social and cultural issues. HIV/AIDS is a factor in almost every major issue of concern to this group.

Australia is one of the few countries around the world that can show a levelling out in HIV infection rates in recent years. However, it should be noted that this decline in infection rates relates to the non-Indigenous population. Rates of HIV infection for Indigenous Australians have been increasing since 1992 (ANCARD, 1997: 25).

### 3.1 Recent statistics

As previously stated in this Report, the position of some Indigenous gay and transgender men, and also that of some women, is quite vulnerable, particularly in light of the increasing rates of HIV transmission in the Indigenous population.

No data is available on HIV or AIDS diagnosis by Indigenous status prior to December 1996, although there has been a significant level of data collected in New South Wales since 1992 (ibid: 27). This data shows that there were a total of 128 HIV notifications, AIDS cases and AIDS deaths for women as opposed to 106 for that of men (ibid.).

Only data collected from Queensland, South Australia and Western Australia give detailed figures for Indigenous gay and/or bisexual men. These figures show that from 1985 to 1996, 54% of the exposure category for HIV notifications among Indigenous Australians was through male gay and or bisexual contact (ibid.).

The high sexually transmitted disease (STD) rates among Indigenous Australians suggest the 'likelihood of HIV transmission rates continuing to rise' (ibid: 28), as STDs are believed to increase the likelihood of HIV transmission particularly where they cause genital ulceration (ibid.).

Also on the increase among Indigenous Australians are rates of notification for gonorrhoea, syphilis, chlamydia and donovanosis. Hepatitis C is less prevalent among Indigenous Australians but Hepatitis B is 4 to 26 times higher than it is for the non-Indigenous population.

Information on exposure categories for HIV infection among the Indigenous population shows that 5 per cent of total infections were due to injecting drug use (ibid: 28-31).

## 3.2 Positive developments

In August of 1989, the Commonwealth Department of Community Services and Health published the *National HIV/AIDS Strategy - a policy information paper*. This paper was commonly known as the first National HIV/AIDS Strategy.

While the priority of this first Strategy was to address the prevalence of HIV infection in homosexually active men, it also identified Indigenous Australians as a 'high risk' group. It recommended that HIV education be incorporated with drug and alcohol programs and delivered to Indigenous communities by primary health care services.

One of the most significant Indigenous responses to HIV/AIDS was the establishment of the National Indigenous Australians' Sexual Health Working Party in December 1987. The 1989 report of this Working Party was called the *National Aboriginal Health Strategy*. This report stressed the importance of primary health care approaches for dealing with the possibility of HIV infections. It put Aboriginal community controlled health providers at the forefront of all approaches in dealing with HIV/AIDS (ANCARD 1997: 34).

The second Commonwealth Strategy, *The National HIV/AIDS Strategy 1993-94 to 1995-96*, brought about the implementation of many local and broader Indigenous responses to HIV/AIDS. However, in a major evaluation of this Strategy, known as the Feachem Report, it was found that while HIV epidemics among injecting drug users, sex workers and heterosexuals had been avoided, HIV infections among homosexually active men remained high.

Of greater concern was the fact that HIV infection in Aboriginal and Torres Strait Islander communities was found to be increasing. Urgent action was recommended to develop an effective Indigenous HIV prevention strategy (ibid: 36). This positioned homosexually active men and Aboriginal and Torres Strait Islander communities as the two most 'at risk' groups in Australia.

Indigenous gay and transgender men were also taking the initiative in responding to HIV/AIDS. Their important work led to the first Aboriginal and Torres Strait Islander Gay Men and Transgender Sexual Health Conference, the development of the Anwernekenhe Report and the formation of a national Working Party, whose work with AFAO has led to the national consultations described in this Report and the *National Indigenous Gay and Transgender Sexual Health Strategy*.

The release of the third *National HIV/AIDS Strategy 1996-97 to 1998-99*, put the prime focus for minimising HIV transmission onto gay and homosexually active men and on Indigenous communities. From the perspectives of the Indigenous gay men and transgender people who I consulted with, recognition of their specific needs and concerns has been long overdue and should be given priority. Clearly, the findings from the national consultations are that Indigenous gay and transgender concerns warrant urgent attention.

The recently released *National Indigenous Australians' Sexual Health Strategy 1996-97 to 1998-99* outlines the latest positive developments in the Indigenous community and in government responses to the HIV/AIDS epidemic in Australia. In developing this Strategy, the ANCARD Working Party paid particular attention to three important Reports (ibid: 2):

- the *Report of the Aboriginal and Torres Strait Islander Forum on Sexual Health*, which was held in Alice Springs from 14 to 17 May 1995 (ANCA, 1995);
- the *Report on 'Anwernekenhe': the First National Aboriginal and Torres Strait Islander Gay Men and Transgender Sexual Health Conference*, which was held at Hamilton Downs in the Northern Territory from 31 October to 4 November 1994 (Anwernekenhe Conference Committee, 1994); and
- the *Review of Research and Program Findings Relating to the Sexual Health of Aboriginal and Torres Strait Islander People* (Reid, D., 1996).

Another positive development is the *Indigenous Care and Support Manual*, put together by Indigenous gay, transgender and HIV positive men and women in conjunction with the Office of Aboriginal and Torres Strait Islander Health Services (OATSIHS), Commonwealth Department of Health and Family Services. This resource manual will not only be a first for Australia, but is also written and designed for wide applicability and adaptability by both Indigenous and non-Indigenous HIV/AIDS and other health and sexual health service providers.

During the final stages of this Project, the Working Party became the AFAO National Indigenous Gay and Transgender Steering Committee and its membership was increased so as to be more representative of each State and Territory. The current Steering Committee members are:

- Colin Ross, Convenor, QLD;
- Rodney Junga-Williams, PLWHA representative;
- Neville Fazulla, SA;
- Jo'Deanne Mohamad-Gleeson, Transgender representative;
- Phillip McGuinness, NT;
- Peter Pinnington, ACT;
- Chris Lawrence, WA;
- Ron Johnson, VIC;
- Shane McLennan, TAS;
- Tim Leach, AFAO; and
- Alan Thorpe, the Commonwealth, ex-officio.

The Steering Committee is an example of gay men and transgenders working on their issues at a national level. At the time of writing this Report, the Committee is planning the second National Indigenous Gay Men and Transgender Sexual Health Conference to be held in Queensland from 8 to 11 July 1998.

Indigenous gay and transgender Australians are beginning to address their issues on a far wider scale than ever before. One important way this has been facilitated has been through the support, particularly of partners, both Indigenous and non-Indigenous. Those with partners who spoke with me during the consultations expressed the especially important role their partners played. Not least of these were the non-Indigenous partners of HIV positive Indigenous gay and transgenders, many of who have taken on added responsibilities as carers and nurturers.

While the majority of participants I consulted with did not have a partner or permanent relationship, and the majority who did were located in the larger cities and towns, there was a general preference or desire for such a relationship.

This *National Indigenous Gay and Transgender Sexual Health Strategy 1998-2000* will complement both the *National Indigenous Australians' Sexual Health Strategy 1996-97 to 1998-99* and the third *National HIV/AIDS Strategy 1996-97 to 1998-99*.

It is also hoped that it will emphasise the need for more Indigenous gay and transgender Australians to become actively involved in the strategic planning of their own issues at both the State and Territory level.

The *National Indigenous Gay and Transgender Consultation Report and Sexual Health Strategy 1998-2000* will further contribute to the ongoing recognition in the fight towards minimising HIV transmission and HIV/AIDS within the broader Indigenous sexual health context.



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# **Sexual Health Strategy 1998 - 2000**

**Putting partnerships into practice**

# Executive Summary

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This *National Indigenous Gay and Transgender Sexual Health Strategy* addresses the issues discussed in the *National Indigenous Gay and Transgender Consultation Report*. Both the Strategy and Report have been produced by the Australian Federation of AIDS Organisations (AFAO) as part of its National Indigenous Gay and Transgender Project.

The Project was developed in response to concerns about sexual health and HIV/AIDS among Indigenous Australians, which were raised by Indigenous gay men and their supporters prior to the first National Conference on 'HIV/AIDS Among Indigenous Communities' held in 1992 in Alice Springs, Northern Territory.

The AFAO Strategic Plan 1996-2000 has prioritised HIV/AIDS issues for Indigenous Australians and their communities. Indigenous Australians have been identified also as a priority population in the third *National HIV/AIDS Strategy 1996-97 to 1998-99*. This third Strategy identifies gay and transgender Indigenous Australians as experiencing specific and significant risks of HIV transmission. Moreover, HIV positive Indigenous Australians experience particular hardship and reduced life expectancy compared with other HIV positive Australians.

This *Sexual Health Strategy* has been designed to address the needs of Indigenous gay men and transgender people. The main needs have been identified in the *Consultation Report* and through other research. They are:

- increased HIV and sexual health awareness in Indigenous communities;
- increased condom use and safe behavioural practices among men irrespective of sexual activity;
- heightened priority for HIV issues among Indigenous health and community services;
- enhanced capacity to address sexual health, HIV and sexuality issues using peer education in Aboriginal and allied medical services;
- addressing drug and alcohol related sexual abuse in a harm reduction framework;
- increased understanding in HIV/AIDS organisations and primary health settings of Indigenous health, sexuality and community issues;
- responses to overcome poor understanding in the Indigenous and gay communities of the issues relating to gay Indigenous men;
- strategies to address the lack of HIV/AIDS prevention information and education targeting Indigenous Australians;
- acknowledgment of, and programs to assist, a significant but hidden population of Indigenous men who have sex with men;

- ending the marginalisation of Indigenous people with transgender issues;
- addressing the lack of understanding of HIV/AIDS prevention, treatment, care and support issues in Indigenous communities and in Indigenous medical services;
- addressing drug and alcohol abuse and sexual assault within Indigenous communities;
- expanding the limited access to primary health care and other social determinants of public health; and
- overcoming the lack of understanding of Indigenous issues within HIV/AIDS organisations.

By applying strategies to address these needs, the health and social outcomes for all Indigenous communities, including their gay and transgender members, will be improved.

The recommendations outlined in the *Sexual Health Strategy* cover broad issues, with responsibilities carried by a range of governments, HIV/AIDS agencies and Indigenous organisations.

Addressing these issues will require a cooperative and strategic approach by service delivery agencies in Indigenous health and HIV/AIDS organisations, as well as their national organisations and funding bodies. The expertise and experience of existing community organisations places them in an ideal position to build partnerships with one another and with funding bodies to address the significant issue of HIV/AIDS among Indigenous Australians. A number of recommendations address the development of cooperative approaches between the organisations at state and national level.

The successful implementation of this Strategy and effective prevention of the further spread of HIV and sexually transmitted diseases among Indigenous Australians is dependent upon a cooperative approach between HIV/AIDS and Indigenous health agencies.

It will also depend on the support and commitment of national organisations such as the Office of Aboriginal and Torres Strait Islander Health Services (OATSIHS), National Aboriginal Community Controlled Health Organisation (NACCHO) and AFAO.

We must move swiftly to develop more effective programs to prevent the emerging HIV/AIDS epidemic and ongoing high rates of sexually transmissible diseases in our Indigenous communities”

Dr Michael Wooldridge  
 Minister for Health and Family Services  
*National HIV/AIDS Strategy 1996-97 to 1998-99*

# Introduction

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This *National Indigenous Gay and Transgender Sexual Health Strategy* builds on the results of a national consultation process that involved visiting Indigenous communities in all states and territories from April to October 1997. The consultation program was carried out with the assistance and support of people within the HIV/AIDS and Indigenous health sectors.

The *National Indigenous Gay and Transgender Consultation Report* was written as a qualitative review of the risk activities and risk situations experienced by gay and transgender Indigenous Australians. Local or regional studies will need to be carefully undertaken to establish which recommendations will be appropriate to address the issues of a particular community and how they can best be developed and targeted for that community.

The *Consultation Report* and the *Sexual Health Strategy* should be considered in conjunction with a number of other resources produced recently in the field of HIV and Indigenous sexual health. These include the 1994 Anwernekenhe (Us Mob) Report of the First National Aboriginal and Torres Strait Islander Gay and Transgender Sexual Health Conference, the *National HIV/AIDS Strategy 1996-97 to 1998-99*, the *National Indigenous Australians' Sexual Health Strategy 1996-1999* and the OATSIHS *Indigenous HIV/AIDS Care and Support Manual*.

HIV/AIDS in Indigenous communities must be seen in broader sexual and public health contexts.

*As Aboriginal Australians, we recognise HIV/AIDS as a major health care threat to Aboriginal Australians. We also recognise and acknowledge Aboriginal Australians are dying alone and in shame and this must stop.*

Rodney Junga-Williams  
*Aborigine must be free, lets control HIV*  
Youth sector training council manual, 1992

# Background

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Australia's first nationally coordinated response to the challenges of the HIV/AIDS epidemic was the formulation of the 1989 *National HIV/AIDS Strategy*.

The priority of the first strategy was to address the incidence and prevalence of HIV infection in the group in which it had first appeared - homosexually active men.

Indigenous Australians were also seen as a group at 'high risk' in this first Strategy. The Strategy stressed HIV education in a primary health care context to be incorporated with drug and alcohol programs.

The second *National HIV/AIDS Strategy 1993-94 to 1995-96* emphasised HIV within a broader sexual health context. It called on Indigenous Australians to be pro-active and involved in the strategic planning of an HIV response at the state and territory level.

A comprehensive evaluation of the second Strategy, known as the Feachem Report, noted with concern that there were growing rates of HIV infection in Aboriginal and Torres Strait Islander communities. The Feachem Report went on to conclude, among other things, that any work done through close partnerships with Indigenous communities should commence on the basis of the recognition of the multiple health and social disadvantages which face such communities.

There was also the understanding that more social and behavioural research needed to be conducted so as to more accurately identify and describe the issues involved in addressing HIV/AIDS and sexual health among Indigenous communities.

With the release of the third *National HIV/AIDS Strategy 1996-97 to 1998-99*, the minimisation of HIV transmissions was now focused on two groups - homosexually active men and Indigenous Australians.

This third Strategy acknowledged that there was indeed a considerable wealth of Indigenous community experience in matters of sexual health. The changing epidemiology of HIV suggested a need for a comprehensive approach to education, prevention, treatment and care and the need to build on the work already being done by Indigenous communities.

The *National Aboriginal Health Strategy* released in 1989 described the health of Indigenous Australians as completely deficient and well below that of other Australians. This Indigenous Strategy offered a culturally sensitive framework for dealing with Aboriginal health. The Strategy strongly emphasised Indigenous community control of health services as a way to ensure that primary health care services were culturally accepted and socially acceptable.

Basic principles were put forward that stated the need for not only recognition of the Indigenous holistic view of health, but also the importance of local community control of and participation in the development and delivery of health care.

These basic principles have guided the *National Indigenous Australians' Sexual Health Strategy 1996-97 to 1998-99*. This national Strategy has achieved the huge task of not only identifying the problems but also assessing the position of sexual health within the broader Indigenous health agenda. Following on from the *National Aboriginal Health Strategy*, the *National Indigenous Australians' Sexual Health Strategy* now provides an opportunity to tackle the problems and to produce sustainable improvements in Indigenous Australians' health.

The implementation of the *National Indigenous Australians' Sexual Health Strategy* is the responsibility of OATSIHS. While responsibility for many areas of health and health services lie with State and Territory governments, it is OATSIHS which is responsible for the coordination of a range of national initiatives, providing funds directly to Aboriginal community controlled health organisations in addition to channelling funding through State and Territory governments.

The *National Indigenous Australians' Sexual Health Strategy* highlights the paucity of research into Indigenous Australians' sexual health (1997: 95-97). Particular mention is made of the need for community involvement in research and the use of methods that take into account the range and diversity of Aboriginal and Torres Strait Islander culture.

Community involvement in research programs and community control of decision-making processes connected with research needs is identified as being crucial to Indigenous involvement. The ANCARD Working Party found that greatest public health benefits will come from research processes that are developed collaboratively between researchers and researched (ibid: 96). Also stressed is the importance of ensuring that research methodologies include strategies to provide the researched community with research results in a format understandable to that community.

One of the other key recommendations of the *National Indigenous Australians' Sexual Health Strategy* concerns the building of partnerships and special mention is given to establishing an alliance between NACCHO and AFAO. A 'Memorandum of Understanding' is being prepared between the two organisations that will enable this alliance to be formalised. Collaboration between sectors is seen as a major step towards the fundamental process of dealing with the sexual health of Indigenous Australians.

But where do Indigenous gay men and transgender people fit into the changing HIV/AIDS and sexual health story? The Feachem Report certainly spelled out the two most 'at risk' groups - homosexually active men and Indigenous Australians - but Indigenous gay and transgender people have felt that they, being a part of both communities, warranted particular attention.

Whatever the equation, Indigenous gays and transgenders have expressed dissatisfaction with their lived experience of marginalisation within the wider, white, gay HIV agenda and even the broader gay 'community'.

In 1994, Indigenous gay and transgender activity led to the planning and staging of the first Aboriginal and Torres Strait Islander Gay Men and Transgender Sexual Health Conference, and the development of the Anwernekenhe Report. This conference was the first time an Aboriginal Medical Service (AMS) in a primary health care setting ran both an Indigenous gay men's project and auspiced the Conference.



The Anwernekenhe Report, which grew out of the Conference, informed the basis of the AFAO National Indigenous Gay and Transgender Project and the research and national consultations that were essential to the Project. This in turn prompted the development of this *National Indigenous Gay and Transgender Sexual Health Strategy*.

With alarming rates of HIV infection in the Indigenous community and with 65% of HIV positive Indigenous Australians identifying as gay or transgender, the implementation of this Strategy is imperative (Kaldor, 1996).

# Key Strategic Responses

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## 1 Indigenous gay men

Indigenous gay men account for 65% of HIV evident in the Indigenous community (ibid: 1996). For this reason particular attention must be given to Indigenous gay men in addressing HIV transmission in the broader Indigenous community.

Indigenous gay men have played a crucial role in the development and implementation of the Indigenous communities' response to HIV/AIDS, including highly significant contributions from Indigenous gay men living with HIV. This has occurred since the first 'National Conference on HIV/AIDS Among Indigenous Communities' held in Alice Springs in 1992, where HIV positive gay and lesbian Indigenous Australians came out publicly to address members of their own and other Indigenous communities.

An Indigenous emphasis or stream should be incorporated into gay community education programs and references to Indigenous gay men should be incorporated into all Indigenous community sexual health education messages.

AIDS Councils have particular expertise in the development of education resources targeting the gay community and addressing safer behaviours.

Aboriginal Medical Services (AMSs) and allied health services have particular experience and expertise in health promotion and sexual health education with Indigenous communities.

Given the expertise of AIDS councils in education and prevention programs particularly peer education for gay and homosexually active men, collaborative arrangements [between AMSs and AIDS Councils] ... should be further developed in the Indigenous community around the country. Strong links are encouraged between the national gay education strategy [and the *National Indigenous Australians' Sexual Health Strategy*] to ensure that national sexual health programs and strategies are inclusive of Indigenous gay men.

*National Indigenous Australians' Sexual Health Strategy*

## Recommendations

- 1.1 The Commonwealth should ensure that all community sexual health education programs and strategies are inclusive of, and address the needs of, Indigenous gay men.

- 1.2 The AFAO Indigenous Steering Committee should develop strong links and communication mechanisms with the Advisory Committee to the Review of Education and Development of a National Education Strategy for Gay and Other Homosexually Active Men, to ensure the respective strategies are complementary.
- 1.3 AIDS Councils, gay and lesbian counselling services and gay and lesbian Pride organisations should run self-esteem programs for local Indigenous gay men. These programs should be designed locally with Indigenous gay and/or transgender collaboration to address issues identified and prioritised by local Indigenous gay men.
- 1.4 AIDS Councils should address Indigenous issues in gay community development campaigns and programs targeting people in sexual identity transition ('coming out').
- 1.5 The Commonwealth, State and Territory Health Departments should, in funding AIDS Councils and allied health services, ensure that funding is provided for programs targeting gay, transgender, homosexually active men and other Indigenous men.
- 1.6 AIDS Councils, AMSs and allied health services should, in collaboration with networks of Indigenous gay men, support and facilitate the establishment of local social support groups for Indigenous gay men in urban, rural and remote areas.

## **2 Men who have sex with men**

In most cases Indigenous homosexually active men, also commonly known as men who have sex with men (MSM), are not identified as gay in a public sense nor are they an identifiable group within Indigenous communities.

The numbers of Indigenous MSM in any given community may be small, and these men may not be a part of a community that is identified by its sexuality. They are more likely to be integrated into a regional and/or Indigenous community as a whole.

In an environment where an individual is not defined by their sexual practices, a person may participate in a range of sexual activity with both men and women. Although these activities may not be promoted or supported in the community, they may however be tolerated. This may make it difficult for an MSM community identity or shared values to develop, precluding the development of a culture of safe sex within such an identity.

This group should be a primary audience for HIV/AIDS and sexual health education within the community as they are likely to have a high level of sexual activity with many male sexual partners, as well as female partners.

As sexually transmitted disease and HIV/AIDS awareness in Indigenous communities is low, and the highest risk group is a 'hidden' group, education should be included in campaigns targeting the general community.

Sexual health and HIV/AIDS education for men who have sex with men should not be carried out in isolation. This needs to be linked with education and support related to drug and alcohol and sexual assault.

Many of the communities involved in the national consultations had histories of sexual activity among people as young as ten. Younger people were often the targets of sexual assault by some alcohol-affected homosexually active men. Community education campaigns would therefore need to address issues of youth sexuality in order to achieve broad community coverage.

MSM were acknowledged to exist in every community visited during the consultation period. This acknowledgment of MSM by women's groups and individual women was accompanied by a denial that this behaviour could occur in their partners. Female partners of MSM, having no knowledge of their husbands'/boyfriends' activity, are powerless and vulnerable to HIV and STD transmission.

As many of the social contexts in which sexual activities occur between men include the use of alcohol, inhibition as well as a sense of responsibility may be reduced. Overall, communities have a very poor understanding of the types and level of sexual activity that occurs within their own community.

There is a generation of younger Indigenous men who have limited awareness of HIV/AIDS and STDs and who require information and education about transmission and safer sex practices. Homosexually active men and men who have sex with men who were the recipients of past education campaigns need support and continued education in order to maintain safe behaviour and protect against complacency.

AFAO Strategic Plan 1996-2000

## Recommendations

- 2.1 AIDS Councils and AMSs should collaborate on developing MSM inclusive, but broad, community targeted HIV/AIDS awareness resources. These campaigns should promote condom use and safer sexual behaviour.
- 2.2 AMSs, AIDS Councils and allied health agencies should carry out drug and alcohol abuse education programs which are inclusive of sexual health issues and which effectively target an MSM audience.
- 2.3 Relevant AIDS Council project workers and AMS education officers should collaborate to offer community development workshops for Indigenous communities which raise issues of Indigenous MSM. These workshops would be intended to overcome issues of denial of MSM activity and offer MSM and people affected by their behaviour an opportunity to discuss relevant issues.
- 2.4 AMSs and Indigenous Community Associations to provide opportunities and resources to enable discussion of specific healthy women's and men's business in relation to MSM and partners of MSM.

- 2.5 State and Territory Government Health Departments should provide funds to primary Indigenous health and counselling services to enable these services to offer education and support to those affected by MSM sexual assault.
- 2.6 AIDS Councils and AMSs should provide support to any community based Indigenous men's groups wanting to offer discussion opportunities and/or peer education on MSM issues.

### **3 Indigenous Australians with transgender issues**

Unlike MSM, people with transgender issues are visible in the community at times when they manifest their transgender nature. The transgender person's visibility may make them a target for vilification, discrimination, violence and sexual assault.

Many people with transgender issues experience high levels of isolation including separation from peers and role models as well as family and other supports. Poverty and drug and alcohol use may lead to sex being exchanged for drugs and alcohol or the taking up of commercial and opportunistic sex work.

Being kicked out of home is a common experience for people, Indigenous or non-Indigenous, with transgender issues. For many, this can lead to forced departure from community, loss of support structures and exchange of sex for accommodation, transport, food and so on.

Poverty experienced by people with transgender issues mitigates against options such as having gender reassignment or moving to a place with a transgender or gay community.

The limited numbers of people with transgender issues in the population as a whole, means that some communities may have no identified people with transgender issues while others may have a few. These low numbers make support for awareness of transgender issues a low priority in many communities.

People with transgender issues are however, at a high level of HIV risk due to factors such as the lack of emotional, psychological and mental health support.

As high profile community members, Indigenous people with transgender issues may become involved in sexual experimentation or may be the targets of assault. This places them at a higher than average risk of HIV transmission.

At the Anwernekenhe conference, transgender representatives identified their specific support and sexual health education needs and welcomed their inclusion in the conference. It was decided from the conference floor that any Indigenous gay community response to HIV/AIDS should be inclusive of transgender issues.

Indigenous transgender people may be in touch with each other through informal networks. Support for Indigenous people with transgender issues could be enhanced through the support and networking of these existing groups.

## Recommendations

- 3.1 AMSs and community gay, lesbian and transgender organisations should encourage Indigenous media to feature materials that address people with transgender issues.
- 3.2 AMSs and organisations addressing HIV/AIDS and /or transgender issues should meet to make links to address HIV/AIDS risk factors among Indigenous transgender Australians.
- 3.3 HIV/AIDS, sexual health and gay and transgender media should be encouraged to profile Indigenous transgender issues and feature individual transgender people.
- 3.4 AIDS Councils, transgender community organisations and AMSs, should collaborate on the production of a resource booklet aimed specifically at Indigenous transgenders and their issues.
- 3.5 Community based transgender organisations should allocate specific resources to meet the health and community needs of Indigenous transgender people, as well as making existing resources available through Indigenous health services.
- 3.6 AMSs, transgender community organisations and AIDS Councils should undertake to collaborate in the development of networks, the provision of outreach services and the development of support for Indigenous transgender Australians.

## 4 Youth sexual identity formation

The formation of an individual's sexual identity is a part of their development as a person. It will be influenced by early childhood experiences and other aspects of individual identity such as Aboriginality and gender. The sexual identity developed will have an impact on a range of behaviours and the individuals' relationship to those behaviours. An affirmative sexual identity will assist people to develop a health conscious and sustainable approach to sex and sexuality.

The development of an individual's sexuality can be made more difficult and confusing by discrimination, secrecy, family, religious and cultural pressures and prevailing myths and attitudes. Behaviours such as sexual assault, discrimination and violence inhibit the development of an affirmative sexual identity.

Attachment to a gay community has been identified by social researchers as an indicator of HIV/AIDS awareness and safe practice among gay men in Australia (Chappel & Kippax, 1996).

In terms of a broader community of sexuality, a person's identification as part of that community will depend on their links and experiences within, and in contact with the community.

Among the issues identified in the *Consultation Report*, young gay and transgender Indigenous Australians were seen to face a higher degree of violence than experienced by other Indigenous Australians. Much of this violence occurs in association with instances of alcohol abuse.

Alcohol abuse and sexual assault have an impact on HIV/AIDS and sexual health in varying ways and perhaps nowhere as prominently as in adult male to youth male rape. This also raises

the issue of incest, since older male relatives of the young men/boys carry out a large number of these assaults.

Most of the assaults are perpetrated within an environment of high levels of violence, which diminishes youth self-esteem. Low youth self-esteem, resulting from a history of alcohol-induced sexual assaults by older men as well as poverty, hopelessness and depression, has pushed many younger Indigenous males to suicide.

Through the national consultations, it has become apparent that unsafe sex, and hence HIV/AIDS and STD transmission, could result from the behaviour of intoxicated homosexually active males who sexually assault younger men.

It is also apparent that intoxication, detoxification and illicit drug use are also associated with high levels of youth suicide in Indigenous communities.

Although most Indigenous youth grow up in supportive networks, young gay and transgender Indigenous Australians grow up in an environment where it may be difficult to access affirmative Indigenous gay and transgender role models and supportive networks. They may also lack appropriate and targeted information regarding sexually transmitted diseases, including HIV/AIDS and sexual health education materials, as well as support and treatments information regarding living with HIV.

## **Recommendations**

- 4.1 AMSs and allied health organisations, AIDS Councils, and gay and lesbian Pride groups should collaborate to promote Indigenous gay and transgender youth through a series of campaigns developing positive affirmation in all media, including Indigenous mainstream and gay press.
- 4.2 AMSs, AIDS Councils, gay Pride groups and allied health organisations should raise the profile of Indigenous gay and transgender youth by placing promotional articles, photos and events relevant to Indigenous gay and transgender youth in the mainstream/non-Indigenous gay media and press.
- 4.3 Commonwealth, State and Territory government health departments should support AMSs and allied health services to address youth sexuality issues through Indigenous health and youth forums.
- 4.4 State, Territory and Commonwealth government health departments, in allocating funds for mental health activities and youth targeted programs, should encourage program providers to address the issue of young people's sexual identity.
- 4.5 The National Centre for HIV/AIDS Social Research, in partnership with specific Indigenous communities, should undertake research into Indigenous youth sexual identity formation and development.
- 4.6 Youth workers, mental health staff, Indigenous drug and alcohol workers, police, sexual health workers and their relevant agencies should develop inter-agency links to discuss the issues arising from alcohol abuse and sexual assault as it impacts on adult male to

youth male rape, and develop programs to address both the perpetrators and the victims.

- 4.7 Youth workers, mental health staff, Indigenous drug and alcohol workers, police, sexual health workers and their relevant agencies should provide culturally appropriate information, support and education in relation to suicide to affected families and communities.
- 4.8 Aboriginal community organisations should carry out Indigenous youth education on sexual boundaries and self-esteem.
- 4.9 Commonwealth, State and Territory government health department funded youth suicide prevention campaigns should address sexual identity, sexual assault issues and Indigenous issues and the counselling and training needs of youth, health, mental health, drug and alcohol and allied health service providers.

## **5 Social and environmental factors affecting health**

Social and environmental factors are recognised as having a significant influence on health outcomes. These factors may include education, drug and alcohol abuse, wealth or poverty, capacity to make decisions that affect health, access to information and homelessness.

Alcohol abuse is a prominent form drug abuse in Indigenous communities. It is recognised that this is a health issue, but it is largely unrecognised that alcohol abuse has a significant impact on sexual health.

Recreational illicit drug use is a significant issue for many Indigenous gay and transgender people. Indigenous health organisations need to work with injecting drug users and sexual health services to address these issues in a harm reduction manner.

The *National Indigenous Australians' Sexual Health Strategy* identified the serious deficiencies relating to research into Indigenous Australians' injecting drug use (IDU). Recommendation 7.7 of this strategy stresses the need for action-based research to be undertaken into injecting drug use and users in Indigenous communities. It also emphasises that such IDU research should focus on the nature of any increase in IDU in Indigenous Australian communities.

Access to health services has a fundamental impact on health outcomes. Many Indigenous Australians have poor access to primary health care and may have even further reduced access to specific health services including appropriate health education, mental health services and sexual health services.

### **Recommendations**

- 5.1 State government departments responsible for family and community services should fund and support training for AMS workers to identify and address health and support issues associated with sexual assault.
- 5.2 AMSs, community based drug user organisations and allied health services need to work



with injecting drug users and sexual health services to develop programs to address recreational illicit drug use issues in a harm reduction manner.

- 5.3 State governments and Indigenous health services should identify and develop programs to address sexual assault as a by-product of alcohol abuse.
- 5.4 AMSs should equip and promote their services as a place where sexual assault issues can be addressed.
- 5.5 Commonwealth, State and Territory governments, through their health and community services departments, should conduct culturally appropriate anti-violence education programs targeting Indigenous communities. These programs should be developed in conjunction with Indigenous communities.
- 5.6 Commonwealth, State and Territory health departments should carry out drug and alcohol harm reduction programs including controlled drinking programs in conjunction with, and targeting Indigenous communities.
- 5.7 Commonwealth, State and Territory health departments, AMSs and drug and alcohol and allied services should address the relationship between the negative consequences of substance and alcohol abuse and STDs, HIV/AIDS and sexual assault.

## **6 Indigenous people living with HIV/AIDS**

Limited work addressing Indigenous people living with HIV/AIDS (PLWHA) has been carried out to date, yet the number of Indigenous PLWHA could be expected to increase as only a small proportion of people at risk have been tested for HIV.

Confidentiality is critical and difficult to maintain in smaller communities. Many Indigenous people may be deterred from taking a HIV test as it would involve admitting to their participation in risk behaviours. Those who are aware of their or others' risk behaviours may choose not to have a HIV test for fear of ostracism and rejection.

Lack of community and individual awareness about HIV/AIDS, treatments, care and support may also inhibit individuals from seeking knowledge of their status as they may expect that it will result in cultural and social problems.

Poverty, drug and alcohol issues, fears around disclosure of their HIV status, and competing community interests and priorities, such as land claims, compete with people's abilities to self care and monitor health and well being.

Access to services is an important issue for HIV positive Indigenous Australians. Access to services is made difficult by isolation and by a reluctance among Indigenous Australians to visit services that are viewed to be mainstream services. Fear of disclosing status or sexual behaviour to mainstream or community health services can be a barrier to access.

Disclosure of a sexual history to a person of the opposite sex may be culturally inappropriate. This may have particular implications for contact tracing protocols for each area or region.

The distance to be travelled to services that can monitor and manage HIV may be beyond the financial capacity of people in isolated or remote communities. Many of the HIV positive Indigenous Australians who are choosing to access treatments are doing so in the larger cities.

Indigenous PLWHA face and fear family rejection if their behaviour is openly known in a discriminatory community. This problem can be addressed through raising community awareness of sexuality and positive people's issues.

Indigenous HIV positive people may choose not to access Indigenous services for a range of reasons including:

- perceived lack of confidentiality;
- fear of being outed;
- the absence of an AMS in their area;
- the AMS not being equipped to deal with HIV, sexual health, drug and alcohol issues or homosexuality;
- AMSs not being experienced in HIV treatments, care & support issues; and
- community and social relations where potential service-users are related to service employees.

The Positive Information and Education (PIE) Project consultation report, which looked at key themes and issues of positive people, identified the primary information needs of HIV positive Indigenous people as:

- the need for basic information;
- the need for compliance education;
- early intervention; and
- access to treatments, services and clinical trials (AFAO & NAPWA, 1997).

Other findings in the PIE consultation report which concern Indigenous Australians are consistent with the findings of the *National Indigenous Gay and Transgender Consultation Report*.

HIV positive Indigenous Australians can play an important role in HIV prevention education, treatments education and support. Well-supported HIV positive people can play a lead role in providing treatments advice, information and support to other positive people. For instance, Indigenous HIV positive people have been crucial for the development of the OATSIHS *Indigenous HIV/AIDS Care and Support Manual*.

## **Recommendations**

- 6.1 AMSs, AIDS Councils and allied health services should work with Indigenous health organisations to raise awareness among health workers of discrimination against PLWHA, of values and attitudes regarding lifestyle choices, including homophobia, and the importance of confidentiality.
- 6.2 The Commonwealth, State and Territory governments and allied health services should train and resource government medical officers, general practitioners and health care

workers in remote and isolated communities to provide HIV treatments and care as part of their service.

- 6.3 The *Indigenous HIV/AIDS Care and Support Manual* should be promoted by OATSIHS through all AMSs, AIDS Councils, PLWHA organisations and allied health services.
- 6.4 AMSs and PLWHA organisations should make links to ensure AMS staff are offered training in relation to HIV/AIDS treatment, care, support, and issues for PLWHA.
- 6.5 AMSs, AIDS Councils and allied health services should engage in networking activities, such as staff exchange, to promote better working relationships between Indigenous health care workers and HIV/AIDS organisations.
- 6.6 HIV/AIDS statistics from the National Centre for HIV/AIDS Epidemiology and Clinical Research should record Indigenous status and regularly report on numbers of HIV positive Indigenous Australians and on their disease progression.
- 6.7 AMS and allied health services should ensure staff are trained in values and attitudes around sexuality, in HIV and STDs and in confidentiality issues and policies.
- 6.8 The Australian National Council on AIDS and Related Diseases (ANCARD), through its Indigenous sexual health working party, and AFAO should collaboratively develop strategies to ensure Aboriginal and Torres Strait Islander people have equitable access to HIV treatment trials and the latest treatments.
- 6.9 AMSs, AIDS Councils and PLWHA organisations should incorporate aspects of the *National Indigenous Australians' Sexual Health Strategy* and the *Indigenous Care and Support Manual* in the development of their responses to Indigenous people with HIV and AIDS.
- 6.10 AIDS Councils, PLWHA organisations and positive speakers bureaus should promote speaking and writing skills among positive Indigenous people.

## **7 Treatment, Care and Support**

Issues of distance, isolation and access to primary and specialised health services will have a significant impact on outcomes for, and experiences of Indigenous PLWHA. Other issues of significance will include housing, poverty, language, education, unemployment and living conditions.

Specific negotiations that include reference to the person's living conditions, lifestyle, level of knowledge and geographical location may need to be made regarding dosing, timing and treatment regimes.

Information on many of the key issues in HIV treatments are not adequately available to staff of AMSs and to the clients that they serve.

Issues of 'shame' and discrimination directed particularly against Indigenous gay men and

transgender people may also have an impact on those seeking testing and the delivery of treatments and support.

Fear of alienation and rejection from the family may inhibit disclosure and therefore remove the opportunity for support, education and treatment.

## **Recommendations**

- 7.1 AIDS Council treatments officers should run workshops for AMS staff on dosing, timing, treatments regimes and social determinants, such as housing, income and discrimination, which operate in relation to multi-drug treatment regimes.
- 7.2 Resources produced for prevention, positive people and treatments information, including the *National AIDS Bulletin*, *Positive Living* and the *HIV Herald*, should be provided to AMSs and NACCHO networks.
- 7.3 NACCHO should work collaboratively with AMSs, AIDS Councils and allied health services to develop and promote a resource, or resources, which articulates Indigenous concepts of sexuality, health, disease, pain and injury to assist in understanding issues such as whole health, health maintenance and monitoring.
- 7.4 The National Centre for HIV/AIDS Epidemiology and Clinical Research should monitor HIV disease progression in Indigenous Australians and report annually on comparisons with non-Indigenous Australians.

## **8 Partnership building in Indigenous health and HIV/AIDS organisations**

AMSs are in an ideal position to respond to the needs of Indigenous peoples and communities around the issues of HIV/AIDS and sexual health. Their expertise in partnership building could go a long way towards alleviating many problems faced by individuals and communities. However, as clinically based services, AMSs may lack experience with HIV/AIDS, gay and transgender people, counselling, care and support and education issues.

As community-based services, AIDS Councils have expertise in working with a community, mostly gay male, at risk of HIV. However, AIDS Councils may lack experience in Indigenous social issues, cultural sensitivity, Men's and Women's Business and culturally appropriate ways of providing Indigenous sexual health education, including an understanding of Indigenous concepts of health, sexuality, pain, injury and sickness.

'Partnership building' has been identified in the National Indigenous Australians' Sexual Health Strategy as a key response to dealing with sexual health in the Indigenous community in Australia. Collaboration between AMSs and AIDS Councils should extend to cross-committee and cross-board membership, in a representative or ex-officio capacity, and the development of memoranda of understanding to facilitate working relationships.

The Anwernekenhe Report of the First National Aboriginal and Torres Strait Islander Gay Men and Transgender Sexual Health Conference also states the need for AIDS Councils, and PLWHA organisations to establish alliances with Indigenous gay and transgender communities.

Consultative and collaborative approaches to the development of HIV/AIDS and sexual health initiatives are encouraged by the National Indigenous Australians' Sexual Health Strategy. Funding has been provided to individual projects through the various state and territory implementation plans developed following the Sexual Health Strategy. These plans have involved all parties to the Aboriginal health framework agreements including state and territory health departments, Aboriginal community controlled health organisations and the Aboriginal and Torres Strait Islander Commission (ATSIC).

AMSs, AIDS Councils and regional Indigenous health organisations, in conjunction with OATSIHS, should develop Indigenous-targeted HIV/AIDS education on the basis that such education initiatives should be:

- regionally specific;
- cooperatively managed; and
- inclusive of regional Indigenous gay communities/groups as partners in resource production and strategic development.

Continued financial support is required to ensure the development and sustainability of programs to address HIV/AIDS issues.

A commitment to Indigenous health is best made as a part of a commitment to the well being and future of the Indigenous people of Australia. HIV/AIDS and gay and transgender community organisations should build on Land Rights/Reconciliation statements by AIDS and gay community groups to ensure that each organisation has policies relating to Indigenous gay and transgender Australians which identify health care as a basic human right.

## **Recommendations**

- 8.1 AMSs should provide skills exchange and training in the areas of cultural appropriateness and Indigenous sensibilities to AIDS Councils.
- 8.2 AIDS Councils should provide a continuity of campaign development information and support to AMSs.
- 8.3 AIDS Councils should run regional courses for AMS staff, based on local need, to address care, treatment and support issues for people living with HIV/AIDS including values and attitudes, sexuality and peer education.
- 8.4 AIDS Council youth-targeted campaigns should include an Indigenous component.
- 8.5 AIDS Councils should contact and provide support to gay and transgender Indigenous groups for the development and production of HIV prevention and awareness resources.
- 8.6 AMS networks and AIDS Councils should work together to develop regional plans to meet the HIV/AIDS needs of Indigenous Australians.

- 8.7 AFAO, with NACCHO, should develop national train the trainer and peer education training schemes for Indigenous health services.
- 8.8 AIDS Councils and AMSs should promote opportunities for staff exchange with a view to increasing links and understanding between service delivery organisations.
- 8.9 All AIDS Councils and affiliates in collaboration with State and Territory Indigenous health organisations should establish, support and maintain a position responsible for Indigenous issues and projects addressing Indigenous issues.
- 8.10 Each AIDS council should develop policies and strategies to address HIV/AIDS and STDs among gay and transgender Indigenous Australians.
- 8.11 AMSs should consult with Indigenous PLWHA in the development of programs for and responses to PLWHA.
- 8.12 AIDS Councils and Indigenous health services should undertake partnership building through shared positions or ex-officio positions on respective boards.
- 8.13 NACCHO and AFAO Executive Directors and Presidents should build partnerships to address HIV/AIDS issues.
- 8.14 NACCHO and AFAO should coordinate an Annual General Meeting to address issues of mutual interest.
- 8.15 In conjunction with AFAO, NACCHO and social researchers, AMSs should be encouraged to carry out local mapping of sexual behaviour, risk activities and HIV prevention.
- 8.16 All HIV/AIDS and sexual health campaigns targeting Indigenous Australians should be focus tested with the target group to assess cultural appropriateness and contextual relevance.
- 8.17 State, Territory and Commonwealth governments should make financial commitments to ensure the development and sustainability of HIV/AIDS and sexual health programs targeting Indigenous gay and transgender Australians.
- 8.18 A national process should be funded by OATSIHS to assist Indigenous community health organisations to develop policies dealing with HIV/AIDS related issues in community organisations.
- 8.19 A special category of the AFAO Media Awards should be established to recognise excellence in HIV/AIDS and Indigenous broadcasting.
- 8.20 OATSIHS and State and Territory health departments should ensure that successful efforts in Indigenous and non-Indigenous community cooperation are evaluated and promoted.
- 8.21 HIV/AIDS and gay and transgender community organisations should build on Land Rights/ Reconciliation statements by AIDS and gay community groups to ensure that each organisation has policies relating to Indigenous gay and transgender Australians which identify health care as a basic human right.

## 9 Other related issues

NACCHO and the AMSs are in the best position to carry out education for health service providers and to deliver primary health services and community safe sex education to indigenous communities. This can be achieved best in a supportive legislative framework where issues of discrimination, marginalisation and sensitive social issues can be discussed.

Aboriginal Legal Services should ensure that gay and transgender Indigenous Australians' have access to legal support to address issues of discrimination, violence and access to rights.

In order to develop locally informed and relevant safe sex education campaigns, AIDS Council project workers and AMS health care workers should be trained in social research techniques that enable the sexual stories of communities to be collected, discussed and used to develop programs to address sexual health issues. AIDS Council project workers could also assist AMSs in addressing the need for HIV and sexual health information and education.

In order for HIV prevention and sexual health promotion to occur in a coordinated and strategic fashion, Commonwealth, State and Territory agencies will need to allocate funds for health and community workers to be trained in Indigenous cultural awareness and sensitivities in relation to HIV/AIDS and sexual health.

Commonwealth, State and Territory funding bodies have a role in ensuring that HIV and AIDS Indigenous education campaigns are carried out and that they occur in a broader sexual health context. This responsibility lies mainly with OATSIHS. OATSIHS works with an array of community and government organisations and carries out planning studies and evaluations of programs. OATSIHS should encourage and fund research into sexuality, sexual activity, identity and gender orientation in Indigenous communities.

Other groups are also producing educational resources and programs that have an impact on Indigenous communities. Commonwealth, State and Territory governments should ensure that agencies carrying out education in Indigenous communities in areas of violence, sexually transmitted diseases, drug and alcohol use, and general health promotion should coordinate their activity to best tailor resources and information to the needs of specific communities and regions.

Addressing issues such as sexuality, sexual orientation and drug use can be a challenge to any community. OATSIHS should explore Indigenous conflict resolution and community development models and promote their effective use in Indigenous community organisations and their utilisation in Indigenous community forums.

### Recommendations

- 9.1 NACCHO and the AMSs should carry out general Indigenous community safe sex education. Education should include community dialogue on HIV risk behaviours. Safe-sex should also be part of alcohol education campaigns.
- 9.2 Aboriginal Legal Services should ensure that gay and transgender Indigenous Australian's have access to legal support to assist in addressing issues of discrimination,

violence and access to rights.

- 9.3 AIDS Council project workers and AMS health care workers in should be trained in social research techniques that enable the sexual stories of communities to be collected, discussed and then used to develop programs to address sexual health issues.
- 9.4 Commonwealth, State and Territory agencies to allocate funds for health and community workers to be trained in Indigenous cultural awareness and sensitivities in relation HIV/AIDS and sexual health.
- 9.5 Commonwealth, State and Territory funding bodies should ensure that HIV and AIDS Indigenous education campaigns are carried out and that they occur in a broader sexual health context.
- 9.6 OATSIHS should encourage and fund research into sexuality, sexual activity, identity and gender orientation in Indigenous communities.
- 9.7 State and Territory governments should ensure agencies carrying out education in Indigenous communities in the areas of violence, sexually transmitted diseases, alcohol use and drug use, coordinate their activity to best tailor resources and information to the needs of specific communities and regions.
- 9.8 OATSIHS should explore Indigenous conflict resolution and community development models and promote their effective use in Indigenous community organisations and their utilisation in Indigenous community forums.



# Priority recommendations

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While all the recommendations contained in this Strategy are important, the AFAO Indigenous Steering Committee has nominated the following as requiring urgent attention.

## 1 Indigenous gay men

- 1.1 The Commonwealth should ensure that all community sexual health education programs and strategies are inclusive of, and address the needs of, Indigenous gay men.
- 1.5 The Commonwealth, State and Territory Health Departments should, in funding AIDS Councils and allied health services, ensure that funding is provided for programs targeting gay, transgender, homosexually active men and other Indigenous men.
- 1.6 AIDS Councils, AMSs and allied health services should, in collaboration with networks of Indigenous gay men, support and facilitate the establishment of local social support groups for Indigenous gay men in urban, rural and remote areas.

## 2 Men who have sex with men

- 2.1 AIDS Councils and AMSs should collaborate on developing MSM inclusive, but broad, community targeted HIV/AIDS awareness resources. These campaigns should promote condom use and safer sexual behaviour.
- 2.5 State and Territory Government Health Departments should provide funds to primary Indigenous health and counselling services to enable these services to offer education and support to those affected by MSM sexual assault.
- 2.6 AIDS Councils and AMSs should provide support to any community based Indigenous men's groups wanting to offer discussion opportunities and/or peer education on MSM issues.

## 3 Indigenous Australians with transgender issues

- 3.4 AIDS Councils, transgender community organisations and AMSs, should collaborate on the production of a resource booklet aimed specifically at Indigenous transgenders and their issues.

## **4 Youth sexual identity formation**

- 4.3 Commonwealth, State and Territory government health departments should support AMSs and allied health services to address youth sexuality issues through Indigenous health and youth forums.
- 4.4 State, Territory and Commonwealth government health departments, in allocating funds for mental health activities and youth targeted programs, should encourage program providers to address the issue of young people's sexual identity.
- 4.9 Commonwealth, State and Territory government health department funded youth suicide prevention campaigns should address sexual identity, sexual assault issues and Indigenous issues and the counselling and training needs of youth, health, mental health, drug and alcohol and allied health service providers.

## **5 Social and environmental factors affecting health**

- 5.6 Commonwealth, State and Territory health departments should carry out drug and alcohol harm reduction programs including controlled drinking programs in conjunction with, and targeting Indigenous communities.

## **6 Indigenous People Living with HIV/AIDS**

- 6.1 AMSs, AIDS Councils and allied health services should work with Indigenous health organisations to raise awareness among health workers of discrimination against PLWHA, of values and attitudes regarding lifestyle choices, including homophobia, and the importance of confidentiality.
- 6.7 AMS and allied health services should ensure staff are trained in values and attitudes around sexuality, in HIV and STDs and in confidentiality issues and policies.
- 6.9 AMSs, AIDS Councils and PLWHA organisations should incorporate aspects of the *National Indigenous Australians' Sexual Health Strategy* and the *Indigenous Care and Support Manual* in the development of their responses to Indigenous people with HIV and AIDS.

## **7 Treatment, care and support**

- 7.1 AIDS Council treatments officers should run workshops for AMS staff on dosing, timing, treatments regimes and social determinants, such as housing, income and discrimination, which operate in relation to multi-drug treatment regimes.
- 7.3 NACCHO should work collaboratively with AMSs, AIDS Councils and allied health services to develop and promote a resource, or resources, which articulates Indigenous concepts of sexuality, health, disease, pain and injury to assist in understanding issues such as whole health, health maintenance and monitoring.

- 7.4 The National Centre for HIV/AIDS Epidemiology and Clinical Research should monitor HIV disease progression in Indigenous Australians and report annually on comparisons with non-Indigenous Australians.

## **8 Partnership building in Indigenous health and HIV/AIDS organisations**

- 8.6 AMS networks and AIDS Councils should work together to develop regional plans to meet the HIV/AIDS needs of Indigenous Australians.
- 8.14 NACCHO and AFAO should coordinate an Annual General Meeting to address issues of mutual interest.
- 8.15 In conjunction with AFAO, NACCHO and social researchers, AMSs should be encouraged to carry out local mapping of sexual behaviour, risk activities and HIV prevention.

## **9 Other related issues**

- 9.1 NACCHO and the AMSs should carry out general Indigenous community safe sex education. Education should include community dialogue on HIV risk behaviours. Safe-sex should also be part of alcohol education campaigns.
- 9.2 Aboriginal Legal Services should ensure that gay and transgender Indigenous Australian's have access to legal support to assist in addressing issues of discrimination, violence and access to rights.
- 9.3 AIDS Council project workers and AMS health care workers in should be trained in social research techniques that enable the sexual stories of communities to be collected, discussed and then used to develop programs to address sexual health issues.
- 9.6 OATSIHS should encourage and fund research into sexuality, sexual activity, identity and gender orientation in Indigenous communities.

# List of recommendations

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## 1 Indigenous gay men

- 1.1 The Commonwealth should ensure that all community sexual health education programs and strategies are inclusive of, and address the needs of, Indigenous gay men.
- 1.2 The AFAO Indigenous Steering Committee should develop strong links and communication mechanisms with the Advisory Committee to the Review of Education and Development of a National Education Strategy for Gay and Other Homosexually Active Men, to ensure the respective strategies are complementary.
- 1.3 AIDS Councils, gay and lesbian counselling services and gay and lesbian Pride organisations should run self-esteem programs for local Indigenous gay men. These programs should be designed locally with Indigenous gay and/or transgender collaboration to address issues identified and prioritised by local Indigenous gay men.
- 1.4 AIDS Councils should address Indigenous issues in gay community development campaigns and programs targeting people in sexual identity transition ('coming out').
- 1.5 The Commonwealth, State and Territory Health Departments should, in funding AIDS Councils and allied health services, ensure that funding is provided for programs targeting gay, transgender, homosexually active men and other Indigenous men.
- 1.6 AIDS Councils, AMSs and allied health services should, in collaboration with networks of Indigenous gay men, support and facilitate the establishment of local social support groups for Indigenous gay men in urban, rural and remote areas.

## 2 Men who have sex with men

- 2.1 AIDS Councils and AMSs should collaborate on developing MSM inclusive, but broad, community targeted HIV/AIDS awareness resources. These campaigns should promote condom use and safer sexual behaviour.
- 2.2 AMSs, AIDS Councils and allied health agencies should carry out drug and alcohol abuse education programs which are inclusive of sexual health issues and which effectively target an MSM audience.
- 2.3 Relevant AIDS Council project workers and AMS education officers should collaborate to offer community development workshops for Indigenous communities which raise issues of Indigenous MSM. These workshops would be intended to overcome issues of denial of MSM activity and offer MSM and people affected by their behaviour an opportunity to discuss relevant issues.
- 2.4 AMSs and Indigenous Community Associations to provide opportunities and resources to

enable discussion of specific healthy women's and men's business in relation to MSM and partners of MSM.

- 2.5 State and Territory Government Health Departments should provide funds to primary Indigenous health and counselling services to enable these services to offer education and support to those affected by MSM sexual assault.
- 2.6 AIDS Councils and AMSs should provide support to any community based Indigenous men's groups wanting to offer discussion opportunities and/or peer education on MSM issues.

### **3 Indigenous Australians with transgender issues**

- 3.1 AMSs and community gay, lesbian and transgender organisations should encourage Indigenous media to feature materials that address people with transgender issues.
- 3.2 AMSs and organisations addressing HIV/AIDS and /or transgender issues should meet to make links to address HIV/AIDS risk factors among Indigenous transgender Australians.
- 3.3 HIV/AIDS, sexual health and gay and transgender media should be encouraged to profile Indigenous transgender issues and feature individual transgender people.
- 3.4 AIDS Councils, transgender community organisations and AMSs, should collaborate on the production of a resource booklet aimed specifically at Indigenous transgenders and their issues.
- 3.5 Community based transgender organisations should allocate specific resources to meet the health and community needs of Indigenous transgender people, as well as making existing resources available through Indigenous health services.
- 3.6 AMSs, transgender community organisations and AIDS Councils should undertake to collaborate in the development of networks, the provision of outreach services and the development of support for Indigenous transgender Australians.

### **4 Youth sexual identity formation**

- 4.1 AMSs and allied health organisations, AIDS Councils, and gay and lesbian Pride groups should collaborate to promote Indigenous gay and transgender youth through a series of campaigns developing positive affirmation in all media, including Indigenous mainstream and gay press.
- 4.2 AMSs, AIDS Councils, gay Pride groups and allied health organisations should raise the profile of Indigenous gay and transgender youth by placing promotional articles, photos and events relevant to Indigenous gay and transgender youth in the mainstream/non-Indigenous gay media and press.
- 4.3 Commonwealth, State and Territory government health departments should support AMSs and allied health services to address youth sexuality issues through Indigenous health and youth forums.

- 4.4 State, Territory and Commonwealth government health departments, in allocating funds for mental health activities and youth targeted programs, should encourage program providers to address the issue of young people's sexual identity.
- 4.5 The National Centre for HIV/AIDS Social Research, in partnership with specific Indigenous communities, should undertake research into Indigenous youth sexual identity formation and development.
- 4.6 Youth workers, mental health staff, Indigenous drug and alcohol workers, police, sexual health workers and their relevant agencies should develop inter-agency links to discuss the issues arising from alcohol abuse and sexual assault as it impacts on adult male to youth male rape, and develop programs to address both the perpetrators and the victims.
- 4.7 Youth workers, mental health staff, Indigenous drug and alcohol workers, police, sexual health workers and their relevant agencies should provide culturally appropriate information, support and education in relation to suicide to affected families and communities.
- 4.8 Aboriginal community organisations should carry out Indigenous youth education on sexual boundaries and self-esteem.
- 4.9 Commonwealth, State and Territory government health department funded youth suicide prevention campaigns should address sexual identity, sexual assault issues and Indigenous issues and the counselling and training needs of youth, health, mental health, drug and alcohol and allied health service providers.

## **5 Social and environmental factors affecting health**

- 5.1 State government departments responsible for family and community services should fund and support training for AMS workers to identify and address health and support issues associated with sexual assault.
- 5.2 AMSs, community based drug user organisations and allied health services need to work with injecting drug users and sexual health services to develop programs to address recreational illicit drug use issues in a harm reduction manner.
- 5.3 State governments and Indigenous health services should identify and develop programs to address sexual assault as a by-product of alcohol abuse.
- 5.4 AMSs should equip and promote their services as a place where sexual assault issues can be addressed.
- 5.5 Commonwealth, State and Territory governments, through their health and community services departments, should conduct culturally appropriate anti-violence education programs targeting Indigenous communities. These programs should be developed in conjunction with Indigenous communities.
- 5.6 Commonwealth, State and Territory health departments should carry out drug and alcohol harm reduction programs including controlled drinking programs in conjunction with, and targeting Indigenous communities.

- 5.7 Commonwealth, State and Territory health departments, AMSs and drug and alcohol and allied services should address the relationship between the negative consequences of substance and alcohol abuse and STDs, HIV/AIDS and sexual assault.

## **6 Indigenous people living with HIV/AIDS**

- 6.1 AMSs, AIDS Councils and allied health services should work with Indigenous health organisations to raise awareness among health workers of discrimination against PLWHA, of values and attitudes regarding lifestyle choices, including homophobia, and the importance of confidentiality.
- 6.2 The Commonwealth, State and Territory governments and allied health services should train and resource government medical officers, general practitioners and health care workers in remote and isolated communities to provide HIV treatments and care as part of their service.
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- 8.10 Each AIDS council should develop policies and strategies to address HIV/AIDS and STDs among gay and transgender Indigenous Australians.
- 8.11 AMSs should consult with Indigenous PLWHA in the development of programs for and responses to PLWHA.
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- 8.18 A national process should be funded by OATSIHS to assist Indigenous community health organisations to develop policies dealing with HIV/AIDS related issues in community organisations.
- 8.19 A special category of the AFAO Media Awards should be established to recognise excellence in HIV/AIDS and Indigenous broadcasting.
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## **9 Other related issues**

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- 9.2 Aboriginal Legal Services should ensure that gay and transgender Indigenous Australian's have access to legal support to assist in addressing issues of discrimination, violence and access to rights.
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