

ACTION RESEARCH

Addressing HIV risks related to injecting drug use
in Victorian Aboriginal Communities

Project Partners:

VACCHO and Anex



VACCHO Inc



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Action Research - Addressing HIV risks related to injecting drug use in Victorian Aboriginal Communities: A report for the Victorian Department of Health, Anex and VACCHO Inc.

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Executive Summary

Aboriginal people are overrepresented in terms of injecting drug use and rates of Blood Borne Viruses (BBVs) and Sexually Transmitted Infections (STIs) (Gray, 2005; Gray & Morfitt, 1996). A higher proportion of HIV transmission amongst Aboriginal Australians occurs through injecting drug use (NCHECR, 2007). The proportion of HIV cases transmitted via heterosexual contact is also much higher amongst Aboriginal Australians than among non-Aboriginal people.

National data on HCV notifications reveal that, while Aboriginal people make up only 2.4% of the Australian population, they account for 8.3% of persons living with HCV (Hepatitis Australia, 2007). It is estimated that some 16,000 Aboriginal people are living with chronic HCV (McNally & Latham, 2009).

The Well Persons Health Check (WPHC) provides useful data on the rates of BBVs and STIs among Aboriginal and Torres Strait Islander people in Victoria. The WPHC tested 1446 people. The results show that 13.3% of participants tested positive for hepatitis C. In the same study 12 people had recently acquired hepatitis B, and 13.74% had previously been exposed to the virus. None of the participants tested positive for HIV (The Victorian Well Person's Health Check Report Sexual Health, 2003).

About the project

The project sought to improve the health of Aboriginal Victorians, particularly those who inject drugs, in relation to BBVs/STIs including HIV. By employing action research methodology, the project partners undertook the following activities:

- Convened a Project Advisory Group;
- Submitted an Ethics Submission to Department of Health (DH);
- Undertook a Literature Review;
- Conducted Service Provider Consultations;
- Conducted interviews with Aboriginal people who inject drugs; and
- Conducted focus groups.

Key Findings

Misinformation regarding BBVs/STIs

Clients interviewed for the project displayed misinformation regarding the transmission of STIs and BBVs and in particular hepatitis. Clients reported they believed hepatitis C can be transmitted through sexual contact, food poisoning, from toilet seats, kissing and sharing eating utensils such as knives and forks. Clients also reported they believed it was safe to share injecting equipment with their sexual partners because they exchange sexual fluids and would have been exposed to any viruses.

Clients in long-term sexual relationships reported they do not use condoms because they perceive the risk of STI transmission to be low.

Sources of information

The project partners explored the ways learnt about safer injecting and BBVs and the participants seemed to prefer messages that came from their peers, being other Aboriginal people or other injecting drugs users or both. Clients also reported receiving information from peers while incarcerated. When asked about safer sex messages the participants most common source of knowledge was from school and family members. There was a strong sense that messages about safer injecting, BBVs and safer sex from researchers and even Alcohol and other Drugs (AOD) workers should not be trusted. Therefore peer based education campaigns need to be investigated, especially if the misinformation discussed above is going to be corrected.

Engaging Aboriginal people who inject drugs - Services

Mainstream health services and Aboriginal Community Controlled Health Organisations (ACCHOs) interviewed for the project reported experiencing difficulties in engaging with Aboriginal people who inject drugs. Lack of specific funding for the delivery of Needle and Syringe Program (NSP); competing health priorities; high staff turnover; lack of skilled/specialist staff particularly in ACCHOs and the stigmatisation of injecting drug use, BBVs and STIs were some of the challenges facing services in trying to engage Aboriginal people who inject drugs.

Recommendations

There is need to target young Aboriginal people and address their information needs in relation to BBVs and STIs. This will provide the foundation for improved uptake of health promotion messages and better use of funding. In order to achieve this, the following steps need to be taken:

- Investigate current health promotion programs targeting young people available through the Department of Education and Early Childhood Development;
- Determine gaps in information provision and reach (how old or young) and further develop programs in collaboration with the Department of Education and Early Childhood Development;
- Consider lowering the target age group for delivery of programs to capture early school leavers;
- Conduct parallel campaigns that target parents to ensure that the provision of messages to young people does not create cultural and/or family division;
- In consultation with Communities, the Australian, State and Territory Governments should give high priority to identifying effective ways of reducing rates of HCV infection among young Aboriginal Australians, and implement policies, projects and practices designed to achieve this (see also 'A Review of enablers and barriers of Indigenous drug users accessing needle

and syringe programs – a report for the COAG Multilateral Group on Needle and Syringe Programs’, 2008).

And more broadly:

- Explore options for modes of delivery of messages to Aboriginal people who inject drugs including the use of dramatic arts based programs;
- Encourage the use of local media to promote local services and therefore increase access;
- Consider the use of peers in the development and delivery of information and support based programs;
- Use Community based activities as a vehicle for delivering messages around BBVs/STIs;
- Consider techniques used in other campaigns e.g. the gay community that emphasise prevention and health promotion messages on safer sex;
- Ensure any program delivery is developed through engagement with representatives from the target group.

Improving access and service responses:

- Ensure improved access for Aboriginal Communities to sterile injecting equipment through syringe vending machines, pharmacy NSPs and outreach mobile services. This would include identification of the most appropriate model for outreach services, e.g. vehicle based, Mobile Drug Safety Worker (MDSW);
- Re-orient services to deliver a home-based model of care to ensure that hard to reach Aboriginal populations are targeted with health promoting messages;
- Fund and support NSP specific staff in secondary NSPs to better engage with their clients in a way that includes health promoting messages;
- Provide funding for NSP provision to ensure that secondary NSPs are able to prioritise access for Aboriginal people who inject drugs;
- Expand the responsibility for the delivery of health promoting messages around BBVs/STIs to the broader health workforce to ensure that these issues remain high on the agenda;
- Provide funding to develop and design effective sexual health promotion strategies through NSPs, including promoting regular screening and testing for STIs;
- Explore options to develop capacity and capabilities for a range of organisations across Victoria who may receive referred Aboriginal people who inject drugs and to facilitate the

development of local partnerships, protocols and referral pathways between mainstream and NSP services;

- Introduce an audit program for all NSPs to review their service design and layout to increase privacy for clients so as to facilitate opportunities for client education and referral in an appropriate environment;
- As per the current review of NSP data collection being undertaken by the Department of Health, develop a minimum data set and common principles for data collection regarding Aboriginal injecting drug use to ensure consistency and enable comparability in data collected.

STIs and BBVs:

- In accordance with the Sixth National HIV Strategy (2010-2013), support NSPs to maintain a focus on HIV prevention including the provision of HIV awareness campaigns and prevention education focusing on risk of infection through sharing of needles and syringes, as well as sexual transmission;
- Develop and fund a range of programs to promote early detection of STIs among Aboriginal people who inject drugs;
- Develop and design effective HCV prevention and education strategies through NSPs, in alignment with the recently released Third National Hepatitis C Strategy (2010 – 2013);
- Continue to encourage NSPs to maintain the provision of condoms and water-based lubricant to clients as part of a broader prevention strategy.

ACCHOs:

- Provide further funding to increase the capacity of organisations working with ACCHOs to assist with the transition to NSP within service delivery;
- Develop and implement a grants regime, including identification of capped costs, to provide incentive grants for ACCHOs seeking to establish NSPs to cover initial implementation costs;
- Provide further funding to organisations working with ACCHOs to provide more intensive 1:1 support in the start-up phase of establishing an NSP. This would include: assistance with operational planning in line with current risk and accreditation processes, policy development, workforce education and training, and provision of financial resources;
- Market ACCHO based NSP services as Safe Sex Programs (SSPs) and provide funding and support for specialist SSP staff to drive the program;

- Create harm reduction specific roles within ACCHOs to build capacity of services to better meet the needs of Aboriginal people who inject drugs;
- Improve the capacity of the Aboriginal community controlled health sector by increasing the number of Aboriginal STI/BBV workers, especially in regional settings. This may include the provision of education, training and support for Aboriginal Health Workers (AHWs) primarily engaged in the delivery of services in sexual health and BBVs as an interim measure whilst a statewide strategy is in development.
- Provide training in the harm reduction sector in the form of a nationally accredited and standardised program;
- Further analyse the support needs of the existing workforce to address burnout and high staff turnover; and
- Further support services to work in a holistic manner which enables them to take into account the impact of the individuals' environment on their health.

Introduction

Background

In 2008, Anex and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) signed a memorandum of understanding outlining an intent to work together to improve health outcomes for Aboriginal Victorians – and particularly those who inject drugs.

VACCHO is the peak body for Aboriginal Community Controlled Health Organisations (ACCHOs) in Victoria. Anex is a not-for-profit, peak body that works to reduce the harms associated with drug use, particularly injecting drug use.

Of particular concern to both VACCHO and Anex are the high levels and spread of blood-borne viruses (BBVs) such as HIV and HCV within Aboriginal¹ communities. VACCHO and Anex are undertaking a broad range of activities to identify and address BBVs/STIs in Aboriginal communities.

Victorian Government context

In order to address an increase in HIV notifications in Victoria, the State Government, through the Department of Health's (DH) HIV Prevention Taskforce, provided funding to a number of prevention programs and projects.

VACCHO and Anex received funding as part of this strategy. The project entitled *Action Research - Addressing HIV risks related to injecting drug use in Victorian Aboriginal Communities*, aimed to improve the health of Aboriginal Victorians, particularly those who inject drugs, in relation to BBV/STIs including HIV. It aimed to do this through identifying barriers to safer injecting drug use and safer sex. Once these barriers were identified, strategies were developed to effectively address these barriers and improve access to harm reduction and sexual health services.

The objectives of the work conducted were to provide meaningful responses to:

- Ongoing and emerging trends in Aboriginal drug use, particularly injecting drug use; and
- The associated harms to individuals, families and communities.

Associated projects and programs funded by DH were:

- Community Engagement Program;

¹ VACCHO and Anex would like to acknowledge that although we use the word Aboriginal throughout the document we are referring to both Aboriginal and Torres Strait Islander people and Communities in Victoria. In March 2009, a VACCHO members meeting was held and it was decided that the use of the word "Aboriginal" was preferred over "Aboriginal and Torres Strait Islander" when in Victoria.

- Rural and Regional Community Engagement Program;
- Community Development – sexual adventurism: gay men and HIV/Hepatitis C/STI Risk Program;
- Action Research with sex workers in unregulated industry;
- Access and Equity Project – to increase NSP access and awareness of BBV for current Aboriginal people who inject drugs; and
- Action research into addressing HIV risks related to injecting drug use in Aboriginal Communities.

Literature Review

A literature review was undertaken to provide information about the risk of HIV infection and transmission among Victorian Aboriginal people who inject drugs, as well as behaviours that may increase that risk, including barriers to accessing Needle and Syringe Programs (NSPs). This literature review process has benefited tremendously from work completed within the context of a related project commissioned by the ANCD².

Rates of injecting drug use amongst Aboriginal Australians

The illegal nature of injecting drug use presents a challenge to reliably assessing its prevalence, due to a reliance on self-identification as an injecting drug user (IDU). This is certainly true amongst the general population, but may be further compounded within the Aboriginal population, who may experience distrust of government and research bodies due to historical precedents (VicHealth, 2000). Furthermore, the shame and stigma that may be associated with injecting drug use presents challenges to service providers accessing people who inject drugs. This may mean people who inject drugs may not self-identify, and responses to questions pertaining to injecting drug use practices may not be wholly reliable (Edwards, Frances & Lehmann, 1998; Meyerhoff, 2001). Within Aboriginal communities, IDUs may hide their use of injecting drugs from family or Community, or may become isolated from the Community (Edwards, Frances & Lehmann, 1998), and therefore may be even more challenging to access.

Given the challenges and limitations in assessing the prevalence of injecting drug use generally and, in particular, within the population of Aboriginal Australians, there does not seem to be a clear response to the question of prevalence of Aboriginal people who inject drugs provided by current literature. However, the available evidence suggests that the prevalence of injecting drug use is likely to be considerably higher amongst the Aboriginal Australian population than it is amongst the general population, and to have increased over the years (Gray, 2005; Gray & Morfitt, 1996). The evidence also suggests that prevalence may vary significantly between different Aboriginal communities (Perkins et al., 1994).

There are several ongoing studies which monitor trends and patterns in substance use in Australia. In the most recent iteration of the Illicit Drug Reporting System (IDRS), 15% of the total sample of 909 self-identified regular injecting drug users also identified as Aboriginal or Torres Strait Islander (ATSI)

² **ANCD Project**

Anex and the National Aboriginal Community Controlled Health Organisation (NACCHO) have partnered on a project funded by the Australian National Council on Drugs (ANCD). The aim of the project is to map out a national picture of injecting drug use (IDU) amongst Aboriginal Australians in order to compile the necessary evidence base on which to build future work. The project involves an extensive review of the literature, as well as consultations with Aboriginal health and AOD services providers in different Australian jurisdictions. The final report for this project is currently in draft form and is therefore yet to be published.

(Black et al., 2008). This proportion varied across states and territories: 24% in NSW; 24% in QLD; 21% in the NT; 14% in TAS; 11% in the ACT; 9% in SA; 7% in WA; and 5% in VIC (Black et al., 2008). This may be an indication of a relatively higher prevalence of injecting drug use amongst Aboriginal Australians in some areas, or it may simply represent more effective engagement and recruitment of Aboriginal people who inject drugs in these areas.

In the most recent iteration of the Australian Needle and Syringe Program Survey (ANSPS), 11% of the 2007 sample of over 1900 NSP service users identified as Aboriginal or Torres Strait Islander (NCHECR, 2008). This is up from 10% in 2005, 8% in 2003 (NCHECR, 2008), 8% in 2001 and 5% in 1995 (NCHECR, 2003). This steady upward trend has not been analysed for statistical significance, however, the increasing proportion of Aboriginal people who inject drugs among all IDUs surveyed may be indicative of an increase in the prevalence of injecting drug use amongst Aboriginal Australians, or it may be related to increased engagement and recruitment of Aboriginal people who inject drugs through NSPs.

HIV rates amongst Aboriginal Australians

Injecting drug use is only one risk factor for HIV. Owing largely to the comprehensive introduction of NSPs across Australia, the rate of HIV amongst IDUs in general has remained low (Health Outcomes International [HOI], 2002). While the incidence of HIV amongst Aboriginal Australians has remained stable over recent years, and perhaps even declined slightly, an unsettling trend has been witnessed in the pattern of transmission (NCHECR, 2007). While transmission has primarily been through sexual contact between men who have sex with men in the general population, a higher proportion of transmission amongst Aboriginal Australians occurs through injecting drug use (NCHECR, 2007). Amongst non-Aboriginal cases of HIV, only 3% of new cases are amongst IDUs, and 4% are amongst men who have sex with men and also inject drugs (NCHECR, 2007). Amongst Aboriginal cases the proportions are 18% and 8%, respectively (NCHECR, 2007). The proportion of cases transmitted via heterosexual contact is also much higher amongst Aboriginal Australians at 34% compared with 19% among non- Aboriginal people.

BBV and STI rates amongst Aboriginal Australians

National data on HCV notifications reveal that, while Aboriginal people make up only 2.4% of the Australian population, they account for 8.3% of persons living with HCV (Hepatitis Australia, 2007). It is estimated that some 16,000 Aboriginal people are living with chronic HCV (McNally & Latham, 2009). In SA, WA and NT, Aboriginal Australians account for 10% of all new notifications (Hepatitis Australia, 2007). However, it is also noted that up to two thirds of new notifications fail to record Aboriginal status (Hepatitis Australia, 2007).

The rate of newly diagnosed cases of HCV amongst Aboriginal Australians increased by 34% between 2002 and 2006 (NCHECR, 2007). This may be indicative of increases in injecting drug use, but may also reflect improvements in testing amongst this population. Nonetheless, in the same time period, the rate of newly diagnosed cases amongst the general population of Australians remained stable (NCHECR, 2007).

The Well Person's Health Check (WPHC) is a "community based health assessment program designed to provide education, early detection and treatment for a range of health issues, including STIs and BBVs" (The Victorian Well Person's Health Check Report Sexual Health, 2003). Although dated, the WPHC provides useful data on the rates of BBVs and STIs among Aboriginal and Torres Strait Islander people in Victoria. The WPHC tested 1446 people. The results provided useful data on the rates of BBVs and STIs among Aboriginal Australians in Victoria, showing that 13.3% of participants tested positive for hepatitis C. The prevalence of HCV was greatest among males aged between 21 and 30 where 36% were found to be HCV positive.

In the same study 12 people had recently acquired hepatitis B, and 13.74% had previously been exposed to the virus. None of the participants tested positive for HIV (The Victorian Well Person's Health Check Report Sexual Health, 2003).

The incidence of hepatitis B (HBV) has remained relatively low amongst non-Aboriginal Australians (NCHECR, 2007). However, since 2002, there has been an increase in the number of newly diagnosed cases amongst Aboriginal and Torres Strait Islander people, despite vaccination programs (NCHECR, 2007). In 2008, there were a total of 246 new notifications of hepatitis B in Australia and Aboriginal and Torres Strait Islander people represented eight per cent (20) of these cases (NCHECR, 2009)

Issues and barriers to access

Several barriers to Aboriginal people who inject drugs accessing existing services are commonly noted in the literature. These issues are often interrelated, and include:

- **A lack of cultural sensitivity** - It is commonly noted that Aboriginal people may find mainstream services culturally inappropriate or insensitive to their needs (Edwards, Frances and Lehmann, 1998; Holly, 2001; Meyerhoff, 2001; MCDS, 2006). Furthermore, some have argued that mainstream harm reduction strategies are not always transferrable to Aboriginal communities (Gray and Morfitt, 1996; van der Sterren, Anderson and Thorpe, 2006).
- **Confidentiality** - The literature notes issues and concerns related to the potential lack of confidentiality or anonymity for Aboriginal people who inject drugs in accessing harm reduction services, for fear of being identified as an IDU (Day et al., 2006; Edwards, Frances and Lehmann, 1998; Holly, 2001; Meyerhoff, 2000). These concerns extend to both mainstream and Aboriginal specific services (Holly and Shoobridge, 2004; Larson, Shannon and Eldridge, 1999; Shoobridge et al., 2000).
- **Shame and Discrimination** - Many Aboriginal people may not access services because of the potential for or experiences of discrimination (Day et al., 2006; Gray et al., 2001; Holly and Shoobridge, 2004). This may occur in services that specifically provide treatment for drug users (Day et al., 2006). Meyerhoff (2001) notes that many staff in mainstream services claim that they prefer to refer Aboriginal people who inject drugs to Aboriginal specific services. This may be perceived by Aboriginal clients as discriminatory.

- **Physical Barriers** - A real barrier to successful interventions may be that services are difficult to access (Day et al., 2006; Holly and Shoobridge, 2004). Physical barriers to services may include their geographic location and their hours of operation.

Aim

The overarching aim of the project was to improve the health of Aboriginal Victorians, particularly those who inject drugs, in relation to BBVs/STIs including HIV. In order to achieve this aim, the project partners set out to:

- Identify HIV incidence, prevalence and associated transmission risk in Victorian Aboriginal people who inject drugs;
- Identify barriers to safer injecting drug use and safer sex;
- Develop strategies to effectively address these barriers and improve access to harm reduction strategies and sexual health services, including reducing the stigma associated with injecting drug use, BBVs and STIs;
- Work with service providers to reflect upon the efficacy of said strategies; and
- Build the skills and expertise of service providers to work effectively and appropriately, and in the case of mainstream service providers, in a culturally sensitive way with Aboriginal people who inject drugs.

Activities undertaken

A mixed methods approach was employed to gather both qualitative and quantitative data. This ensured all stakeholders were adequately and comprehensively consulted and acknowledged. The project partners undertook the following activities:

- Convened a Project Advisory Group;
- Submitted an Ethics Submission to DH;
- Conducted a Literature Review;
- Conducted Service Provider Consultations;
- Conducted interviews with Aboriginal people who inject drugs; and
- Conducted focus groups.

Project Advisory Group

The first step undertaken by the project partners was to convene a Project Advisory Group (PAG), which was comprised of individuals with a high level of knowledge, experience and expertise in matters relating to illicit drug use and its effects on Aboriginal populations. Members of the PAG were drawn from ACCHOs, mainstream health services and research organisations and they all identified as Aboriginal or Torres Strait Islander.

The role of the PAG was to provide advice and guidance on all aspects of the project, especially in regard to sensitivities that may surround the topic of Aboriginal injecting drug use. The group also ensured the project was undertaken in a culturally sensitive manner and provided advice on ethical considerations in reporting the information collected.

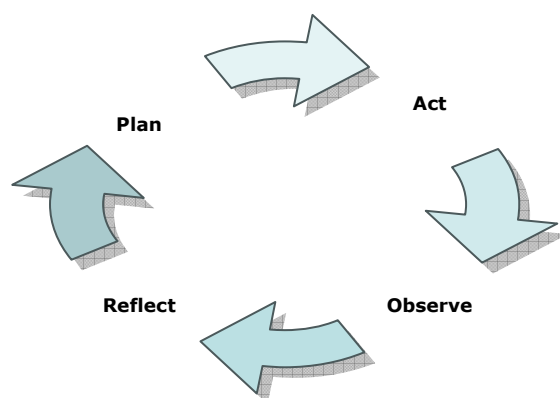
Ethics Submission

Given the sensitivity of this project, and the proposed methodological approach, the project partners first sought approval from the DH's Human Research Ethics Committee (HREC). This was particularly important given the cultural issues associated with injecting drug use within some Aboriginal communities. Furthermore, the project proposal was guided by VACCHO's Ethics Process in keeping with National Health & Medical Research Council's *Values and Ethics Guidelines*. Approval was received from the HREC in May 2009.

Methodology

Action Research

An action research approach was used within this project. This approach was selected based on its ability to offer a valuable yet practical methodology for intervention, development and change within communities. It seeks to improve a community's potential for better health outcomes and wellbeing through the implementation of a cycle of planning, taking action, observing and critical reflection.



Effective action research requires involvement of the very people who will be affected by any social change and extension of knowledge that may occur throughout all phases of the action research process. Consequently, members of the Aboriginal injecting drug user Community and service providers from ACCHOs and mainstream health services were consulted directly and were actively involved in the development of strategies and solutions. Therefore, they were integral to the success of this project.

In-depth interviewing

The technique of in-depth interviewing as a form of qualitative research was used within the consultation process with both Aboriginal people who inject drugs and Service Providers. There are many reasons why one-on-one in depth-interviews are preferred over other methods of collecting data such as focus groups or questionnaires, including:

- In-depth interviews allow for better quality data to be collected by exploring participants' beliefs and attitudes towards a topic;
- There is greater depth of data collected because interviewers are able to explore in greater detail participants responses to questions;
- Participants are more likely to engage in an open discussion than in a group setting; and
- More information is collected through one-on-one in-depth interviewing (Wallace Foundation, undated).

Both action research principles and in-depth interviewing have been enacted in the processes described below.

Service Provider Consultations

The service provider consultations sought to achieve the following:

- Determine percentage of Aboriginal clients accessing NSPs;
- Explore local issues and concerns relating to Aboriginal people who inject drugs;
- Identify gaps in service delivery;
- Identify pre-existing networks and partnerships; and
- Identify previously successful and unsuccessful health promotion and harm reduction campaigns relating to BBV/STI prevention in Aboriginal communities.

Prior to conducting the service provider consultations, the project partners attended a number of stakeholder meetings to obtain support and endorsement for the project. On the 25th of March 2009, Anex and VACCHO attended the ACCHO managers and area representatives meeting in Echuca. This meeting was attended by managers from all ACCHOs across regional Victoria and metropolitan Melbourne. On the 29th of May 2009 project partners attended Telkaya's network meeting at the Aborigines Advancement League (AAL) office in Northcote. Telkaya is the Victorian Aboriginal Drug and Alcohol Network and is made up of AOD workers from ACCHOs from across the State.

Project partners provided those present at both meetings with information on the VACCHO/Anex partnership. Project partners presented on activities currently being undertaken, including the *Action Research - Addressing HIV risks related to injecting drug use in Victorian Aboriginal Communities*.

Attending this meeting allowed Anex and VACCHO to provide detailed information to key stakeholders prior to the commencement of service provider consultations and interviews with Aboriginal people who inject drugs. The project partners received positive feedback from the members present indicating the project was well received and supported by key stakeholders. This in turn helped to strengthen the projects' sustainability and long term goals of improving the health of Aboriginal Victorians, particularly those who inject drugs, in relation to BBVs/STIs including HIV.

Service providers were then primarily recruited through telephone contact and/or e-mail and were invited to participate in either one-on-one or group consultations. The project partners were aware of relevant organisations to invite to participate in the consultations based on pre-existing relationships they had with these organisations. Organisations were then asked to nominate individuals who work with Aboriginal people who inject drugs. Service providers were recruited from the following services: NSPs, mainstream health services, ACCHOs, and AOD services.

A Project Information sheet and consent form was mailed/mailed to service providers who agreed to participate in the consultations prior to the interview/group consultations (see Appendix 1).

The project partners conducted a combination of one-on-one and group consultations with staff from 18 mainstream health services and 23 ACCHOs in regional and metropolitan Victoria, namely:

- **Melbourne** – and surrounding areas
- **Bairnsdale** – Sale – Morwell – Orbost – Lake Tyers
- **Mildura** – Robinvale – Swan Hill
- **Shepparton** – Wodonga - Echuca
- **Bendigo** – Ballarat
- **Geelong** – Warrnambool – Heywood – Portland – Halls Gap – Horsham

Client Consultations

The purpose of the client consultations was to confirm previously cited reasons and/or ascertain previously unidentified reasons for increased HIV risk, including barriers to practising safe injecting drug use and safer sex. This included identifying gaps in knowledge regarding HIV prevention, gaps in knowledge of safer using and safer sex practices and barriers to accessing new injecting equipment and/or condoms/dental dams. This information was then used to guide and determine appropriately targeted strategies to support Aboriginal people who inject drugs and the services they access to minimise HIV risk.

To best ascertain the potential barriers faced by Aboriginal people who inject drugs in regard to safer injecting drug use and safe sex, and to accrue accurate and informative data, the project partners aimed to interview a total of 75 Aboriginal people who inject drugs (with a minimum of 50) state wide.

The project partners employed a variety of recruitment strategies, including those considered culturally appropriate to the Aboriginal Community. In the first instance, the project partners enlisted the assistance of service providers at mainstream health services, AOD agencies and ACCHOs, with which Anex and VACCHO have pre-existing working relationships. Data on Victorian NSPs that have contact with Aboriginal people who inject drugs, gathered through an internet survey of Victorian NSPs, was also used as a starting point for recruitment.

Service providers were provided with copies of a flyer and business cards containing brief information about the research and how to participate (see Appendix 2 and 3 respectively). These flyers were posted in recruiting organisations and potential participants were able to contact the project partners directly, or ask for assistance from service providers to contact the project partners. Contact was made via a dedicated 1800 number, which was located at Anex (instead of VACCHO) due to possible concerns around anonymity.

The flyers and business cards also contained information on the selection criteria for potential participants. In order to participate in the consultations, participants had to:

- Have injected drugs in the last two years;

- Be over 18 years old;
- Identify as Aboriginal or Torres Strait Islander or both; and
- Be willing and able to provide informed consent.

The project partners also employed 'snowballing' techniques to recruit other participants into the research project, whereby clients who had taken part in the consultations were asked to inform other participants about the opportunity to take part in the consultations.

Those identified as appropriate and interested in participating then took part in a 30 minute in-depth interview (either face to face or telephone). The interview was semi-structured and sought to elicit responses about participants' knowledge on safe injecting, safer sex and BBVs/STIs. Interviews were conducted by project staff from either Anex or VACCHO. Interviewees were remunerated for their time and contribution. In accordance with DH's Human Research Ethics Committee, participants were provided with an information sheet and were requested to provide informed consent (see Appendix 4).

A total of 73 clients from rural, regional and metropolitan Victoria participated in the consultations. Participants were recruited from areas such as Mildura, Shepparton, Bairnsdale, Sale, Geelong, Warrnambool, Corio, Melbourne and Dandenong.

Focus Groups

Three focus groups were held in regional and metropolitan Victoria, namely Wodonga, Ballarat and Melbourne. These locations were decided on based on previous work that had been undertaken by the project partners as part of the MOU. Participants from surrounding areas attended focus groups nearest to them. The focus groups were advertised on a number of electronic forums including the NSPForum (a national electronic forum set up to facilitate daily information sharing, problem solving and networking within the harm reduction sector – hosted by Anex), VAADA, ADCA e-list and Telkaya. The forums were also advertised on the Yiaga ba Wadamba website developed by the project partners for this project, which also served as a marketing opportunity for the website. In addition, the project partners sent personal invitations to service providers who had been consulted as part of the service provider consultations.

The purpose of the focus groups was to present the findings of the initial consultations to service providers and propose a plan of action that would be effective in addressing these findings. The focus groups also sought to increase the understanding of how change in actions and practices can mutually benefit both Aboriginal people who inject drugs and service providers. By conducting the focus groups, the project partners aimed to:

- Develop strategies to effectively promote access to NSPs and other health services;
- Develop strategies to promote safer using among Aboriginal people who inject drugs; and
- Develop strategies to promote safer sex practices among Aboriginal people who inject drugs.

The focus groups were attended by 23 key stakeholders from a range of services including ACCHOs, mainstream health services, youth services, family services, the Australian Drug Foundation, Hepatitis C Victoria and AOD agencies. Focus group participants also came from New South Wales (NSW). Some of the key stakeholders who attended the focus groups had participated in the first round of consultations.

The project partners presented on the findings of the consultations with Aboriginal people who inject drugs, namely issues affecting access to services and misinformation regarding safe injecting, safer sex and BBVs/STIs. Service providers were then given the opportunity to advise and comment on proposed strategies to address the issues and misinformation that was identified through client consultations.

Website/Message Board

A website was identified by project partners as a key component of the project as a way of providing support and resources for services who work with Aboriginal people who inject drugs. The website consists of information on project partners including the MOU (with links to VACCHO and Anex websites), current projects (including PDF downloads with detailed information on projects), contact details and information on how to get involved (including dates and times of consultations and focus groups that were conducted as part of this project).

The website name – Yiaga ba Wadamba (Find and Renew), a Wurundjeri word, was provided by the Victorian Aboriginal Language Service

Findings

Demographics

The project partners consulted with a total of 73 Aboriginal people who inject drugs from regional, rural and metropolitan Victoria. As part of a mid-project reflection and review, the project partners determined it would be useful to collect data on client demographics including age, gender, primary drug injected, length of injecting (see table below). Therefore the data shown below represents information collected from 53 of the 73 participants.

The recruitment process attracted relatively older clients, with the average age for both male and female clients being 35. More males than females participated in the client interviews. Most of the clients interviewed for the project reported they had been injecting for between 5 and 10 years and the drugs most commonly injected were heroin and amphetamines.

	Male	Female
Clients	34	19
Average Age	35	35
Length of injecting (mode)	5-10years	5-10years
Rural	15	8
Metropolitan	19	11
Primary drug injected	Amphetamines, Heroin	Amphetamines, Heroin

Injecting drug use

Access to services

The consultation process was designed to identify where clients go to access sterile injecting equipment. According to the literature, several barriers exist that may prevent Aboriginal people who inject drugs from accessing harm reduction services, including NSPs. These have been discussed in the literature review above.

The majority of clients interviewed for the project reported they accessed sterile injecting equipment from NSPs located in mainstream health services. (It is important to note that none of the ACCHOs in Victoria currently provide sterile injecting equipment. Four ACCHOs are authorised NSPs but have never commenced services). Clients interviewed in metropolitan Victoria were more likely to frequent mainstream NSPs compared with those in regional areas. Clients from smaller regional areas were concerned about identifying as an IDU to both service providers and the Community in general, therefore they tended to access sterile injecting equipment from other sources (as discussed below).

Pharmacies were reported as the second most common source of sterile injecting equipment. Clients in regional areas in particular tended to access sterile equipment from pharmacies compared with clients in metropolitan Victoria. This was also because clients in regional areas appeared to be more concerned about identifying as an IDU and pharmacies are perceived as being able to offer anonymity.

"I just normally go to a chemist I don't really go to needle exchange places where I get seen"

Clients in regional areas also reported they often access sterile injecting equipment from hospital emergency departments. Some clients reported they prefer hospital emergency departments because they are open after hours and are able to offer a discreet service. Clients living in border towns also preferred accessing sterile equipment from hospital syringe vending machines located in other (non-Victorian) states.

"That's the thing, you probably go to the hospital, because you have got a thing up there a vending machine."

Due to the fear of shame and stigma associated with injecting drug use, some of the clients interviewed for the project reported they were reluctant to access any services for sterile injecting equipment. Therefore they relied on other IDUs to access sterile injecting equipment for them – these people were described as "having no shame." This was more common with clients interviewed from regional areas, who expressed concerns about identifying as an IDU in smaller communities. However, relying on someone else for injecting equipment may result in clients not always having access to sterile injecting equipment when they need it and they may resort to sharing or re-using their old needles. Clients also expressed concern about whether or not injecting equipment supplied to them by other IDUs would be sterile.

"One of my mates, he had no shame, he would just go down, he would go to the needle exchange and get like big boxes of fifties and stuff, so you know what I mean, we all got to share that which was pretty good."

"...I was embarrassed at first getting them, even would prefer someone else to go in and get them, because you don't want the workers to recognise your face, or to point the finger at you, 'that person is a user'..."

"Yeah like um, when I go to the needle exchange I know, I know for sure it's clean but if I go to someone's room um, I got that slight, you know, that slight hesitation...but the err, um, the drug overrides that sometimes."

Public transport, distance, co-located services

Other issues identified by the project partners affecting access to services that provide sterile injecting equipment include distances travelled to services, the availability of public transport, opening hours and co-location with other services such as welfare services.

Clients interviewed for the project reported they often experience difficulty in accessing sterile injecting equipment at certain times of the day or times of the week. This is related to NSP opening times. Weekends, public holidays and after hours are particularly difficult times/days of the week to access sterile injecting equipment, with clients reporting they may resort to sharing injecting equipment or re-using their old needles. Clients in Melbourne reported they experienced more difficulty in accessing sterile injecting equipment after hours and weekends compared with their regional counterparts who are often able to access sterile equipment 24 hours a day from hospital emergency departments.

Clients from regional areas reported they often have to travel long distances in order to access sterile injecting equipment. Coupled with a lack of reliable public transport in most regional areas, clients reported they are not always able to access these services and therefore may resort to sharing injecting equipment or re-using their old needles. Clients living in Melbourne reported they are often unable to access the only service that is open 24 hours, that is the NSP at St. Kilda Crisis Centre, due to the unavailability of public transport after hours.

“When we’re at home usually, when we’re at home and we’ve got gear on us but we don’t have any needles, cause you know we live a bit far out, so to come in on public transport just for a fit we just can’t be bothered and but we’ll share only with each other, not with anybody else”

Some clients reported they may be reluctant to access NSPs in community health services because they may be co-located with other services, such as welfare. This may act as a deterrent to accessing sterile injecting equipment from these services due to concerns around identifying as an IDU and the possible consequences for parents and families.

“They have made it now where I live in (area named), you used to go to the hospital, but now you have to go to (community health centre named), and that’s also where welfare is, so I won’t go in there because I...have (had) trouble with welfare before, so I can only get clean ones after hours, or a weekend.”

Shame and stigma

The project partners explored the issue of shame and stigma around injecting drug use. The biggest concern with clients interviewed for the project was their family’s negative reaction towards their injecting drug use behaviour. As a result clients tended to hide their drug use from family members, elders and the Community in general. Clients reported they feared being judged and stigmatised within the family.

“Family can be um really um judgemental like they can tell which ones are the ones that are using so they won’t really talk to ya, you’d be banned.”

“We’d get a belting from our family if they knew we did stuff like this. They’d hurt us.”

“See a lot of with the Aboriginal people, a lot has got to do with the elders and respect, like they feel ashamed, so because the elders judge you know they’re really against drugs and all that.”

As previously mentioned, concerns around the stigma and shame associated with identifying as an IDU have an impact on where clients go to access sterile injecting equipment. Clients interviewed for the project reported they were more likely to access mainstream health services than ACCHOs, as they were concerned about being recognised by family members who may access the same services or may be employed in the service.

“...I went into the health clinic once and my auntie was down for a doctor’s appointment so I had to come up with another excuse for why I was there you know what I mean, I was so embarrassed so um yeah. I ended up walking out and I didn’t end up getting any so um situations like that you know that make it hard you don’t want to be recognised by anyone by family members or anything do yeah”

Clients also reported they preferred not to be seen in the company of other IDUs, for fear of being identified as an IDU.

“Certain company, because basically if you have certain people around you that are well known for it, so basically you get a title put on you because are hanging around that person and what not, and getting stuff for them, so you’re almost classed as being one of them.”

Injecting practices

Initiation into injecting

Some of the clients interviewed for the project discussed issues around initiation into injecting. Of those clients who discussed this issue, the majority were female and reported that it was their male sexual partners who had initiated them into injecting.

“Well when I first tried heroin I was smoking it and I found that it wasn’t doing anything for me in the first four weeks, so then my ex partner was injecting and I said to him ‘I want to try that, I want to see how that works’ and he goes ‘do you really want to’ cause I had needles and um so then he started injecting me”

Older IDUs were also often reported as having initiated clients into injecting drug use as well as providing information on safer injecting. This is especially common in prison settings, where clients reported that older prisoners would source the drugs and demonstrate how to inject the drugs.

“Yeah. They were older, that’s how I started, I had older friends when I was a teenager, I started when I was about 15 or something”

“Like I got taught by old Pentridge criminals and all that... you know they’re the ones that showed me, they’re the ones that gave me my first taste of it.”

Injecting by others

Throughout the consultations, a number of clients reported they often get other IDUs to inject the drug for them. This practice was commonly reported by female IDUs, with their male sexual partners injecting the drugs for them. Clients also reported that their close friends often assist in the injecting process. However, clients expressed concern about the risks associated with allowing other people to inject, including missed veins and the risk of transmission of BBVs.

“I’ve got two people that I trust, um, I’ve tried other people but they’ve like seriously missed my veins and um bruised me up real bad so these two I can like have a hit and there won’t be a bruise or a mark from these guys....the other person was like my best mate and the other one was my boyfriend...”

“Yeah that’s right I’ve got quite a few people, um, that do it and like um what I find a bit, I don’t know, the word for it, I might use disturbing, is when they inject me and they use their finger...yeah and if there is a bit of blood they use a finger instead of a swab.”

Sharing injecting equipment

All of the clients interviewed for the project were aware of the risk of BBV transmission associated with sharing needles. However, some of them reported that in spite of being aware of these risks, they had shared needles in the past for a variety of reasons. The nature of injecting drug use is such that it is difficult for clients to plan ahead and collect sterile needles. Clients also reported they may be hesitant to carry sterile needles for fear of being searched by the police. This means they may end up sharing needles available at the time. Clients also discussed occasions where they had shared needles because they were unable to wait to inject the drug, especially when they were experiencing withdrawal symptoms.

“You shouldn’t share your tourniquet, you shouldn’t share your needle, you shouldn’t share your spoon, none of it, I know that and I think everybody sort of knows it, but whenever you get desperate it all goes out the window, when you are shaky and achy and you’re vomiting and you trust other people too where you shouldn’t.”

“Yeah, it’s because the equipment is not available, or because you have got the stuff right there and then you have had to wait so long for it, you don’t want to wait another half an hour for these people to come, you don’t even know if they are going to meet you at the front or at the side, or if they will meet you, it’s more wait, no have it, you have been waiting for so long.”

“Yeah they don’t have the equipment and obviously they have tagged along with someone else to go and score with. ‘Just let me borrow your fit brother.’ Or something like that, you know. If there’s fits available of course they will use them”

“Yeah, I have done that once, in sharing....he put a needle in his arm and drew blood and said ‘put it in’, I had it, I was hanging right out...so I had that and that was it, that’s the only time I have ever done it.”

The project partners also sought to investigate whether clients interviewed for the project would share injecting equipment other than needles, such as mixing spoons, tourniquets and filters. Again, the majority of clients were aware of the risk of transmission of BBVs associated with sharing injecting equipment. However, clients reported there had been occasions where they had shared injecting equipment, especially when using in a group.

“I don’t think it’s a good idea to share spoons you know but um we have done that hey...like if someone else was chucking in, but usually no yeah no.”

There were some clients who reported they shared injecting equipment as they believed that the risk of transmission of BBVs was low.

“In my books you’re allowed to share your tourniquets because there is really nothing on them touching each other, they are only touching the skin...and your spoons you can wash them under a tap, or you know you can use anything on them to clean them up and make sure they’re clean.”

Sharing injecting equipment with sexual partners

The consultation process was designed to elicit responses regarding the people with whom clients would be most comfortable sharing injecting equipment. Most clients interviewed for the project reported they preferred to share injecting equipment with their sexual partners. Clients reported that because they exchange sexual fluids, they believed they would have been exposed to any BBVs/STIs their partner may have. Intimacy and trust were also cited as reasons for sharing with sexual partners. Clients also reported they believed they were less likely to contract a BBV by sharing with someone familiar to them, such as a sexual partner, than with IDUs they are unfamiliar with.

“Yeah, um, I believe, with the partner um, if she’s got anything uh she’s obviously going to give it to me, so that’s basically the bottom line you can’t get out of it.”

Interviewer: *Is there anyone that you’d be comfortable sharing with like say your partner or a friend?*

Interviewee: *Yeah I’d rather my partner*

Interviewer: *Is there a reason why you’re more comfortable sharing with your partner?*

Interviewee: *Cause I love him*

However, in spite of sharing with sexual partners as a means of possibly reducing the risk of transmission of BBVs, some clients reported they had contracted a BBV through sharing with their partner.

Interviewee: *Yeah, but I shared with my partner. Yeah and I got hep C from him.*

Interviewer: *Did you know he was hep C positive.*

Interviewee: *No*

Interviewer: *And he didn't tell you*

Interviewee: *No, I don't actually think he knew. Because I just thought I'm sleeping with him and I just thought that whatever he's got, I got. You know what I mean? I didn't know...it was blood to blood contact or anything like that. I've learnt it all afterwards.*

According to clients interviewed for the project, sharing with sexual partners is not only seen as a way of reducing the risk of transmission of BBVs between partners but also reducing the risk of transmission to the wider Community.

"Because I believe that being partners (you are) both in it (injecting) together and instead of spreading that out to the wider community and sharing around with other people and spread it more and more"

Other than sexual partners, clients interviewed for the project reported they would share injecting equipment with close friends and family members. Clients reported they were least likely to share with IDUs not known to them.

Re-using injecting equipment and cleaning injecting equipment

Clients interviewed for the project discussed some of the strategies they use when they are unable to access sterile injecting equipment. Clients reported they would clean and re-use one of their old needles first before sharing needles with other IDUs.

"Yep. I basically I sort of, if I didn't have access to clean ones I usually had my own. At some point in time you know I had a few in the cupboard or something that I'd previously use (d) and I'd you know try to clean them out..."

Despite being aware of the accepted best practice of cleaning needles, clients interviewed for the project reported they preferred to use boiling water to clean their old needles. Others reported they draw up the liquid from saline wipes to clean their old needles.

"If I have used it, I might have normally boiled it in boiling water for some time"

"I've reused one of my own needles only once because I never had any fresh ones but I sterilised that properly before using it in boiling hot water"

However, clients admitted that there may be occasions where they are unable to determine ownership of needles, especially where people use and dispose of their needles in a group. This may place clients at risk of transmission of a BBV should they end up re-using a needle that does not belong to them.

"Yeah, yeah and that's silly you know cause they end up going and re-using their old equipment and they get it mixed up and it could be someone else's."

Clients interviewed for the project also discussed some negative experiences resulting from re-using their own needles. Abscesses, bacterial infections and collapsed veins were some of the commonly reported consequences resulting from the re-use of old injecting equipment.

"I used the same needle all the time and I ended up getting an infection that's how come this (vein) collapsed, because it got infected."

"Yes there's been a lot of times and I've always used blunt ones, one time I used a blunt one but me arm got infected and stuff, that's when I spent three months in hospital."

Strategies for engaging with Aboriginal people who inject drugs

Clients interviewed for the project discussed strategies that services could employ to target Aboriginal people who inject drugs around safer injecting. Clients suggested that drug and alcohol education should be targeted at young people in schools because they are often exposed to injecting drug use early, either at home or within the Community.

"Oh it's gotta be education. And whether we start it in schools, maybe we should."

"The kids know, the kids aren't silly, they know you know I've got a niece that uses speed, her daughter knows she's not stupid."

Clients also suggested ways in which services could promote access to NSPs and other health services, as well as target messages around safer injecting and safer sex. Strategies such as increased advertising through posters, flyers or pamphlets were suggested by clients interviewed for the project. Clients suggested that these posters should also be displayed in areas where IDUs are known to frequent such as parks and laneways. The use of media such as radio and TV was reported as being particularly effective modes of message delivery.

"...we need to be able to reach out beyond our own Community and health services to be able to get the equipment and that, that we need at the time, um and I think that we need to be made more aware of other services out there that are more accessible for us in our own areas. Maybe you could have more groups or flyers, posters for the health services and things like that."

“That’s all I can think of maybe even some ads on TV cause there’s not anything directed at the Aboriginal Community...one of our health services called (name supplied) put out an ad on their local TV...it was really good at getting people to come in for health checks.”

Outreach as a model of service provision was suggested by clients interviewed for the project. Clients suggested that workers should go out into the Community to engage with Aboriginal people who inject drugs and to provide sterile injecting equipment. Clients also suggested that ACCHOs should employ NSP-specific workers to provide sterile injecting equipment and harm reduction information. Clients reported that IDUs were more likely to build trust with these workers and therefore access ACCHOs around their injecting drug use behaviour.

“But I do think if they (ACCHOs) had some worker, they don’t have a worker, they don’t have a worker or anything that does needle exchange...if they did have someone too, they probably should hand out boxes of hundreds instead of packs of fives and stuff like that so there’s always an abundant supply of clean ones.”

Blood Borne Viruses

Rates of Blood-Borne Viruses

As previously mentioned, the project partners interviewed 73 Aboriginal people who inject drugs in rural, regional and metropolitan Victoria. Although the client consultations did not seek to find out the BBV status of those participating in the project, a significant number of clients interviewed reported they had tested positive for HCV. About a third of the clients interviewed for this project disclosed they were HCV positive. It may be likely that the rate of HCV infection among the clients interviewed was higher, but as stated earlier, the consultations did not seek to find out about the client's BBV status.

Although no clients directly commented on their HIV status, on at least one occasion, discussions with the client alluded to a potentially positive HIV status.

Knowledge about Blood-Borne Viruses

The project partners sought to determine the level of knowledge Aboriginal people who inject drugs possessed regarding BBVs and their transmission risk. The majority of clients interviewed for the project had a basic understanding of BBVs and in particular injecting practices that are likely to place them at greater risk of acquiring a BBV, such as sharing injecting equipment.

However, a significant number of clients interviewed for the project were misinformed regarding the modes of transmission of BBVs. This is discussed in detail below.

Misinformation regarding the mode of transmission of Blood-Borne Viruses

A significant number of clients interviewed for the project were misinformed regarding the modes of transmission of BBVs, particularly HCV. The most commonly reported misinformation regarding HCV transmission included the belief that HCV can be transmitted through sexual contact, food poisoning, from toilet seats, kissing and sharing eating utensils such as knives and forks.

"I learnt about hep C when I caught it, because I caught it through boys and through sex."

"..also orally, kissing a girl"

"You know and start eating off different plates, start using knives and forks with different people."

Clients interviewed for the project also reported that the hepatitis virus could 'grow' in the needle and a number of them believed they had acquired HCV in this manner.

"Cause you can get hep C just from the needle even if it's a clean needle you know so."

"Just from the syringe cause I haven't shared needles and I've got hep C and that's the only thing I can think of it being is from the needle."

“I’ve been diagnosed with hep C a couple of years ago so I don’t know how I would have got that. Considering I didn’t use – share a needle you know what I mean? And the doctor said that it could be from my needle itself”

There was also some misunderstanding regarding the use of the term blood-borne virus. Many clients interviewed for the project reported that they thought the term referred to a virus that is passed onto an infant at birth. This finding highlights the importance of using simple language rather than technical terms when engaging with clients.

“Yeah that’s a bug, when a child has been born with hepatitis C or HIV or something. Yeah?”

“That’s when a child is born with something, I am not sure I am just guessing here. A baby born with HIV or something, that’s what I think.”

Misinformation regarding the different types of Hepatitis

The majority of clients interviewed for the project were aware of the different types of hepatitis, that is hepatitis A, B, C, D and E. However, there was some misunderstanding regarding co-infection with the different types of hepatitis, with some clients reporting a belief that co-infection with all five types of hepatitis would result in an HIV diagnosis.

“Like I heard about it in jail I think (hepatitis) A, B, C, D and E and like we only thought there was hep A and B in jail and then one day a person in the crowd said nah there’s brothers there’s five brothers mate and I was like what do you mean there’s five brother’s mate? He said when you’ve got the five brothers you know what that equals? What? AIDS”

Misinformation regarding the different genotypes of Hepatitis C

A significant number of clients interviewed for the project were unaware of the different genotypes of hepatitis C. As a result, they reported they would be willing to share injecting equipment with other IDUs who are also hepatitis C positive.

“Yeah, maybe a good friend if I know, you know what they’ve got. I have already got hep C, so if they’ve got hep C as well, then I might not feel as bad.”

Sources of information on Blood-Borne Viruses

In addition to determining the level of knowledge Aboriginal people who inject drugs possess regarding BBVs, the project partners also sought to establish where Aboriginal people who inject drugs were accessing information on BBVs.

The majority of clients interviewed for the project reported they had learnt about BBVs from prison. The project partners did not ask any specific questions relating to incarceration but a significant number of clients disclosed they had been to prison. Some clients interviewed for the project reported that BBV education was a mandatory part of their sentence, while others reported that BBV education was routinely provided to all prisoners when first entering prison. Most of the clients who had learnt

about BBVs in prison reported this was the first time they had been taught about BBVs. This indicates that clients may not be accessing health services for BBV information and may have already acquired a BBV prior to entering prison.

Interviewer: *“Where did you learn about or who taught you about BBVs?”*

Interviewee: *“Yeah only in jail, I didn’t know anything about it until I got locked up.”*

“I watched a video up in Queensland when I went to jail and that stuck in my head too.”

Clients interviewed for the project also reported that in some instances they were initiated into injecting by other prisoners and they were the ones who provided information on safer injecting and BBVs.

Interviewer: *“Where did you learn about or who taught you about BBVs?”*

Interviewee: *“Jail...we get pumped into our heads by some of the elders every now and then.”*

The second most common source of information about BBVs according to clients interviewed for the project was other IDUs. Clients reported they had learnt more about injecting and BBVs from other IDUs than from health services. However, some clients interviewed for the project expressed concern about the reliability of information obtained from other IDUs.

“Oh the hepatitis I heard about down here on the street, so I learnt a lot of stuff off the streets. More from the streets than I did from the service.”

“...you get all different opinions about that (hepatitis C) and not til you come to services like this (ACCHO) and they’ve got pamphlets.”

Clients interviewed for the project reported they had also obtained information from both mainstream and Aboriginal health services. However, this was less frequently reported than information obtained whilst in prison or from other IDUs.

“Workers in there say ‘do the right thing, and don’t share this and that, they are always handing out information for us to go wherever.”

“I did a first aid course, also before I used I had a boyfriend that used, and I made sure I knew all about it, because he didn’t...and I was scared about catching something, so I went to the crisis centre in St. Kilda and asked them heaps of questions, and just did lots of reading.”

Other sources of information on BBVs reported by clients interviewed for the project include family members and AOD agencies including rehabilitation centres.

Preferred method of learning

Clients interviewed for the project also discussed some of the preferred ways they had learned about BBVs which helped to retain key messages. The majority of clients reported they preferred the information to come from their peers (either Aboriginal or IDU or both). Peers were regarded as a credible source of information because clients reported they could relate to the peers' life experiences.

"...so when jail was first telling us, we didn't listen, but then we had an ex user come in and speak to us, then we sat up and listened."

"...you can't really talk about something unless you have actually done it, that's the way I look at it."

As discussed in the literature review, there was some level of distrust regarding information that is provided by researchers and/or workers in health services, which may impact on message uptake and retention.

"I would rather have someone that comes from the Community to tell me, not someone, like a professor from university to say 73% of people don't do this, how do they know when they haven't even been to the communities that I have been to, you know what I mean."

"Those people haven't actually been to ...where I come from, and seeing what happens in the mirrors. That's one thing that pisses me off about drug and alcohol workers....not a lot of things they tell you is true, most of it, they wouldn't have a clue."

The use of language was also identified as key in determining how information is received. Clients interviewed for the project reported they preferred information that was delivered in simple, easy to understand language. In terms of written information, clients reported they preferred the use of more pictures and less words.

"I'm gonna sound like a school kid, but more pictures. Um yeah, less like big sophisticated technical words um I know a lot of my mates that are big on like heroin and stuff like they're not gonna know what half the words mean."

"...and a lot of the words they use we can't understand. And there's no need to use all the germs that we are going to catch, you don't need to break it into big words, you can just break it down and we will understand it."

"Yeah he talked at my level, do you know what I mean? He didn't talk in doctor terms."

Clients also discussed the importance of providing information in a respectful manner. Some clients described instances where they did not like the manner in which information had been provided to them and how this had negatively impacted on their ability to retain these messages.

“It’s the way they put it across, if you’re going to put it across to people that use...talk to them, not look down on them, then we listen and then we take it in...”

“...so when jail was first telling us, we didn’t listen, but then we had an ex user come in and speak to us, then we sat up and listened...because it’s the way they spoke, they didn’t speak to us, (they spoke) down to us.”

Motivation for learning about BBVs

The project partners also sought to establish the clients’ motivation to learn about BBVs. The majority of clients interviewed for the project reported they were motivated to seek information on BBVs only after testing positive for BBVs. Clients interviewed for the project reported they were more likely to seek information in this instance from health services as opposed to other IDUs.

“You know if you’ve already got it and you see something at the exchange or at the um methadone clinic, then you might pick it up and have a look.”

Interviewee: *“...because I just thought I’m sleeping with him and I just thought that whatever’s he’s got, I got. You know what I mean? I didn’t know...it was blood to blood contact or anything like that. I’ve learnt it all afterwards.”*

Interviewer: *“Ok, so after you got Hep C that’s when you...”*

Client: *“...looked into it yeah”*

This finding has important considerations for services as it highlights the need to engage with clients early in their injecting career in order to minimise the risk of transmission of BBVs.

Shame and Stigma

The majority of clients interviewed for the project who disclosed they had tested positive for hepatitis C also discussed experiencing feelings of shame and guilt for having acquired a BBV. These feelings of shame and guilt are further compounded by the fact that the BBV is acquired through injecting drug use (Treloar, Hopwood and Loveday, 2002).

“I wouldn’t want to have got anything else because I don’t know how I would cope with it. That was enough, I was in tears with that (hepatitis C). And then trying to tell your husband, and he hasn’t got it, so I have got it, so it’s my fault that he has got it, you know that’s a nightmare.”

“I was totally clean before that, and I feel totally disgusted that I have gotten it (hepatitis C).”

“Maybe if people are a bit more educated on hepatitis and all that, if they knew that it’s more embarrassing to be diagnosed with a disease that you could hardly get rid of...”

Clients also discussed concerns about experiencing discrimination from other Community members as a result of acquiring a BBV, particularly hepatitis C. Again, this stigma and discrimination may be

due to the perception that hepatitis C is a “second-class” disease affecting IDUs (Treloar, Hopwood and Loveday, 2002).

“Cause I don’t want to die and leave my kids or I don’t want to have the name of “Oh she died of um injecting. I don’t want to have that that would be absolute shame for my sons. I want to die with a bit of dignity.”

Safer Sex

The consultation approach was also designed to explore issues around safer sex practices and sexual health knowledge among Aboriginal people who inject drugs. The project partners explored a number of issues regarding safer sex with clients and these are summarised below.

Access to condoms and safer sex information

Clients interviewed for the project reported easy access to safer sex consumables such as condoms from a number of mainstream health services, ACCHOs, chemists, supermarkets, GPs, family members and some public toilets.

However, clients also reported they may feel embarrassed to access condoms and dental dams, especially if they have to come into contact with a worker. Male clients in particular reported they found it difficult to access safer sex consumables from female workers. Clients reported they preferred self-service type models where they are not required to engage with a worker.

“Yeah it’s just like if you’ve got a female working. If she’s sitting at her desk and that and you go up to her and say “can I get some condoms?” you know she’s going to look at you strange.”

The project partners also sought to establish where interviewees had obtained information about safer sex. The majority of clients interviewed for the project reported they had been taught about safer sex in schools.

“I think I learnt about sex in school, Health and Human Relations. Yeah, that’s the only place I really learnt about sex was in school in year nine. I learnt a lot of things, still today, you know that blew my mind that I didn’t know.”

“The school showed us a video where did I come from so they did teach us, in year five they taught us that yeah...”

Family members were also a common source of information regarding safer sex. Most clients interviewed for the project reported that family members such as parents, aunts, uncles and even elders in the Community had provided them with information on safer sex.

“My auntie, because I never really had a mum, she was a bad alcoholic, my auntie actually gave me a book in a brown paper bag, and sort of ‘read this’, got all embarrassed, but I read it, and that’s where I first learnt, I was probably 14.”

“My mum she did by the time I was 13 , condoms were always on the kitchen bench...and then when her first grandchild came along she said “I didn’t teach you too good did I ?”

“Oh and my dad’s girlfriend she sat down and spoke to us about condoms and that when we was about 12 years old. Yeah she was talking to her daughter and we was camping over. She gave us all a talk yeah.”

Very few clients interviewed for the project reported they had learnt about safer sex from health services, both mainstream health services and ACCHOs. However, they reported they would now access health services to obtain current information on safer sex.

However, some of the clients interviewed for the project reported they may be reluctant to access certain services for sexual health information and consumables. Some clients reported they would not access ACCHOs regarding their sexual health needs, usually due to concerns that either their family members access the same service or are employed at the service.

Other sources of information on safer sex that were identified by clients interviewed for the project include: television, the internet and general practitioners (GPs).

Preferred method of learning

The project partners also discussed the different ways in which clients learnt about safer sex, including any strategies that were employed in giving out information that may have helped clients retain these messages. As previously discussed, a significant number of clients interviewed for the project learnt about safer sex from family members. Given the sensitivity of the subject matter, many clients reported they felt it was less embarrassing to learn about safer sex when the information was coming from a family member with whom they could relate to.

“They tried to teach me at school but I just didn’t understand it, and I thought it was embarrassing putting all boys and girls in the room. So I didn’t really learn at school, I just learnt it from my auntie, about different diseases out there...”

“I found it easier from um, like relatives, you can relate to a lot more easier”

The use of humour was also identified as aiding message uptake and retention. Many of the clients interviewed for the project reported they were more likely to retain information on safer sex that is delivered in a light hearted manner.

“Well they joked around when they were teaching which made it interesting to take on board instead of all shame and hide kind of thing, they made it fun to learn, they didn’t treat it as a joke, but they didn’t get too serious about it either.”

“They tried to make it funny, all these people were laughing, and I was way ahead of the class.”

The majority of clients interviewed for the project were able to recall popular slogans on sexual health messages that had been used in the past. Throughout the consultations references were made to slogans such as ‘Don’t be Dippy, Cover Your Pippy’, ‘If it’s not on, it’s not on’ as well as popular

characters that had been used in the delivery of sexual health messages such as 'Condom Man' and 'Captain Koori.' Clients reported that the use of these slogans and characters had helped them retain safer sex messages.

Condom use

All of the clients interviewed for the project reported that the use of condoms was the most effective way to prevent STIs. However, clients also discussed the reasons why they may not use condoms with every sexual interaction.

Clients in long-term sexual relationships reported they were unlikely to use condoms. Clients reported they perceived the risk of transmission of STIs to be low in the context of a long-term relationship. Trust within the relationship reportedly played a significant part in this decision not to use condoms.

"Maybe with one night stands, but once you get a girlfriend or something like that you don't."

"Not really, because I have had the same girlfriend for about eleven years now."

"Or you could do it (sex without a condom) on trust isn't that what love and being in a relationship is all about? Trusting the other person?"

A few of the clients interviewed for the project reported they would ensure that both partners got tested for STIs before making the decision to not use condoms. However, the majority of clients reported they would either ask their partner to disclose their STI status, if any, or they would rely on information passed onto them by other people in the Community regarding their reputation. Some clients reported they could tell by looking at someone if they were healthy or not.

"No I've known her for a long time mate no I've known her for years you know I know who she's been with and I know who she's going with. I don't sleep with anybody, I don't just sleep with anybody. People that I have a relationship with they know me family, they know my uncles and they know my aunties you know, I know her aunties and uncles."

"Basically word of mouth from other people that know of them, as well as approaching them themselves and just being as blunt as you have to be, and say 'look if there are any diseases if so tell me now.'"

"Just talking to the girl and finding out if she has got anything wrong or even realising just what they look like and whether they could have a disease they could be shutting up with, that sort of thing. And keeping away from the girl and wearing a condom if you're not really sure."

A significant number of clients interviewed for the project equated safer sex with the prevention of pregnancies. As a result, they reported they were unlikely to use condoms if one or both sexual partners were using some form of contraceptive. Also some of the clients interviewed for the project reported a belief that contraceptives such as the pill were effective in preventing both pregnancies and the transmission of STIs.

Interviewer: "What do you think is meant by safer sex?"

Interviewee: "It means stopping pregnancies at a young age"

"There are a lot of things, you could be on the pill, she could have an implement (sic) in her arm that doesn't get her pregnant."

A few female clients who are sex workers discussed issues around sex work and condom use. Sex workers reported they may use condoms with their clients, but they tended not to use condoms with their sexual partners.

"I should use a condom all the time, but with my boyfriend I don't. But I work sometimes and I always use a condom."

Clients interviewed for the project discussed other reasons why they may not use condoms and these included being substance affected, the perception that condoms decrease sexual pleasure and the fact that some sexual interactions are not planned and therefore they may not have condoms with them.

"If you're off your head plus I don't think any bloke likes condoms but yeah"

"A condom is supposed to be like a lack of sex excitement, it's like you are not having the real thing. So I don't know for some reason condom, I have used it probably twice and I didn't really enjoy it, that was with my girls' dad."

"Um no, not every time. Um if it's a heat of the moment thing and it just ends up happening then no I'm not gonna stop so yeah."

Clients interviewed for the project reported some misinformation regarding condom use. Some clients reported they preferred to use two latex condoms instead of one, as they believe this offers them better protection against STIs. However, wearing more than one condom may result in the condoms tearing, thereby increasing the risk of transmission of STIs.

Scare tactics

Many of the clients interviewed for the project discussed how scare tactics in relation to STIs and in particular HIV that had been used in the past had been effective in creating awareness. Clients made reference to the Grim Reaper advertisement that was shown in Australia in the 1980s, which they felt was very effective in not only raising awareness about HIV, but was also attributed with influencing their decision to practice safer sex.

"And back in the day they used to have the Grim Reaper and the bowling and all ..."

"The AIDS was the big thing, you know, that's what keeps me in check you know"

As a result, older clients suggested using scare tactics as a possible strategy with young people, particularly around safer sex and STIs. Clients suggested that young people need to be made aware of some of the 'dangers' associated with sex.

"Yeah, because most other things are told but they are sort of more scare things, like if you don't use a condom, you know what's going to happen, and it's oh, yeah ok then I will use a condom."

"They (young people) need to know all the negative side of it, it's all glowy, everything is beautiful, they don't know anything that's hard about it (sex), there's so many things that can go wrong"

Service Provider Consultations

Mainstream Services:

Sexual Health Services

The mainstream health services interviewed for this research project were a mix of specialist AOD services and generalist community health services. All of the mainstream health services reported they offered safer sex consumables such as condoms, dental dams and lubricants. As these are also usually provided through NSPs, IDUs are able to access them. The majority of mainstream health services also reported that they employ either GPs or sexual health nurses who offer services such as pre and post test counselling and STI screenings. A number of mainstream health services also run women's clinics through their sexual health nurses and they provide services including pap smears, family planning services and breast screens.

"...there's a women's health clinic that does pap smears and she (sexual health nurse) does talk about women's health issues with people that access that service."

Just encouraging people to take condoms from the NSP they attend, and answering questions that may arise..."

Those services that do not routinely provide sexual health services reported they refer to appropriate services in the area. Mainstream health services in regional areas in particular reported they have established good working relationships with other sexual health services and this allows for effective referrals to occur.

"...and as in most cases, we make appropriate referrals, it's a sort of small community and we've got good connections, good networks and know the appropriate people locally to refer to."

Injecting Drug User Services

All of the mainstream health services interviewed for the project operated NSP and therefore provided sterile injecting equipment. In addition, they offered a range of other services through community health programs, including detoxification (home based and residential), withdrawal, counselling, pharmacotherapy, health promotion resources, hepatitis C management and referral into rehabilitation.

"We've got drug and alcohol counselling, drug and alcohol youth outreach, mobile safety and withdrawal nurses - home based and residential, or assessment for residential."

Availability of sterile injecting equipment from community health services was mainly restricted to 9 to 5 on weekdays. Primary NSP and some regional hospital emergency departments provided access 24 hours, 7 days a week.

Strategies to engage Aboriginal people who inject drugs

In addition to determining the sexual health and harm reduction services offered to IDUs, the project partners sought to establish whether services employed any strategies to specifically target Aboriginal people who inject drugs. Many health services cited Aboriginal artwork and/or plaques recognising traditional owners of the land, as being the key or sole strategy employed to engage Aboriginal people who inject drugs. Mention of Aboriginal specific resources was also common.

"We have made an effort to become Indigenous friendly by having brochures with a, well specifically for the Indigenous Community with a picture on the front."

"...that room is actually loaded with a range of Aboriginal specific resource materials as well as general resource materials."

Many of the services reported they had some connections with ACCHOs in their local area, including providing attachment opportunities for AOD workers from ACCHOs. However, they noted that the success of these relationships was reliant on individual workers and they tend to fall away should these individuals leave their positions. Services that employ Aboriginal Liaison Officers reported the most success in engaging with Aboriginal people who inject drugs.

"We have an Aboriginal liaison person. A couple of particular workers at the health service where they have brought clients in and sat in on sessions with your client until they're feeling like they can actually come by themselves."

"...it was about building the relationship between the two services... joint memorandums of understanding. What we found is that often there's not always experienced workers, so we have supported people, because we are a fairly large Alcohol and Drug agency with a lot of experience, having them come in and spend time with us, has supported their development around the Alcohol and Drug component of their work, and so conversely it's about trying to learn the cultural things that we need to adapt...some of our clients have come back two or three times, our Indigenous clients, because they've felt welcomed and I think that the smaller unit and openness of the unit appeal to them."

Services reported that the majority of Aboriginal people who inject drugs accessing mainstream services had been referred through the local court system. Outreach services were also reported as particularly effective in engaging with Aboriginal people who inject drugs, potentially due to the anonymity of the service offered.

"We do have ... Koori drug diversion worker, goes to Koori court, so often we will get referrals that way from solicitors and things on the day."

"I think the outreach services are probably the highest contact point, because it is a really nice anonymous service."

Many of the services reported that issues about confidentiality at ACCHOs would probably mean that most Aboriginal people were accessing mainstream services. Mainstream health services also reported that Aboriginal people who inject drugs may be reluctant to engage with ACCHOs because of the shame and stigma associated with identifying as an IDU. There were also concerns about family members working at ACCHOs, therefore they were more likely to access mainstream health services.

“Koori population tend to feel more comfortable seeing somebody who is not part of that Community, because of the embarrassment and shame.”

However, according to a personal source, there are opportunities for improved engagement with clients where Aboriginal workers employed at ACCHOs and mainstream health services are not from the local area and therefore do not have family ties with the Community (G Drage 2010, personal communication, 31 March).

Challenges/barriers in engaging with Aboriginal people who inject drugs

Mainstream health services reported the biggest challenge they face in engaging with Aboriginal clients was building trust. There was some acknowledgement of the need for mainstream health services to work on building trust and rapport with Aboriginal people who inject drugs and the Community in general.

“You have got to be there for the long haul with the Aboriginal Community and I think you have to realise that our sector shifts so much.”

“We’re finding actually they are presenting to our services but for other issues, health checks, and then their drug use will come up in that.”

Mainstream health services also acknowledged that a lack of cultural awareness may act as a barrier to accessing mainstream health services for Aboriginal people who inject drugs. For example, a few services reported there was a tendency to approach Aboriginal culture in a homogenous manner, while failing to recognise the differences within the Aboriginal culture.

“We keep referring to people as Koori and a lot of our population don’t see themselves as Koori.”

Mainstream health services acknowledged that very few clients were accessing NSPs to collect sterile injecting equipment. They reported on the tendency of some Aboriginal people who inject drugs to collect sterile injecting equipment in bulk and distribute to their peers who may be reluctant to access services.

“...we often get people saying, we’re picking up for someone else, we’re picking up for a group, and that could be 2 or 3 hundred syringes.”

“We do have one client that we do see probably weekly, and they do collect for others as well, other Aboriginal people on our behalf, because like they have told us, they feel uncomfortable contacting us, which that’s fair enough and it does happen with a lot of other Community members as well, we have someone who collects for them, drops off for them.”

Training/skills required to work with Aboriginal people who inject drugs

The majority of mainstream services acknowledged that better access to training was required, particularly in regards to cultural sensitivity and cultural awareness.

“I had to go and do a lot of reading about the stolen generation. My sense was that probably that these clients would have felt more comfortable if I had already had some sense of knowledge of that, because it was important to me, to them I think that was understood. Personally I would like general training around cultural sensitivity stuff.”

“Cultural training: I think we would probably jump at that because we are always looking at trying to connect with Aboriginal services.”

“More resources for Aboriginal people and maybe more pictures and diagrams that actually show them what to do.”

Workers from mainstream health services located in regional areas and those working out of secondary NSPs reported they required further training on drug and alcohol issues. This is because they are not always able to access updated information and/or training, as a result of being located in regional areas, staff shortages and competing priorities.

Aboriginal Community Controlled Health Organisations (ACCHOs):

Sexual Health Services

All of the ACCHOs interviewed for the project provided safe sex consumables such as condoms and Aboriginal specific sexual health promotion resources. Many of the ACCHOs reported they provided STI screening as well as counselling and education.

The ACCHOs interviewed for this project did not have specialist Sexual Health Workers, with only one having a specialist nurse. Therefore the role of Sexual Health Workers is often carried out by other workers including AOD workers, AHWs and Maternal and Child Health workers. Most ACCHOs reported these workers will often incorporate sexual health screens and/or information provision into routine health checks, including the Well Persons Health Check.

Most of the ACCHOs employed general practitioners (GPs) who also carry out sexual health screens.

“Yeah, yeah and also we do their health checks, like the same thing, so a lot of that’s put on that, so yeah. Yeah I was in my first one the other day, they talk about sexual health, they talk about STD, safe sex, all that kind of stuff through that health check”

“We also have a Well Women’s Clinic nurse that comes and does any sexual health information and talks and stuff...”

“Well (names supplied), the Maternal Health Worker and the Midwife, they do a lot of that. So you know the mum’s coming in, they do a lot of that and so does the nurse, they test for all of that...”

The majority of ACCHOs placed emphasis on the provision of sexual health information for young people. Many of the ACCHOs reported they routinely organise youth activities such as camps or youth nights with the aim of engaging young people and providing sexual health education.

“We run some youth focused activities, for example we have our sort of youth night...doing some education around basically safe sex and STDs and things such as that.”

“About five years ago we had a young women’s camp. So we took girls aged between 14 and 18 away for the weekend and we touched base on all the STI and all that information that’s what the camp was about as well as having fun, but we had a sex specialist come in, come in and talk about that as well.”

However, it is important to note that the Commonwealth has provided funding to the State for an expansion to the Aboriginal Sexual Health Workforce under the **Victorian Teenage Sexual and Reproductive Health Program**. This project, which will run for five years, will be coordinated by Melbourne Sexual Health Centre in partnership with VACCHO. A senior Sexual Health Practitioner has been employed and two Aboriginal Sexual Health Workers will soon be employed to work with Communities. After a detailed, consultative analysis of each community's needs these workers will a)

work directly with young people around sexual health issues, b) provide workforce development training, and c) build capacity within health services (B Kaaden 2010, personal communication, 31 March)

Injecting drug user services

The project partners sought to gain a better understanding of the types of services specific to injecting drug use, if any, that are available to Aboriginal people who inject drugs within ACCHOs. On investigation, there appears to be a greater focus on providing treatment-type services, including referrals to detoxification and rehabilitation facilities. Support was also provided for people who are accessing pharmacotherapy. Harm reduction services tended to involve the provision of educational materials such as pamphlets and brochures that are easily accessible within the organisation.

Many of the ACCHOs had Aboriginal AOD workers and when asked about services for IDUs, many of the services said they would be referred to the AOD workers.

“...we also have a Drug and Alcohol worker who provides sort of minimal support, doesn't really have the training to get involved in any sort of detox or anything like that. But yeah, it's mainly just a supportive role.”

None of the ACCHOs consulted for the project offer needle and syringe programs. A number of the ACCHOs are registered NSPs, but have either never provided sterile injecting equipment or have withdrawn these services. However, they reported that they routinely refer clients requiring access to sterile injecting equipment to mainstream services that provide NSP.

Interestingly, some workers from ACCHOs reported that on occasion they have provided sterile injecting equipment to some of their clients, even though they are not a registered NSP. This means they may be risking their jobs by providing a service that neither they nor the organisation they work for is registered to provide.

“Upon the sly” is not a good word. I would rather “innovative”. But, of course, because we're not a registered NSP here, but we do it anyway.”

Level of acceptance of NSPs within ACCHOs and the Community

The project partners sought to establish the level of acceptance of NSPs as a harm reduction strategy within ACCHOs and the Aboriginal Community.

The majority of ACCHOs interviewed for the project reported they supported NSPs as a prevention strategy for BBVs and other associated risks. Many staff within ACCHOs reported they would be in favour of providing NSP services to Aboriginal people who inject drugs. However, they suggested that the biggest challenge would be the location of the NSP, as they felt it would not be appropriate to locate the NSP at the ACCHO. Concerns were raised about the safety of other people accessing the service.

“Look I think ummm we’re all about preventive health, there’s a huge focus on what we do here so harm reduction is certainly a big part of that. But also the needle exchange is our main concern and close proximity to children’s areas and the risk factor that is then involved in that.”

“Yeah we are Community run, but also too with the, is, it’s not, I would say personally and it’s just my belief that the majority of Community members would support it. But out of this building I’m not so sure, because of the holistic services.”

“The approach of having it or the idea or philosophy of having the program I agree with, I wonder about what risks are there to people that are here?”

ACCHOs interviewed for the project also reported that people were not likely to access sterile injecting equipment from an NSP located at the ACCHO due to concerns about identifying as an IDU. Some ACCHOs reported they had previously tried to operate NSPs but Aboriginal people who inject drugs had been unwilling to access the NSP. It was suggested that a better option would be to locate the NSP off-site with a specific worker with whom Aboriginal people who inject drugs could build trust and rapport.

“It’s also I guess where you place the actual NSP within the service, whether it’s something that they go straight through and everybody sees them getting their needles while they are in the waiting rooms”

“Look we definitely need one within the local area, but just where do we sit it is the issue because it hasn’t worked here...so we’d have to really think about that, just where and when we think the mob would be comfortable going to utilise or access, you know. But like I’ve said I’m sure we’ve tried it here before but it just didn’t work.”

Very few staff from ACCHOs talked about possible resistance from the Community, including Community elders. Where there might be resistance, there was concern that providing NSP services may be seen as promoting the illicit use of drugs.

“They’re really traditional here as in – they’re very suspicious of new things here sometimes and if it is something to do with changing their lifestyle they’re not really good at that, you know.”

Strategies to engage Aboriginal people who inject drugs

Most ACCHOs interviewed for the project reported they do not employ any strategies to specifically target Aboriginal people who inject drugs within their service. Typically, Aboriginal people who inject drugs will access ACCHOs about other health issues, but not necessarily about their injecting drug use. However, workers from ACCHOs reported that often they do become aware of their clients injecting drug use behaviour during the course of routine health checks or other medical

examinations. They will then attempt to engage with these clients or refer them to appropriate services, including NSPs.

Given the shame and stigma that may be associated with injecting drug use, most staff from ACCHOs agreed that the most effective strategy to engage with IDUs would be to do so in a group setting, where issues regarding injecting drug use, BBVs and STIs was addressed as part of a broader discussion on health, as opposed to a one-on-one discussion specifically targeting injecting drug use.

Group activities such as art and craft workshops and barbeques were reported as being effective in engaging people accessing ACCHOs around other health issues. The same strategies could therefore be employed in engaging with Aboriginal people who inject drugs.

“But if you got a group in to say ‘right we are going to talk about sexually transmitted infections today’ will they feel ashamed coming to just that group, because we have a craft group, and then we sit down and talk about STI’s, and breast .. and pap smears and stuff, so we trick them a bit, they know it’s a women’s health day and that we will touch on women’s health issues, but they don’t know that we are going to be quite specific about it. And we do say, we are going to talk about this now, if you want to go out for a coffee you can, if not have a bit of a yarn with us. And that does work, if you said to them, ‘we are talking about Hep B today’ like ‘oh I have got Hep B I better go to that.’ I just don’t think that would work.”

Challenges/barriers in engaging with Aboriginal people who inject drugs

ACCHOs interviewed for the project reported the biggest challenge in terms of engaging with Aboriginal people who inject drugs is that they tend to be a hidden population, and are often difficult to access. Aboriginal people who inject drugs may be reluctant to access ACCHOs about their injecting drug use behaviour, for fear of being identified as an IDU. This is particularly so in regional areas where communities tend to be smaller.

“I guess you guys agree that it’s a fairly sort of hidden Community as you were saying earlier, and because it’s such a small Community as well, I think it sort of just heightens the stigma of presenting for services and things such as that, and just building up trust within that sort of group as well is quite challenging.”

Many of the ACCHOs talked about the lack of trained Aboriginal AOD workers. Where there were Aboriginal AOD workers employed at ACCHOs, most reported they primarily worked with people with alcohol and yarndi (marijuana) issues. They reported they did not feel confident to address issues relating to injecting drug use.

“We desperately need more trained Aboriginal health workers and we’ve got a majority of main stream here. The last four people that have been hired have been main stream – they’ve been white people and we’ve – we can’t get them trained.”

“Yeah, we sort of don’t have a high level of expertise within the Co-op, myself included, and so any sort of training and an update process would be good.”

In addition to the need for more Aboriginal AOD workers, ACCHOs discussed the difficulty in recruiting and retaining trained AOD workers in general, particularly in regional areas. High staff turnover was reported as making it particularly difficult to provide continuity of care for Aboriginal people who inject drugs.

“I’d like them to run things every month and have them, so that the Community would get to know on this Tuesday every month this is happening, you know, there would be something on, that’s what I would like to but we’ve had a huge changeover in staff. We just get someone and then they leave. I think there have been about 40 to 50 left in the four years I’ve been here. How can you get something up and running?”

“I just think we need to get a stabilised base of staff members so that we can run programs and run them all the time and get some continuity of care.”

“Its a small town in terms of employing people with qualifications and...training, there's not really many to draw from so it's pretty much training people on the job is the only way to build on”

The issue of competing health priorities within ACCHOs was discussed. Focus on chronic health conditions including diabetes and hypertension often means that drug and alcohol issues are not given a high priority. Coupled with high staff turnover, this presents a real challenge in engaging effectively with Aboriginal people who inject drugs.

“And I think it comes back to priorities within the service, just in terms of under resourcing and things like that, and just some of the issues like diabetes and stuff like that, the acute sort of issues which come to the forefront and take a lot of our time and focus. I think we definitely still try, I mean our services could definitely be improved to the injecting drug users.”

Training/skills required to work with Aboriginal people who inject drugs

Training on cultural awareness was identified as being essential, even within ACCHOs. This is because there were a number of non-Aboriginal AOD workers in ACCHOs and they expressed a desire to develop a better understanding of Aboriginal culture.

“We need more cultural - with the injecting drug users and being Aboriginal we definitely – because we’ve got a main stream base here of workers – cultural training definitely. I haven’t had any cultural training since I’ve been here really in four and a half years. There used to be people here that did it before I came. I think we need more cultural training because it just doesn’t work if you go in swinging an axe and, you know, all that.” ACCHO

“Certainly anytime there has been any specific cultural opportunities around training, we’ve always tapped staff into, one of the things that is still outstanding is that we were meant to have a cultural audit, and that hasn’t occurred yet, and I think that would be another enabler to improving our approach and understanding of people’s and what’s required.” Mainstream health service

General AOD training was also identified as important, covering topics such as drug identification, drug effects and BBVs. It was suggested that training should be provided not just to AOD workers, but to all workers who may come into contact with IDUs such as reception staff and drivers.

ACCHOs identified the need to provide training for AHWs, in addition to Aboriginal AOD workers. This is because AHWs often come into contact with Aboriginal people who inject drugs, even though they may not necessarily disclose that they are injecting. While the role of AHWs is to provide general health care, they may end up carrying out the role of AOD workers, due to staff shortages. It is therefore essential to equip them with skills to effectively manage Aboriginal people who inject drugs.

Focus Groups

As part of the action research process three focus groups with service providers were held in Wodonga, Ballarat and Melbourne. The aim of the focus groups was to reflect on strategies that could be developed to improve services for Aboriginal people who inject drugs. A total of 23 participants attended the focus groups across the three sites. Findings from the client consultations indicated that although Aboriginal people who inject drugs were aware of the BBV risks associated with sharing needles and the risk of STIs associated with not using condoms there was a lot of misinformation regarding the transmission of STIs and BBVs. The focus group discussions were primarily aimed at generating strategies to address this level of misinformation.

The focus groups were used to discuss a range of issues relating to injecting drug use and safer sex issues in Aboriginal communities. It is important to note that during all of the focus group discussions there was a sense that some of the health promotion challenges facing Aboriginal people who inject drugs in relation to STIs and BBVs were too difficult to address or may even be unsolvable. The key issues discussed in the focus groups are outlined below:

Families

All the participants in the focus group thought that engaging families in the health promoting activities around BBVs and STIs would be an effective strategy to address the misinformation occurring with Aboriginal people who inject drugs. It is worth noting that focus group participants from ACCHOs reported they have traditionally worked with families through outreach. By visiting clients in their homes, workers from ACCHOs reported they are able to engage the entire family and not just the individual. Mainstream services however reported they may not always be able to work with families, usually due to funding constraints.

"..the clients that I work with a lot of them have huge family issues and I try engage the family as a whole to do education and stuff is going to take along time to build up those relationships between the older family members and workers." (ACCHO)

"..in needle and syringe programs we don't work with family. We work with people who come in and get whatever equipment they need but we never really look at educating the rest of the family. There's usually no time, there's usually no money and no access to the people as well" (Mainstream health service)

However, the shame and stigma and the issue of confidentiality around STIs, BBVs and injecting drugs was raised as a possible barrier to working with families

"I'd say I have difficulty accessing families and there's a whole lot of reasons for that there's the shame, there's the stigma, it's the confidentiality – there's a whole heap of stuff involved"

The role of elders in health promotion activities was also discussed. Given the respected position of elders in the Aboriginal Community and in the family structure, they were identified as a key group to

target with health promotion messages which they can disseminate to the Community. There was discussion around traditional learning styles in the Aboriginal Community and how the current health system may ignore the role played by elders in providing information. This may lead to divisions within the family and Community.

‘..in the Aboriginal way the way you learn is from the elders and if you remove the young people and teach the young people and expect those messages to go back and teach the elders it’s the wrong way around and it wont work and all that happen is that those young people will identify with us as workers as their mentors and that creates a division at home”

While elders play an important role within the Aboriginal Community, focus group participants reported that too few people are recognised and respected as elders in most Aboriginal Communities and they often end up carrying out the various roles expected of an elder. A solution to this problem was the need to encourage programs and strategies that build the confidence of older people to take on the role of elders in the Community and to become educators in the Community and the family structure.

“..the people that we do view as elders are very few and they get dragged along to every thing and its always the same couple that are opening everything and doing all those elder tasks..”

“..we’re involving more of the mature Community to help build them up to give them the self esteem and the confidence to then be able to take that role in the Community..”

Young people

Both mainstream health services and ACCHOs felt there was a gap in their services in terms of engaging young people and addressing their information needs in relation to BBVs and STIs. Some of the participants suggested that ACCHOs and mainstream health services need to work in partnership with other services that work with young people in order to improve engagement and access to services. The participants suggested that through engaging the broader youth workforce, STI and BBV health promotion messages might reach a wider audience.

“there’s a big gap in trying to engage youth into the service” (ACCHO)

‘How much do we really do with the youth group, how much do we do with youth workers? How well are youth workers trained up on those issues I mean they do know the youth culture they do know what works with youth” (Mainstream)

As previously discussed, clients interviewed for the project reported they had been taught about safer sex in schools. However, focus group participants were concerned about at risk early school leavers who may miss out on these health promotion messages. This highlights the need to engage with young people in a variety of settings.

All the focus group participants agreed that there is a need to engage parents in health promotion campaigns that target young people. Focus group participants reported that involving parents in

health promotion activities ensures that young people continue to identify with their family members rather than health workers and reduces conflict within families.

“If you want to get through to the kids you’re better of targeting the parents if you can get it through to the parents the parents will filter it through down to the children.”

However, focus group participants were unsure of the most effective way of engaging parents. Some suggested targeting specific social groups such as mother’s groups or men’s groups.

“I think that targeting the parents is the good way to go because that’s where any early intervention is actually going to happen with educating parents around the young kids and stuff like that but I’m not really sure how you would do it”

“There was a mother’s group that did safe sex or sex education and maybe that’s a way of doing it targeting parents”

“Or target perhaps men’s group or mums groups or even youth groups.”

Focus group participants also acknowledged that parents may find it difficult to talk to their children about sexual health matters and injecting drug use issues. Therefore services need to adequately support parents to carry out this role.

“..i think its very difficult for parents to be able to do that in a really objective way because of all the emotion and that protective factor trying you know never wanting them to be injecting drug users so I’m not even going to talk about it..”

The issue of using creative methods and new media when targeting young people was discussed as effective in disseminating health promotion messages around STIs and BBVs. Internet based media such as Facebook, Youtube, MSN and Twitter were discussed as tools that could be utilised to disseminate health promotion messages.

“I think we need to get a little bit more creative and use modern media a lot more things like Youtube, MSN and text messages particularly with the younger people. No one really looks at written information.”

“Twitter and Facebook”

The “Chopped Liver” play produced by Illbjerri Aboriginal Theatre Company was mentioned as a very successful way of educating the Community about issues related to hepatitis C. The play discussed issues about injecting drug use, hepatitis C transmission and treatment options in Aboriginal communities and has toured extensively both nationally and in Victoria.

The focus groups participants also raised the issue of using scare tactics on young people and they agreed they could be used effectively with young people.

“Scare them straight programs like they do in prisons something like that. It would be quite handy to set up for them”

“Not so much with the older people – with the young ones it works really effectively and I got those old books that prostitutes collect in Victoria about STI and they were fantastic working with young people.”

“...graphic pictures of the disease...”

Older/Experienced Users

Older/experienced users need to be targeted with health promotion messages as they were identified as a common source of information for younger inexperienced users and often initiate younger users into injecting.

However, focus group participants thought that getting health promotion messages to older or experienced users about STIs and BBVs may be difficult. Most older or experienced users believe they do not need to access information on STIs and BBVs and are therefore less likely to access this information. Focus group participants discussed the need to provide information to older users before they present to services

“Yeah I think a lot of the time the provision of the information is only at the point where you’re accessing a service what we really need to be doing is getting to people before they have a need to do that really.”

Strategies to engage Aboriginal people who inject drugs

Focus group participants also discussed different ways to engage with Aboriginal people including injectors. The provision of food as an incentive or strategy for people to come to groups to get health promotion information was discussed as a strategy that has been successfully used in the past.

“Around lunchtime that is the only time that we can seem to get good numbers to come in for conferences and stuff, we have a BBQ and supply food in, in drones it seems.”

The focus group participants discussed strategies that had been successfully used in the past to provide information, for example, the provision of health promotion messages in fit packs.

“What we found at work in our two packs we’ve been putting little messages we do sort of Koori friendly and just put in messages about hep C about using old needles etc etc. “

The issue of health promotion in prisons was also discussed. More information about STIs and BBVs should be provided in prisons given the high rates of Aboriginal people including many injectors that are incarcerated.

“It’s a captive audience – that’s the perfect place to be getting that information to people really it is.”

All of the focus group participants discussed the idea of providing mobile or outreach services as a means of reaching Aboriginal people who inject drugs who may not present to services. However, most participants also agreed that this model is not cost effective and is not favoured by current funding arrangements..

“Yeah it’s a matter of getting out into the Community and into the homes and that’s the only way to do it to get the message through...”

“..and its really been a shift from community based work and going out there to sitting on the computer and waiting for clients to come to you..”

Focus group participants also felt there should be more Aboriginal workers employed in mainstream health services as most mainstream services do not employ Aboriginal workers, particularly in regional areas.

Peer education was also mentioned as a strategy for health promotion as many Aboriginal people who inject drugs learnt about STIs and BBVs from their peers, as previously discussed. However, workers in the focus group expressed some moral dilemma about trying to promote harm reduction on the one hand but also trying to help their clients though drug addiction issues.

During the focus group discussions a few radical approaches were discussed including using drug dealers as health promoters or peer educators.

“I’ve got a really radical idea – we educate drug dealers and they become the peer educators”

“Well they’re the people who come in touch with most users, when you think about it and if they were able to give out safe using messages at the same time they’re selling their wares.”

The over arching issue raised by all the focus group participants was the challenge of promoting safer sex and drug using practices given the shame and stigma involved. Any strategies that can address this shame and stigma will go a long way in facilitating all the other strategies mentioned in this section of the report.

“I think we’re battling with that whole social shame and stigma of being a user”

Discussion and Critical Reflection

Yiaga ba Wadamba is a Wurundjeri phrase VACCHO and Anex have used as a working title for this action research project. The Aboriginal phrase means to “Find and Renew” and aptly applies to the projects target population of Aboriginal people who inject drugs living in Victoria. Aboriginal people who inject drugs are a marginalised and hidden population within the general IDU population and even more so in the general community given the nature of illicit drug use and cultural differences. To ‘find’ this group was not easy and to address the ‘renewal’ of services to this group raised more issues than solutions. The following outline some points of discussion and critical reflection during this project:

Processes and methods during the research

The process used to recruit clients proved to be very effective. The use of the toll-free 1800 number, the discreet contact business cards and the incentive payment of \$30 per participant interview were all very successful ways to get to this hard to reach population. The recruitment was assisted by initial face to face visits to all service providers. The services then recruited known Aboriginal people who inject drugs for the project and word of mouth recruitment soon followed. The project partners were able to recruit 73 clients in the study but could have attracted more had the study continued.

The interview process was culturally respectful and non-judgemental. Participants had the choice of being interviewed by an Aboriginal or non-Aboriginal person, with most participants indicating no preference. The 1800 number was located at Anex, which reduced the likelihood of concerns around confidentiality participants may have felt by contacting an Aboriginal service. Given the findings, this appears to be a particularly important issue for any interaction between Aboriginal people who inject drugs and services.

Selection of interview questions used in the consultations could have been broader to include information on drug using behaviours, as well as health promotion messages. The project partners were initially concerned about the sensitive nature of illicit drug use and the risk of causing unintended harm to participants by talking about potentially traumatic issues. Reflecting on this, the participants were willing to share information freely.

The success of the focus groups lay in the fact that they were held in both rural and metropolitan locations and this increased participation across Victoria. Attendance by staff from both mainstream health services and ACCHOs was considered to be an indication of interest and investment in the outcomes of the project. However, there was also a sense of fatalism amongst the groups that the problems faced by Aboriginal people who inject drugs are unsolvable and focus group participants felt they did not know what to do with this group. The focus groups were often hard going and much prompting was required to elicit responses.

Results – service provider consultations

One of the overriding issues identified through this project is the collection of accurate data. The true number of Aboriginal people who inject drugs is hard to estimate in Victoria because NSPs do not routinely collect data on ethnicity. This is especially noticeable in the secondary NSP data collection. Accurate data collection will help to identify the level and extent of need and related issues, which will in turn improve service provision for this population group.

Mainstream primary NSPs receive funding to provide a range of services to IDUs. Secondary NSPs e.g. community health services and hospital emergency departments, do not receive specific funding for the delivery of NSP. As a consequence, most secondary NSPs do not have the time or resources to intensively engage with IDU clients nor build in health promotion and harm reduction messages to interactions with clients, as they have a wide range of services to provide with higher priorities.

Similarly, the findings indicate that ACCHOs are under resourced to cope with the competing health issues in the Aboriginal Community. As opposed to primary NSPs, which are funded to provide services to IDUs, ACCHOs address all health and welfare issues in the Communities they service. IDUs are not a priority population for ACCHOs, and issues such as STIs and BBVs are also stigmatised, making them harder to address. This makes it more difficult to compete against management of other chronic health conditions for example, hypertension, diabetes and renal disease.

None of the ACCHOs the project partners visited in this project were operating NSP services at the time of consultation and a few would supply syringes in an ad hoc manner. Reasons for not operating NSPs were varied including the preference to refer to mainstream NSPs in the area, but most had not considered it within their organisations and felt that it belonged in the realm of AOD services. Having NSPs at ACCHOs would increase access to clean injecting equipment, would increase service choices for Aboriginal people who inject drugs and provide an entry point for Aboriginal people who inject drugs into other services provided by the ACCHOs. The issue of injecting drug use and BBV transmission needs to be seen in a health promotion context and not solely as an AOD issue as it currently stands. Harms associated with injecting drug use, including BBVs, need to be addressed from a general health promotion perspective in all the ACCHOs across Victoria.

The project partners found the AOD workforce, both in mainstream health services and ACCHOs, is constantly changing. High staff turnover is more pronounced amongst the Aboriginal AOD workforce. This makes continuity of care for, and engagement of IDUs, and in particular Aboriginal people who inject drugs, challenging. ACCHOs reported there is a lack of specialist harm reduction staff who are able to engage and support IDUs directly. Most workers referred IDUs to the AOD workers in the service who, for the most part, acknowledged they did not have specialist expertise in harm reduction or issues associated with injecting drug use. This would appear to be a gap in the current workforce profile and also indicate the need for better access to specialised training in harm reduction, especially NSP.

Equally, there appears to be gaps in the sexual health workforce, particularly within ACCHOs. The majority of service providers consulted did not have specialist sexual health workers and therefore relied on other generalist workers and GPs to undertake assessments, screening and health promotion. Of most concern is the added burden put upon AHWs to undertake these activities when they have not been trained in this specialist area and, more than often, are already overloaded with responsibilities beyond their scope of practice.

Relationships between mainstream NSPs and ACCHOs are varied across Victoria and these relationships are mainly reliant on key individuals and personal friendships, which means they can easily break down if one of the people leaves the service. Interestingly, regional services were more likely to have established formal and informal networks with each other than their metropolitan counterparts. This may in turn affect the way Aboriginal people who inject drugs are referred across the two sectors and reduce the quality and continuity of care and well being of this group.

The project partners are committed to improving and fostering networks between mainstream NSPs and ACCHOs. A strategy is in place to ensure ongoing engagement on the issues of harm reduction, injecting drug use and the Aboriginal Community. This will include the provision of opportunities for mainstream health services and ACCHOs to come together for a range of activities e.g. information sessions, forums, and training and development. As previously mentioned, there is also a website www.findandrenuew.com.au which provides some common ground and acts as a mechanism for access to information and exchange.

Results – Client Consultations

This research project aimed to address the HIV risks related to injecting drug use in Victorian Aboriginal Communities. However, through the service provider and client interviews the project partners found the issue of hepatitis C was raised on many occasions. The clients were willing to disclose their hepatitis C status to the project partners with ease and given the high rates of hepatitis C in the injecting drug using population it seems that it is a normalised part of the Aboriginal people who inject drugs life. This normalisation of hepatitis C is an emerging trend of concern which needs to be addressed as part of a broader campaign around the issue of BBV prevention in Aboriginal people who inject drugs, and the Victorian Aboriginal Community in general.

The project partners explored the way Aboriginal people who inject drugs learned about safer injecting and the participants seemed to prefer messages that came from their peers, being other Aboriginal people or other injecting drugs users or both. When asked about safer sex messages the participant's most common source of knowledge was from school and family members. There was a strong sense that messages from researchers and even AOD workers should not be trusted. Unfortunately the research also found that there was a lot of misinformation or gaps in the participant's knowledge around safer drug using and safer sex and therefore the current information amongst peers does not appear to be very accurate.

Therefore improvements could be made around the use of peers, in particular ensuring peer-educators receive adequate training on their role and that they have access to up-to-date information. It is also worth noting that many of the Aboriginal people who inject drugs in this study reported being injected on occasion by peers, indicating another reason why developing quality peer-based education is a priority. Peer education programs could also be considered within correctional facilities, as it was in this setting that many of the participants learnt BBV transmission information from their peers. Education about STIs and BBVs needs to be strengthened in schools, prisons and within the Victorian Aboriginal Community, as they are common information sources for Aboriginal people who inject drugs.

The participants also reported learning about safer sex at school but there were no such responses in regards to safer drug use. Given the illicit nature of injecting drug use, and the strong moral stance taken against drug use in the school education system, the health promotion messages around injecting drug use are not getting to young people who may transition into injecting later in life. The project partners believe there needs to be more emphasis on the prevention of both STIs and BBVs before the transition into injecting drug use occurs, as many of the participants in this project only became interested in obtaining information about STIs and BBVs after a positive diagnosis of an STI, and in most cases, a BBV.

Aboriginal people who inject drugs in this study were aware of the BBV risks associated with sharing needles and the risk of STI associated with not using condoms. However, there was a lot of misinformation regarding the transmission of STIs and BBVs, especially hepatitis C as mentioned in the previous paragraph. Many of the participants mentioned the Grim Reaper HIV/AIDS advertisements from the 1980's - this scare tactic approach seemed to have left a strong impression on these participants. The issues faced by Aboriginal people who inject drugs around misinformation are similar to non-Aboriginal people who inject drugs in other studies, but the strategies to target this group need to be culturally sensitive, including the choice of language and delivery methods.

The research also found that the participants in this project thought sharing with a partner in the context of a sexual relationship was acceptable, which may indicate messages about pre-relationship STI/BBV screening is not seen as important in this group and that intimacy and trust between partners is more important. The participants felt that because they exchanged sexual fluids they would already be exposed to any STIs or BBVs their partners had. Also, many women in the study reported being initiated into injecting by their male sexual partners. Health promotion campaigns about HIV prevention that target sexual partners have been very successfully used in other at risk populations such as the gay community and should be explored for useability within this at risk group. The project partners believe Aboriginal people who inject drugs would benefit from a campaign exploring the implications of sharing in relationships in relation to STIs, BBVs and injecting drugs.

One of the positive findings of this project was the recall the participants had for popular Aboriginal sexual health slogans and the fact that these forms of health promotion helped them retain safer sex messages. The possibility of creating the same sort of health promotion campaigns for safer injecting

needs to be explored. The project partners also believe the use of local media as a source of health promotion messages and information for Aboriginal people who inject drugs needs to be explored.

An example of a successful program was an advertisement run by Rumbalara Aboriginal Health Services (Shepparton) on local television stations that encouraged people to visit the service for health checks. The advertisement featured local Aboriginal people and health staff. In this project many of the Aboriginal people who inject drugs interviewed mentioned TV as a common source of information and felt it could be used as a successful vehicle for safer using and safer sex messages. The project partners feel that although this medium could potentially reach Aboriginal people who inject drugs in their homes, it would be a challenge to use this medium for messages around safer injecting.

In summary, there is evidence to suggest that the current health system is not fulfilling its role in relation to health promotion and prevention around BBVs and STIs. This is particularly so for Aboriginal people who inject drugs, a population already identified as having greater risk than the general population. Issues contributing to this ineffectiveness include: gaps in skilled workforce (both sexual health and harm reduction); lack of access to training and development; culturally inappropriate service settings and models; lack of engagement aimed specifically at Aboriginal people who inject drugs; perceived confidentiality conflict within ACCHOs; lack of options for access to NSP (including broader primary health services including health promotion); reduced capacity (both funding and resources) for ACCHOs to focus on sexual health and harm reduction; and ad hoc networking across mainstream and ACCHOs which can impact on referral and treatment pathways.

Recommendations

There is need to target young Aboriginal people and address their information needs in relation to BBVs and STIs. This will provide the foundation for improved uptake of health promotion messages and better use of funding. In order to achieve this, the following steps need to be taken:

- Investigate current health promotion programs targeting young people available through the Department of Education and Early Childhood Development;
- Determine gaps in information provision and reach (how old or young) and further develop programs in collaboration with the Department of Education and Early Childhood Development;
- Consider lowering the target age group for delivery of programs to capture early school leavers;
- Conduct parallel campaigns that target parents to ensure that the provision of messages to young people does not create cultural and/or family division;
- In consultation with Communities, the Australian, State and Territory Governments should give high priority to identifying effective ways of reducing rates of HCV infection among young Aboriginal Australians, and implement policies, projects and practices designed to achieve this (see also 'A Review of enablers and barriers of Indigenous drug users accessing needle and syringe programs – a report for the COAG Multilateral Group on Needle and Syringe Programs', 2008).

And more broadly:

- Explore options for modes of delivery of messages to Aboriginal people who inject drugs including the use of dramatic arts based programs;
- Encourage the use of local media to promote local services and therefore increase access;
- Consider the use of peers in the development and delivery of information and support based programs;
- Use Community based activities as a vehicle for delivering messages around BBVs/STIs;
- Consider techniques used in other campaigns e.g. the gay community that emphasise prevention and health promotion messages on safer sex;
- Ensure any program delivery is developed through engagement with representatives from the target group.

Improving access and service responses:

- Ensure improved access for Aboriginal Communities to sterile injecting equipment through syringe vending machines, pharmacy NSPs and outreach mobile services. This would include identification of the most appropriate model for outreach services, e.g. vehicle based, Mobile Drug Safety Worker (MDSW);
- Re-orient services to deliver a home-based model of care to ensure that hard to reach Aboriginal populations are targeted with health promoting messages;
- Fund and support NSP specific staff in secondary NSPs to better engage with their clients in a way that includes health promoting messages;
- Provide funding for NSP provision to ensure that secondary NSPs are able to prioritise access for Aboriginal people who inject drugs;
- Expand the responsibility for the delivery of health promoting messages around BBVs/STIs to the broader health workforce to ensure that these issues remain high on the agenda;
- Provide funding to develop and design effective sexual health promotion strategies through NSPs, including promoting regular screening and testing for STIs;
- Explore options to develop capacity and capabilities for a range of organisations across Victoria who may receive referred Aboriginal people who inject drugs and to facilitate the development of local partnerships, protocols and referral pathways between mainstream and NSP services;
- Introduce an audit program for all NSPs to review their service design and layout to increase privacy for clients so as to facilitate opportunities for client education and referral in an appropriate environment;
- As per the current review of NSP data collection being undertaken by DH, develop a minimum data set and common principles for data collection regarding Aboriginal injecting drug use to ensure consistency and enable comparability in data collected.

STIs and BBVs:

- In accordance with the Sixth National HIV Strategy (2010-2013), support NSPs to maintain a focus on HIV prevention including the provision of HIV awareness campaigns and prevention education focusing on risk of infection through sharing of needles and syringes, as well as sexual transmission;
- Develop and fund a range of programs to promote early detection of STIs among Aboriginal people who inject drugs;

- Develop and design effective HCV prevention and education strategies through NSPs, in alignment with the recently released Third National Hepatitis C Strategy (2010 – 2013);
- Continue to encourage NSPs to maintain the provision of condoms and water-based lubricant to clients as part of a broader prevention strategy.

ACCHOs:

- Provide further funding to increase the capacity of organisations working with ACCHOs to assist with the transition to NSP within service delivery;
- Develop and implement a grants regime, including identification of capped costs, to provide incentive grants for ACCHOs seeking to establish NSPs to cover initial implementation costs;
- Provide further funding to organisations working with ACCHOs to provide more intensive 1:1 support in the start-up phase of establishing an NSP. This would include: assistance with operational planning in line with current risk and accreditation processes, policy development, workforce education and training, and provision of financial resources;
- Market ACCHO based NSP services as Safe Sex Programs (SSPs) and provide funding and support for specialist SPP staff to drive the program;
- Create harm reduction specific roles within ACCHOs to build capacity of services to better meet the needs of Aboriginal people who inject drugs;
- Improve the capacity of the Aboriginal community controlled health sector by increasing the number of Aboriginal STI/BBV workers, especially in regional settings. This may include the provision of education, training and support for Aboriginal Health Workers (AHWs) primarily engaged in the delivery of services in sexual health and BBVs as an interim measure whilst a statewide strategy is in development.
- Provide training in the harm reduction sector in the form of a nationally accredited and standardised program;
- Further analyse the support needs of the existing workforce to address burnout and high staff turnover; and
- Further support services to work in a holistic manner which enables them to take into account the impact of the individuals' environment on their health.

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Appendices

Appendix 1: Service Provider Participant Information and Consent Form

PARTICIPANT INFORMATION AND CONSENT FORM

VACCHO (Victorian Aboriginal Community Controlled Health Organisation) and Anex

Full Project Title: Action Research - Addressing HIV risks related to injecting drug use in Victorian Aboriginal Communities

Principal Researcher: John Ryan

Associate Researcher(s): Peter Waples-Crowe; Liz Sutton

Your Consent

You are invited to take part in this research project titled 'Action Research - Addressing HIV risks related to injecting drug use in Victorian Aboriginal Communities.' This is because we value your knowledge and experiences.

This Participant Information Form contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Participant Information carefully. Feel free to ask questions about any information in the document.

Once you understand what the project is about and if you agree to take part in it, you should sign the Consent Form

You will be given a copy of the Participant Information and Consent Form to keep as a record.

Purpose and Background

The project aims to improve the health of Aboriginal Victorians, particularly those who inject drugs, in relation to Blood Borne Viruses (BBVs) /Sexually Transmitted Infections (STIs) and in particular Human Immunodeficiency Virus (HIV).

Appendix 1

Both Aboriginal communities and Injecting Drug Users (IDUs) are recognised as being over-represented in terms of incidence and risk of BBVs and STIs – including HIV. The project seeks to involve service providers working in mainstream and Aboriginal health services as well as Aboriginal people who inject drugs to identify and reflect upon new and innovative strategies that have been used or could be used to prevent the transmission of BBVs and STIs and in particular HIV.

A total of 115 people will participate in this project. Participants include Aboriginal people who inject drugs, staff of Aboriginal Community Controlled Health Organisations (ACCHOs), NSP coordinators and staff from other related health services.

The project will be conducted through a partnership established between VACCHO and Anex with the aim of addressing issues related to the harms caused by injecting drug use in Aboriginal communities.

This research has been funded by the Department of Human Services.

Appendix 1

Procedures

Participation in this project will involve;

- One-on-one consultation and/or group interviews of approximately one hour duration with one of the project's associate researchers which will be audio-taped.

There will be a critical reflection process whose main purpose will be to present the findings of the initial consultations to Aboriginal people who inject drugs and service providers and propose a plan of action that would be effective in addressing these findings.

Reimbursement for your costs

You will not be paid for your participation in this project.

Possible Benefits

We cannot guarantee or promise that you will receive any benefits from this project. However, your participation will help us to identify strategies to reduce the risk of BBVs/STI infections and in particular HIV, amongst Aboriginal people who inject drugs and to improve access to prevention and treatment programs.

Possible Risks

There are some risks associated with participation in the study, although these are minimal. The risks include:

- *Risks associated with the collection of information regarding illicit drug use;* All information disclosed during interviews will be treated as confidential. The findings of your interview will be coded to ensure that your information can be withdrawn at your request except where you have participated in a group interview. Information will not be directly attributed to any individual nor will it be identifiable in any project reports or documents.
- *Risks associated with the disclosure of criminal activity;* This research is not designed to collect information specific to any criminal activity. All information disclosed during interviews will be treated as confidential. The findings of your interview will be coded to ensure that your information can be withdrawn at your request with the exception of information collected during a group interview. Information will not be directly attributed to any individual nor will it be identifiable in any project reports or documents.

Participation is Voluntary

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to.

If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

However, if you do consent to participate in a group interview, you may only withdraw prior to the group interview beginning. This is because the group format does not enable us to extract individual comments from the entire recorded conversation.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with VACCHO or Anex.

Appendix 1

If you do decide to participate, you are not required to answer any questions that may make you feel uncomfortable.

Before you make your decision, you can ask the associate researcher any questions you may have about the research project. You can ask for any information you want. The Consent Form should only be signed after you have had a chance to ask your questions and have received satisfactory answers.

Appendix 1

Results of the Project

Once the report has been publicly released and the Department of Human Services is agreeable, as is VACCHO, the results of this project will be made available at www.anex.org.au and www.vaccho.org.au, as well as participating NSPs, ACCHOs and other related health services in a form considered suitable by VACCHO and Anex and ensures that the community is informed in a culturally sensitive, appropriate and respectful manner. The project partners are in the process of developing a website for the various projects we are currently undertaking as part of the memorandum of understanding between VACCHO and Anex. A community report will also be available on this website (name of website to be supplied by the Victorian Aboriginal Corporation for Languages), subject to approval by the Department of Human Services and VACCHO.

The final results of the project will be available in March 2010 (subject to project approval by the Human Research Ethics Committee of the Department of Human Services).

Further publication and dissemination may occur in accordance with VACCHO and Anex management decisions with the agreement of the Department of Human Services.

A copy of the report will be sent to each key informant.

Privacy, Confidentiality and Disclosure of Information

Any information obtained in connection with this project and that could identify you or your service will be de-identified ensuring your anonymity. It will only be disclosed with your permission, except as required by law.

All information arising from the research project will be stored in a locked cabinet at VACCHO for a period of seven years (according to national standards). It will be shredded and destroyed at the end of this period. All electronic data will be stored at VACCHO for a minimum period of seven years (according to national standards) on a secure computer requiring a password. It will be destroyed at the end of this period. All consent forms will be stored separately to the information to ensure privacy. The principal and associate researchers will have access to this information and it will be destroyed appropriately after a period of seven years.

In any publication where reference is made to the information you provide, you will be referred to as a key informant, and you will only be identified by job role (e.g. Aboriginal AOD Worker, NSP Coordinator, Drug and Alcohol Counsellor), type of organisation (e.g. NSP, Aboriginal Health Service, Drug and Alcohol Service) and location (i.e. metropolitan Melbourne or regional).

Accessing Research Information kept about you

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access information collected and stored by the researchers about you. Please contact one of the researchers named at the end of this document if you would like to access your information.

In addition, in accordance with regulatory guidelines, the information collected in this research project will be kept at VACCHO for seven years.

Appendix 1

Ethical Guidelines

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of The Department of Human Services.

This project will be carried out according to the *National Statement on Ethical Conduct in Research Involving Humans* (June 1999) produced by the National Health and Medical Research Council of Australia (NHMRC). This statement has been developed to protect the interests of people who agree to participate in human research studies.

As the research involves the inclusion of people identifying as Aboriginal or Torres Strait Islander or both, it will also be carried out according to the NHMRC Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research (June 2003) and the National Aboriginal Community Controlled Health Organisation Data Protocols.

The NHMRC *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research* (June 2003) identifies six values that underpin ethical conduct in relation to working with Aboriginal communities – Spirit and Integrity, Reciprocity, Respect, Equality, Survival and Protection, and Responsibilities.

Needle and Syringe Programs and ACCHOs in Victoria are aware of this research project

Further Information or Any Problems

If you require further information or if you have any problems concerning this project you can contact the principal researcher responsible for this project, Mr. John Ryan, on 03 9486 6399 or any of the following people:

Name: Peter Waples-Crowe

Name: Liz Sutton

Role: Associate Researcher

Role: Associate Researcher

Telephone: 03 9419 3350

Telephone: 03 9486 6399

Other Issues

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

Name: Mr Jeffrey Chapman

Position: Secretary, Human Research Ethics Committee.

Telephone: C/O Ethics Committee Secretariat (03) 9096 5239.

E-mail: research.ethics@dhs.vic.gov.au

Thank-you for your time and consideration.

Appendix 1

VACCHO (Victorian Aboriginal Community Controlled Health Organisation) and Anex

Consent Form

Full Project Title: Action Research - Addressing HIV risks related to injecting drug use in Victorian Aboriginal Communities

I have read and I understand the Participant Information dated / / 2009.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details, if information about this project is published or presented, in any public form.

I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements.

Participant's Name (printed)

Signature.....

Date.....

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's Name (printed)

Signature.....

Date.....

* A member of the research team must provide the explanation and provision of information concerning the research project.

Note: All parties signing the Consent Form must date their own signature.

<i>Office use only</i> Survey code:
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Appendix 1

VACCHO (Victorian Aboriginal Community Controlled Health Organisation) and Anex

Revocation of Consent Form

Full Project Title: Action Research - Addressing HIV risks related to injecting drug use in Victorian Aboriginal Communities

I hereby wish to WITHDRAW my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT jeopardise my relationship with **VACCHO (Victorian Aboriginal Community Controlled Health Organisation) or Anex**

Participant's Name (printed)

Signature.....

Date.....

Appendix 2: Client Recruitment Poster

Study participants required



- ❖ **Have you injected drugs in the last two years?**
- ❖ **Are you over 18 years old?**
- ❖ **Do you identify as Aboriginal or Torres Strait Islander or both?**
- ❖ **Are you willing and able to provide informed consent?**



If so, we would like to interview you about injecting drug use, sexually transmitted infections and blood-borne viruses, including HIV.

Interviews are confidential and will last about 30 minutes (a \$30 reimbursement will be provided for your time and effort).

Please phone 1800 836 990 for more information about participation.

This study is being conducted by VACCHO (Victorian Aboriginal Community Controlled Health Organisation) and Anex and has ethical approval.



Appendix 3: Business Cards for Client Recruitment



Study Participants Required



- 1) Have you injected drugs in the last 2 years?
- 2) Are you over 18 years old?
- 3) Do you identify as Aboriginal or Torres Strait Islander or both?
- 4) Are you willing and able to provide informed consent?

If so, we would like to interview you about injecting drug use, sexually transmitted infections (STIs) and blood-borne viruses (BBVs), including HIV.

Please phone 1800 836 990 or ask your NSP worker/AOD worker for more information about participation



Study Participants Required



- 1) Have you injected drugs in the last 2 years?
- 2) Are you over 18 years old?
- 3) Do you identify as Aboriginal or Torres Strait Islander or both?
- 4) Are you willing and able to provide informed consent?

If so, we would like to interview you about injecting drug use, sexually transmitted infections (STIs) and blood-borne viruses (BBVs), including HIV.

Please phone 1800 836 990 or ask your NSP worker/AOD worker for more information about participation



Study Participants Required



- 1) Have you injected drugs in the last 2 years?
- 2) Are you over 18 years old?
- 3) Do you identify as Aboriginal or Torres Strait Islander or both?
- 4) Are you willing and able to provide informed consent?

If so, we would like to interview you about injecting drug use, sexually transmitted infections (STIs) and blood-borne viruses (BBVs), including HIV.

Please phone 1800 836 990 or ask your NSP worker/AOD worker for more information about participation



Study Participants Required



- 1) Have you injected drugs in the last 2 years?
- 2) Are you over 18 years old?
- 3) Do you identify as Aboriginal or Torres Strait Islander or both?
- 4) Are you willing and able to provide informed consent?

If so, we would like to interview you about injecting drug use, sexually transmitted infections (STIs) and blood-borne viruses (BBVs), including HIV.

Please phone 1800 836 990 or ask your NSP worker/AOD worker for more information about participation



Study Participants Required



- 1) Have you injected drugs in the last 2 years?
- 2) Are you over 18 years old?
- 3) Do you identify as Aboriginal or Torres Strait Islander or both?
- 4) Are you willing and able to provide informed consent?

If so, we would like to interview you about injecting drug use, sexually transmitted infections (STIs) and blood-borne viruses (BBVs), including HIV.

Please phone 1800 836 990 or ask your NSP worker/AOD worker for more information about participation



Study Participants Required



- 1) Have you injected drugs in the last 2 years?
- 2) Are you over 18 years old?
- 3) Do you identify as Aboriginal or Torres Strait Islander or both?
- 4) Are you willing and able to provide informed consent?

If so, we would like to interview you about injecting drug use, sexually transmitted infections (STIs) and blood-borne viruses (BBVs), including HIV.

Please phone 1800 836 990 or ask your NSP worker/AOD worker for more information about participation



Study Participants Required



- 1) Have you injected drugs in the last 2 years?
- 2) Are you over 18 years old?
- 3) Do you identify as Aboriginal or Torres Strait Islander or both?
- 4) Are you willing and able to provide informed consent?

If so, we would like to interview you about injecting drug use, sexually transmitted infections (STIs) and blood-borne viruses (BBVs), including HIV.

Please phone 1800 836 990 or ask your NSP worker/AOD worker for more information about participation



Study Participants Required



- 1) Have you injected drugs in the last 2 years?
- 2) Are you over 18 years old?
- 3) Do you identify as Aboriginal or Torres Strait Islander or both?
- 4) Are you willing and able to provide informed consent?

If so, we would like to interview you about injecting drug use, sexually transmitted infections (STIs) and blood-borne viruses (BBVs), including HIV.

Please phone 1800 836 990 or ask your NSP worker/AOD worker for more information about participation

Appendix 4: Client Participant Information and Consent Form

PARTICIPANT INFORMATION AND CONSENT FORM

VACCHO (Victorian Aboriginal Community Controlled Health Organisation) and Anex

Full Project Title: Action Research - Addressing HIV risks related to injecting drug use in Victorian Aboriginal Communities

Principal Researcher(s): John Ryan

Associate Researcher(s): Peter Waples-Crowe; Liz Sutton

This Participant Information and Consent Form is four (4) pages long. Please make sure you have all of these pages.

1. Your Consent

The purpose of this Participant Information Form is to explain to you as openly and clearly as possible what is involved in this project, *Action Research - Addressing HIV risks related to injecting drug use in Victorian Aboriginal Communities*. You are invited to take part in this research project because we value your knowledge and experiences. Please read this information carefully before you decide whether or not to take part in the project. Feel free to ask any questions about the project or information in the document.

Participation in any research project is voluntary. If you do not wish to take part you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand what you have read or what has been read to you and consent to take part in the research project.

You will be given a copy of the Participant Information and Consent Form to keep as a record.

2. Purpose and Background

VACCHO and Anex have been funded by the Department of Human Services (DHS) to carry out a research project to improve the health of Aboriginal Victorians, particularly those who inject drugs, in relation to BBVs/STIs. The project is a participatory action research project that will involve Aboriginal people who inject drugs, as well as service providers working in mainstream and Aboriginal health services, to identify and reflect upon new and innovative strategies that have been used or could be used to prevent the transmission of BBVs and STIs.

Appendix 4

3. Procedures

Participation in this project will involve one face-to-face interview of approximately half an hour for which your comments will be audio-taped by the associate researchers.

You may also wish to find out what we learned by doing this research. If you are interested and you agree, we can recontact you to provide you with a hard copy of your interview and give you an opportunity to learn about the research findings. At that time, we would also like to invite you to be part of a focus group discussion to provide us with your feedback on the research findings. This will require us to collect personal contact details, including a contact name, phone number and/or e-mail. This information will be destroyed at the end of the project.

4. Reimbursement for your costs

You will be reimbursed \$30 for any costs that you incur as a result of participating in this research.

5. Possible Benefits

Possible benefits include the opportunity to help us to identify strategies to reduce the risk of BBVs/STIs infection amongst Aboriginal people who inject drugs and to improve access to prevention and treatment programs.

6. Possible Risks

There are some risks associated with participation in the study, although these are minimal.

The risks include:

- *Risks associated with the collection of information regarding illicit drug use;* All information disclosed during interviews will be confidential. The findings from your interview will be coded to ensure that your information can be withdrawn at your request.
- *Risks associated with the disclosure of criminal activity;* This research is not designed to collect information specific to any criminal activity. All information disclosed during interviews will be confidential. The findings of your interview will be coded to ensure that your information can be withdrawn at your request. A serious and imminent threat to harm yourself or others may be subject to reporting to a third person. Any information concerning the protective safety of children is subject to reporting to relevant authorities. Confidentiality of the information you provide will be safeguarded except where disclosure is required, authorised or permitted under law.

If you become upset or distressed as a result of your participation in the research, the researcher is able to arrange for counselling or other appropriate support. Any counselling or support will be provided by staff who are not members of the research team.

Below is a list of contact details of organisations that may be of assistance:

Turning Point Counselling Service – (03) 8413 8444

Turning Point Counselling Online – www.counsellingonline.org.au

Melbourne Sexual Health Centre – (03) 9341 6200 Free call – 1800 032 017

Directline – 1800 888 236

Positive Counselling – (03) 9530 2311

Appendix 4

Victorian AIDS Council/Gay Mens Health Centre Counselling Service - (03) 9865 6700

Lifeline – 131114

7. Privacy, Confidentiality and Disclosure of Information

The information you give us will only be seen by the people involved in the study (the research team) and you will not be personally identified. Hand-written notes or tape-recorded interviews will be destroyed at the end of seven years. All electronic files will be kept on password protected computer files at VACCHO for seven years. Hard copies will be kept in a locked cabinet at VACCHO for seven years.

Any information obtained in connection with this project and that can identify you will remain confidential. It will only be disclosed with your permission, except as required by law. If you give us permission by signing the consent form, we plan to publish the results in a community report. In the report, information will be provided in such a way that you cannot be identified. You can use a pseudonym (fake name) if you do not want to use your real name.

8. Results of Project

The report will be made available at www.anex.org.au and www.vaccho.org.au, as well as participating NSPs, ACCHOs and other related health services, in March 2010. A community report will also be available on a website the project partners are developing (name of website to be supplied).

9. Ethical Guidelines

This project will be carried out according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) and Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research (June 2003) and the National Aboriginal Community Controlled Health Organisation Data Protocols.

The project has been approved by the Human Research Ethics Committee of the Department of Human Services.

10. Further information or any problems

If you require further information or if you have any problems concerning this project, you can contact the principal researcher responsible for this project, Mr John Ryan, on 03 9486 6399 or any of the following people:

Name: Peter Waples-Crowe

Role: Associate Researcher

Telephone: 03 9419 3350

Name: Liz Sutton

Role: Associate Researcher

Telephone: 03 9486 6399

Appendix 4

11. Other Issues

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact

Name: Mr Jeffrey Chapman

Position: Secretary, Human Research Ethics Committee.

Telephone: C/O Ethics Committee Secretariat (03) 9096 5239.

E-mail: research.ethics@dhs.vic.gov.au

Thank-you for your time and consideration!

Appendix 4

VACCHO (Victorian Aboriginal Community Controlled Health Organisation) and Anex

Consent Form

Full Project Title: Action Research - Addressing HIV risks related to injecting drug use in Victorian Aboriginal Communities

I have read and I understand the Participant Information dated 20th May 2009.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements.

I am over the age of 18 years.

Participant's Name/Participant's Pseudonym (printed)

Signature.....

Date.....

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's Name (printed)

Signature.....

Date.....

* A member of the research team must provide the explanation and provision of information concerning the research project.

Note: All parties signing the Consent Form must date their own signature.

Office use only

Client code: