Government of **Western Australia**
Department of **Health**

SiREN
WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network

Department of **Health**

An evidence review from Australia, Aotearoa/New Zealand and Canada for the WA Aboriginal Sexual Health and Blood-borne Virus Strategy

Sexual Health and Blood-Borne Virus Applied Research
and Evaluation Network (SiREN)

Supporting assets

2019

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Citation:
An evidence review from Australia, Aotearoa/New Zealand and Canada for the WA Aboriginal Sexual Health and Blood-borne Viruses Strategy. 2019, Perth: Department of Health: Perth, Western Australia.

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

Contents

This supporting document consists of a series of checklists and summaries on the six domains and the priority populations identified in the *WA Aboriginal sexual health and blood-borne virus strategy 2019–2023*. This document is a supplement to the full evidence review, *An evidence review from Australia, Aotearoa/New Zealand and Canada for the WA Aboriginal Sexual Health and Blood-borne Viruses Strategy.* You can access the review here: https://siren.org.au/evidence-review-for-the-wa-aboriginal-shbbv-strategy.

For further information or support in accessing any of the cited resources, please contact the Sexual Health and Blood-Borne Virus Applied Research and Evaluation Network (SiREN) at ***siren@curtin.edu.au***.

1. Checklists

Clinician checklist

Aboriginal Australians experience significant sexual health issues, including high rates of sexually transmitted infections and blood-borne viruses [1]. One factor which significantly improves sexual health within these populations is culturally-appropriate primary health care [2, 3]. This checklist was developed from the Department of Health's *Working with Aboriginal populations on sexual health and blood-borne viruses: An evidence review from Australia, Aotearoa/New Zealand and Canada* [4]; the following actions can significantly increase the quality of sexual health-inclusive care provided by clinicians and other service providers.

Prior to the consultation

- Undergo cultural safety [5] and sexuality and relationship education [6] training (where available)
- Familiarise yourself with guidelines on processes such as taking a sexual history and ensuring adequate contact tracing [7, 8], and providing women's business-appropriate sexual health care [9]
- Collect feedback from, and include, Aboriginal community members and peer workers in group supervisions and clinic-wide decision-making, including in medical/clinical practicums
- Familiarise yourself with the community/ies which you will most likely be working with and their specific cultural health needs through community consultation, participation, and partnership
- Build relationships with ACCHOs and other clinics and services who work with the same community/ies
- Make Aboriginal-specific/culturally appropriate sexual health education resources available, including visual resources or those written in/alongside language [10-14]
- Develop intake forms with options for gender/sexual diversity, as well as places to disclose priority populations (see next section)
- Where possible, coordinate data collection methods and priorities with neighbouring services

- Consider ways to make your clinical space more culturally secure
    - Adequate staffing of both men and women
    - Adequate staffing of Aboriginal professionals, including peer workers
    - Adequate staffing of sexual health-trained or specialised professionals
    - Communicating the availability of sexual health-trained and/or culturally informed/appropriate staff clearly in the waiting room
    - Discrete means of pathology collection
    - Offering outreach services
    - Offering self-testing where possible
    - Providing condom machines or other forms of contraception distribution which do not involve entering the clinic
    - Separation between men’s spaces and women’s spaces (e.g. waiting rooms)
    - Utilising TTANGO (Test, Treat ANd GO)

In the consultation

- Confirm Aboriginal/Indigenous status, including language group/country where possible/appropriate
- If not included in intake form, confirm whether patient belongs to a priority population, including any person who is
  - A current or previously incarcerated person
  - A parent or someone who has experienced pregnancy either currently or historically
  - A person who uses or injects drugs
  - A sex worker or has previously engaged in sex work
  - Diagnosed with an STI, either currently or historically
  - Gender and/or sexually diverse
  - Houseless or is experiencing high geographic mobility
  - Living remotely
  - Living with HIV/AIDS
  - Living with hepatitis
  - Qualifies as experiencing low income [15]
- Record above factors clearly into data management system
- Offer at-risk population/sub-population-specific testing and treatment regardless of symptomology or diagnosis/lack thereof
- Offer to follow up with primary clinic/practitioner if person is away from home or otherwise geographically mobile
- Provide education or educational resources on any issues which the person may be affected by (e.g. Undetectable Viral Load for HIV+ people or those at higher risk of acquisition)
- Follow up on vaccination schedule and/or STIBBV treatment

Following the consultation

- Ensure demographic data is recorded and appropriately stored in the system
- Document any complex cases and bring into supervision
- Regularly analyse collected data to detect potential patterns of STIBBV transmission
- Share relevant, anonymised information and statistics with neighbouring services and the broader community/ies (where possible)
- Follow up with patients who are high-risk or have received a positive STIBBV diagnosis
- Provide adequate partner STIBBV notification where appropriate

Public health practitioners checklist

Current public health approaches need to be significantly modified to appropriately accommodate for the needs of Aboriginal Australians and their communities [1, 2]. While some of these needs are due to socioeconomic factors such as low income, transience, and lack of available services [3-14], there are approaches to sexual health prevention and education which can significantly improve Aboriginal Australians' experiences of sexual health and general healthcare. This checklist was developed from the Department of Health's *Working with Aboriginal populations on sexual health and blood-borne viruses: An evidence review from Australia, Aotearoa/New Zealand and Canada* [15]; the following actions can significantly increase the quality of Aboriginal people-oriented sexual health education provided by educators and other public health practitioners.

Alternative and innovative education and prevention frameworks

- Embed Aboriginal knowledge and traditional ways into your program, and focus on culturally competent, empowering, and community-led approaches [16-23]
- Focus on people's and communities' strengths, resilience, and wellness (as opposed to deficiencies, vulnerability, and illness) [2, 24, 25]
- Construct education and prevention frameworks which include pleasure, intimacy, and relationship navigation [26-29]
- Facilitate dialogue between family members (particularly young people and their parents or guardians) and engage with whole family units (where possible) when delivering programs [26, 30-36]
- Construct programs and strategies which focus on skill development, promoting self-efficacy, and creating tools that communities can continue to use following any intervention [19, 37-42]
- Centre trust-building and relationship development in the construction and delivery of your program [43-45]
- Integrate pre-existing frameworks such as Sexuality and Relationship Education (SRE) into your own approach [46]
- Approach sexual health education and prevention as a continuous process which can be embedded into everyday life, rather than restricted to clinics and classes [47, 48]

Community-focused education and prevention methods

- Include peer educators and mentors [18-23]
- Include other experts by experience (e.g. sexually transmitted infections and blood-borne virus [STIBBV] positive people) [49]
- Create program delivery protocols which significantly address issues of confidentiality and privacy [6, 33, 50-55]
- Advertise your service or program widely and inform communities of what is on offer [23, 56]

- Utilise Aboriginal languages and work towards bridging language gaps around topics such as the physiology of sexual health and human biology [48, 57]
- Utilise art and other creative media [19, 58-62]
- Utilise yarning, storytelling, and other means of education and prevention which make room for community members' voices [17, 22, 35, 52, 63-70]
- Utilise humour and accessible language [71]
- Embed pleasure and intimacy into your program delivery, particularly with younger or mixed audiences [28, 29]
- Deliver materials in a wide variety of contexts, and consider which contexts are most beneficial for which demographic or community [5, 47, 48, 72]
- Undergo sexual health and cultural competence training [46, 73-75]
- Treatment as prevention, such as pre-exposure prophylaxis (PrEP), is highly effective with certain STIBBVs [76]
- Maintain and expand the use of contraception and harm reduction dispensaries such as condom machines and needle and syringe programs [23, 77-80]
- Include mobile and outreach methods which reach mobile people and communities
- Provide vaccinations and appropriate, timely follow-up [81-86]
- Utilise technological aides such as mobile phone apps and social media, where communities or research has indicated that it is appropriate [26, 87-91]

Research practitioners checklist

Aboriginal Australians experience significant sexual health issues, including high rates of sexually transmitted infections and blood-borne viruses (STIBBVs) [1]. Culturally-competent research with these populations has been shown to have a significantly positive impact on how communities' sexual health needs are evaluated and met [2]. However, current research in the area has significant gaps in how complete and accurate the data are, particularly around rates of STIBBV transmission and treatment; this data incompleteness affects funding bodies' and health services' capacity to properly assess communities' needs, thereby negatively affecting the quality and quantity of services made available to affected populations [3-8]. This checklist was developed from the Department of Health's *Working with Aboriginal populations on sexual health and blood-borne viruses: An evidence review from Australia, Aotearoa/New Zealand and Canada* [9]. The following actions can significantly increase the quality of research in the area of Australian Aboriginal sexual health and should be considered in conjunction with other general guidelines on conducting ethical research within Aboriginal communities [10-12].

Inclusive research epistemologies

- Engage with methodological frameworks which centre the perspectives of Aboriginal people and focus on the ways Aboriginality intersects with other sociocultural issues such as poverty, race, or class (e.g. decolonising, Indigenist, and/or intersectional methodologies) [13, 14]
- Utilise frameworks and research standpoints, as well as produce outputs, which acknowledge the role of colonisation in shaping Aboriginal history [15-18]
- Centre the research on Aboriginal ways of knowing, and consider the difference in approaches to research which Aboriginal knowledge and ways of being may provide [15-24]
- Consider the impact your research may have on the researched community/ies, and orient your study in ways which benefit those communities [17-21, 23-26]
- Wherever possible, utilise Participatory Action or similar community-based research approaches [22, 27-49]

Methods of research

- Prioritise community consultation, employment, and leadership, both through individual Aboriginal participants/researchers and Aboriginal community-controlled health organisations (ACCHOs) [14, 29, 43-51]
- Pay particular attention to including the voices of Elders, as they are often decision-makers and keepers of stories within different communities [51-54]
- Construct study frameworks which ask 'the right questions in the right ways'. This can be worked towards by focusing on: interview and study schedules which treat communities and participants with respect, patience, and a sense of equity; working at data collection and study implementation more broadly with an awareness of Aboriginal peoples' unique position as experts by experience, and; negating current research discourse which either positions Aboriginal people as entirely disempowered or wholly responsible for their marginalisation [55-57]

- Provide clinical testing and treatment wherever possible and useful, in order to maximise community benefits from, and participation in, the study [58]
- Embed reflexive practices such as journaling, intra-team discussion, and community consultation into the study structure, in order to be better responsive and conscious of any biases forming within the research and its execution [13, 18]
- Technologically-assisted research approaches, such as methods utilising mobile phones, are increasingly becoming useful tools for research, particularly with more remote communities [59-62]

Areas of focus

There are many areas of Aboriginal sexual health research which require further investigation and on-going surveillance. The list below is by no means exhaustive, but represents some current trends and necessities in the field, as well as knowledge gaps:

- Rates of testing, diagnosis, and treatment for sexually transmitted infections and blood-borne viruses (STIBBVs)
- Innovative methods for education, testing, and treatment
- How racial discrimination and violence affects sexual health
- Impact of socioeconomic (e.g. income, housing, number of people per household) and other intersecting life factors (e.g. intravenous drug use, sex work, childhood sexual assault) on sexual health
- Evaluating and improving health service architecture and protocols
- Protocols to evaluate and improve data completeness and linkage
- Integration of traditional methods into biomedicine
- Natal care and birthing parents' health
- Population-specific STIBBV strains and their treatment
- Specific communities and their needs
- The impact of technology on research
- Priority populations
  - Young Aboriginal people
  - Incarcerated people
  - Aboriginal people living with HIV and other blood-borne viruses
  - Sex workers
  - Women and women's business
  - Men and men's business
  - People who inject/use drugs
  - Gender and sexually diverse people, including brotherboys and sistergirls
  - Aboriginal people living in rural and remote communities
  - People experiencing houselessness

2. Domain summaries

Prevention and education

What are the issues?

Education and knowledge on sexual health and prevention strategies is a significant issue for Australian Aboriginal communities. Many Aboriginal communities have stigmatising or incomplete understandings of sexual health and blood-borne viruses (SHBBVs) [1-3], which leads to inconsistent individual prevention practices [4-6]. This low literacy is often further impacted by differences between Western and Aboriginal language and conceptions of the body [6, 7]. There are also on-going issues with communities' inability to access ongoing affordable prevention tools such as condoms, vaccinations, safe injecting equipment, and health services as a whole [8-14]. Rural and remote communities, as well as Aboriginal people who are often geographically mobile, are particularly impacted by these factors, often due to compounding factors such as a lack of resources, healthcare frameworks which do not take into account rural communities' specific needs, and communities' lack of awareness of available resources [3, 14-18].

In addition to community-level issues around education and prevention, healthcare providers and school-based educators also contribute to ongoing sexual health issues within Aboriginal communities. Health workers and educators who are under-trained in sexual health and/or culturally-competent practices provide insufficient or inappropriate care to community members [19-21], which significantly affects Aboriginal people [22-25]. These insufficient individual practices are often due to gaps in current training, policies, and governing officials' attitudes around these issues [2, 26, 27].

What's working?

There are several education and prevention strategies which encourage and maintain community engagement and learning [28]. Education programs which use arts, yarning, humour, and approaches which include discussions of pleasure, intimacy, and navigating relationships are both popular and effective for many Aboriginal communities [29-42]. Additionally, sexual health education is improving by using frameworks which take sexual education out of the classroom and into everyday situations, focus on individuals' strengths and developing skills and resources, and include peers (both Aboriginal and those with a sexually transmitted infection or blood-borne virus diagnosis), families, communities, and traditional ways in how they are developed and delivered [7, 14, 35, 43-57]. These approaches are further improved by services working to develop strong and long-lasting relationships with the communities they work for [58-60]. Although some studies suggest that utilising technology, particularly social media, may be a useful education tactic [61, 62], current knowledge is inconclusive/contradictory [63], and further research is needed [28, 64, 65].

In the area of prevention, there are several promising approaches. Treatment as prevention (TasP) strategies, specifically pre-exposure prophylaxis (PrEP), are highly effective tools in HIV prevention specifically [66]. Similarly, providing communities with condoms, clean needles, and other sexual/blood health supplies significantly reduces the chance of sexually transmitted infections and blood-borne virus (STIBBV) transmission [14, 67-69]. These approaches are particularly impactful in prisons and more rural/remote areas where STIBBV prevalence is high [13, 68, 70, 71], as well as with other Aboriginal populations.

What needs to change?

Healthcare professionals and school-based educators require significant training in sexual health and Aboriginal cultural competence [3, 21, 72, 73]. These are best addressed by sexuality and relationship education and cultural competence upskilling frameworks [21, 74]. More broadly, healthcare workers and educators need to immerse themselves in the communities they service [58-60], in order to counteract the mistrust and avoidance many Aboriginal communities have of healthcare services and workers [12, 37, 75-77]. Condom machines and needle syringe programs also need wider proliferation in order to reach more of the Australian Aboriginal population [13, 14, 67-71].The ethical considerations related to the growing set of digital education and prevention strategies need to be further evaluated as the field evolves, particularly around management of boundaries, confidentiality, and data storage [78-80].

Testing and diagnosis

What are the issues?

Aboriginal Australians are at high risk of acquiring sexually transmitted infections and blood-borne viruses (STIBBVs) and experiencing related complications such as cancers, co-infection, and forward transmission of STIBBVs due to lack of virological suppression [1-33]. Although this means that Aboriginal Australians as a marginalised population are one of the most tested for STIBBVs in Australia [33, 34], they continue to face issues with the frequency, quality, and consistency of STIBBV testing and follow-up, which negatively impacts their capacity to prevent and treat STIBBVs in a timely manner [9, 35-37]. This includes increased risk of developing infections and experiencing other sexual health and blood-borne virus (SHBBV) complications [38-40]. These issues are caused by a broad range of factors, including insufficient services and staffing (particularly rurally), lack of culturally competent and sexual health-trained service providers, direct experiences of racial discrimination in clinical settings, societal and in-community stigmatisation and lack of knowledge of STIBBV testing and treatment, and insufficiently discrete clinic layouts [34, 41-46].

In addition to issues with delivery of testing and follow-up, there are significant issues with how testing and diagnosis rate data are collected. Australian data on STIBBVs remains incomplete or inconsistent across cities/states [25, 47-49]. Less complete data often results in inadequate service provision, which in turn often further damages the data’s accuracy [50]. Aboriginal Australians’ data is particularly incomplete [51-54], especially for overall infection rates and rates of prevention service use [48, 55, 56].

What’s working?

Services which provide well-timed and consistent follow-up significantly improve their clients’ capacity to prevent and manage STIBBVs [57-61]. The efficacy for testing and follow-up is aided by data linkage i.e. data from one service being available to other services which work with the same community, thereby making it clearer to see which clients are attending regularly and which require additional contact [62-64]. In addition to these administrative tasks, alternative testing methods such as tests which are self-administered, delivered in non-clinical settings, or otherwise opportunistic rather than scheduled (e.g. point-of-care, rapid testing) are effective complementary tools to use alongside regular clinical testing [39, 58, 65-83].

What needs to change?

Overall, protocols around testing, diagnosis, follow-up, and related data collection and dissemination need to be significantly improved for Aboriginal Australians [51-54]. This includes increased support and planning for a broader range of testing methods and venues, more cohesive data completeness and linkage, and utilising these tools to provide better follow-up on diagnoses and treatments. Finally, increasing cultural competence for all health workers in testing and diagnosing services would significantly reduce the amount of stigma and discrimination experienced by Aboriginal Australians, and increase their likelihood of attending services and receiving adequate care [84-86].

Disease management and clinical care

What are the issues?

Aboriginal Australians experience significant delays, inconsistencies, and insufficient access to sexual health and blood-borne virus (SHBBV) healthcare [1-6], with few services achieving the required attendance and treatment quotas for their serviced communities [7, 8]. This issue particularly affects Aboriginal Australians living with HIV, who are unable to sufficiently reduce their viral load and achieve an 'undetectable' status due to these inconsistencies [5]. There are several barriers to providing better sexually transmitted infections and blood-borne virus (STIBBV) healthcare for Aboriginal Australians, including:

- Lack of funding (particularly for rural and remote areas)
- Lack of financially-accessible services and treatment options
- Clients being given insufficient information about STIBBV risks and treatments
- Current biomedical models of testing, treatment, and management being in conflict with the less linear approaches to health adopted by many communities
- There is insufficient knowledge of STIBBV strains specific to certain Aboriginal populations
- Service providers insufficiently addressing the psychological issues which co-exist alongside sexual health issues
- Insufficient data linkage fails to account for the increase in likelihood of infection for clients with previous STIBBV diagnoses
- Services which do not appropriately accommodate for the cultural needs of a community (e.g. kinship systems, health-related rules around gender) [9-21]

What's working?

Person-centred, culturally-competent approaches to treatment are highly effective with Aboriginal Australian communities [22-26]. These are made even more effective by providing Aboriginal Australian clients with psychological support [11-14], and addressing a person's needs while taking into account how their broader community operates [27, 28]. Integrating Aboriginal approaches to medicine alongside Western biomedicine, through the use of traditional medicines healers, and healing methods, increases community engagement and the likelihood of providing community members with appropriate treatment [29-31]. With the advancement of telemedicine and online sexual health information, communities which have been provided with sufficient technological access have shown improvement in engagement with healthcare providers [32]. Utilising outreach services to supplement in-clinic SHBBV support is also proving effective at increasing engagement and the provision of healthcare to more hard-to-reach subpopulations such as Aboriginal people living in remote communities [33-35].

What needs to change?

In order to provide appropriate SHBBV disease management and clinical care to Aboriginal Australians, service providers need to address the significant economic, cultural, and geographic gaps between Aboriginal Australians and the broader population. This includes providing services which are flexible in timing and location, accessible to people with lower or no income, and operate in a way that is inclusive of both people and their communities' needs. By providing services which are structured with Aboriginal cultures, systems, and perspectives in mind, healthcare providers are able to increase engagement and access for a broader range of Aboriginal Australians.

Workforce development

What are the issues?

Australian Aboriginal health workers (AHWs) (e.g. Aboriginal Liaison Officers, Aboriginal Health Workers, Aboriginal Cultural Advisors) significantly improve healthcare providers' quality of service to Aboriginal communities, by using their skills to increase community engagement and empowerment, proactively address the Aboriginal health gap, and provide greater accountability from their health service to the community [1-8]. However, there are several barriers which prevent AHWs from being as present and impactful as they can be in working on sexual health and blood-borne virus (SHBBV) issues with Aboriginal Australian communities. These include:

- Racism and discrimination in workplace and training environments, and its impact on both AHWs and Aboriginal clients
- High staff turnover, service under-staffing, and overall under-employment compared to their non-Aboriginal counterparts
- Lack of SHBBV training and guidelines
- Insufficient employment of male staff in particular, due to the specific requirements of men's business
- Conflicts with other health services
- Lack of supervision and support
- Time and funding pressures [6, 9-26]

Non-Aboriginal health workers (NAHWs) also experience barriers to delivering culturally-competent and cohesive sexual health services. While many experience some of the same barriers mentioned above, their capacity to engage with Aboriginal communities is further impacted by a lack of training in culturally-appropriate means of communication [27]. Even for those NAHWs who are well-trained or otherwise well-immersed in their serviced communities, structural inequalities and organisational frameworks which lack cultural safety protocols can significantly inhibit their capacity to provide appropriate services [28].

What's working?

AHWs benefit significantly from workplaces which focus on appropriately recruiting, retaining, training (including SHBBV specialisation), and supervising AHWs, as well as including them in workplace decisions and design [24, 29-32]. This includes involving AHWs as educators, particularly in clinical education settings [33]. AHWs' capacities are further developed through service approaches which are interdisciplinary (both clinical and non-clinical), collaborative with other agencies in their area, responsive to the specific methods which best address their community's needs, and empower AHWs to increase access to knowledge for themselves, their colleagues, and their community [17, 18, 20, 34-37]. NAHWs benefit significantly from training which reorients their communication style and promotes community immersion and engagement, which in turn allows for more comfortable and safe interactions with people and communities [27, 38-40]. For both AHWs and NAHWs working with Aboriginal communities, individual training must be coupled with organisational and structural guidelines which are oriented towards benefiting Aboriginal peoples, in order to fully facilitate their capacity to engage with communities constructively and effectively [28].

What needs to change?

There are individual, community, and structural factors that need to be improved in order to best facilitate both AHWs and NAHWs in SHBBV healthcare settings. At an individual level, they need to be provided with SHBBV-specific training such as safe syringe disposal and safe sex practices [24, 29-32]. At a community level, AHWs in particular need to feel empowered and be supported to engage with their serviced community and provide the appropriate support [6, 17], while NAHWs require training and support to safely and deeply engage with their serviced communities [27, 38-40]. Structurally, workplace discrimination requires significant focus, including cultural competence training for all employees and the creation of best practice policies which directly address cultural safety and the impact of racism on workers and Aboriginal/non-Aboriginal work relations [9-15]. Alongside these, AHWs need more financial and structural support to remain employed and have access to the resources needed to work with their community.

Enabling environments

What are the issues?

Racial discrimination against Aboriginal Australians within the healthcare system is rooted in Australia's history of colonisation, and the ways in which these early experiences have evolved into contemporary issues of racism and created intergenerational trauma [1-3]. Experiences of racial discrimination and marginalisation significantly impact Aboriginal Australians' quality of healthcare, including disruptions to childhood development which affect these communities later in life [4-18]. Racial discrimination often impacts Aboriginal healthcare providers, reducing their capacity to provide efficient clinical care [19, 20]. In addition to individual-level discrimination, institutional racism (the exclusion and marginalisation of Aboriginal Australians at a structural level e.g. policies, social norms, architecture) results in Aboriginal peoples' cultural, health, and safety needs often not being met, and at times directly opposed [4, 12, 20-26].

In the realm of sexual health and blood-borne viruses (SHBBV), experiences and perceptions of racism within clinical spaces translates to community members either attending clinics insufficiently or avoiding them entirely due to discomfort and safety concerns, which affects testing and treatment rates for sexually transmitted infections and blood-borne viruses (STIBBVs) [3, 5-8, 12, 13, 26-30]. Community members' aversion to clinic attendance can also increase the likelihood of unsafe sex practices and the resultant increase in STIBBV transmission, due to insufficient SHBBV education [3, 12, 30-37]. Often, racial discrimination against Aboriginal Australians within SHBBV healthcare settings is the result of staff who have not received sufficient cultural competence and sexual health training, which results in the provision of incomplete care [38-43].

What's working?

Staff, service providers, and institutional bodies who operate within a culturally competent framework and integrate Aboriginal cultures into their practices significantly improve Aboriginal peoples' comfort, safety, and access to healthcare [44-56]. There are several key methods which assist in providing culturally-competent healthcare practices:

- Decolonisation as a lens highlights the connection between Aboriginal peoples' histories, particularly experiences of colonisation, and how these affect modern day experiences and practices; this includes addressing the shame and stigma associated with SHBBVs both within Aboriginal communities and broader society, and the ways in which sociocultural factors such as income and traditional cultural practices might require altering the path taken to achieving better Aboriginal sexual health [36, 42, 46, 57-79].
- Syndemic (also known as holistic or systematic) approaches involve empowering communities to utilise their resilience, strengths, and pre-existing capacities to work towards better health; policy-makers, service providers, and health workers utilising these frameworks work collaboratively with communities to create better-equipped leadership, stronger community ties, more culturally competent services, and SHBBV/general health resources which utilise traditional language, images, and methods in order to develop better rapport and deliver more comprehensive and useful healthcare [36, 45, 46, 66, 78-102].
- Respectful design refers to physically structuring health services in ways which are in line with Aboriginal Australians' needs; the primary issues that respectful design contends with is ensuring that SHBBV services provide ample gender separation (to accommodate for men's and women's business) and privacy (to reduce shame or embarrassment), and to structure service venues with communities' needs and consultation as the priority [21, 22, 24, 68, 103, 104].
- Clinical training plays a significant role in increasing service providers' capacity to provide culturally-competent and factually complete sexual health care; well-trained clinicians are able to provide holistic and well-informed care, build trust and develop sustainable relationships with their serviced communities, as well as advocate on behalf of Aboriginal clients and their communities for better standards of health [44-56, 82, 105-110].

What needs to change?

In order to improve Aboriginal Australians' sexual health, there is a need to address racial discrimination at an individual, societal, and institutional level. The methods discussed in the above section can provide some insight into some of the ways these larger processes of change can be enacted and reinforced. This includes creating healthcare providers and developing workers who are trained in culturally-competent service provision, as well as directly countering the negative impacts of colonisation through individual and societal education. Government policies need to be developed with communities' needs in mind, and utilise community consultation and leadership wherever possible.

Research, evaluation and surveillance

What are the issues?

Despite the effectiveness of program evaluations and other means of sexual health and blood-borne virus (SHBBV) surveillance [1], research in the area of Aboriginal SHBBVs is providing an incomplete picture of current Aboriginal communities' needs. SHBBV national data has multiple gaps in terms of particular diseases, testing, and treatment rates being collected, leading to insufficient SHBBV service provision [2-7]. Alongside issues with clinical data, there are difficulties with Aboriginal communities' mistrust of researchers, due to misrepresentation and mishandling of Aboriginal communities in a significant portion of research projects historically and in the present day [8]; this mistrust reduces communities' likelihood of participating in vital SHBBV research. Additionally, research and evaluation projects are often met with barriers such as insufficient funding, changes in sexually transmitted infections and blood-borne viruses (STIBBVs) testing and data collection protocols and pro forma, and bureaucratic delays and blockages [5, 6, 9-15].

What's working?

There are several methods and methodologies which contribute to more comprehensive and holistic SHBBV research with Aboriginal communities. Research methodologies which take a decolonising, collective impact, participatory action and/or intersectional lens are centred around collective and collaborative action, community benefits, consultation and leadership, accessibility of knowledge, and addressing the impact that colonisation and contemporary marginalisation have had on Aboriginal peoples [16-38]. These methodologies also focus on building trust, rapport, and long-term relationships between researchers and communities, and utilising those relationships to gain deeper and richer knowledge of community members' experiences and needs, as well as challenging social norms and stigmas within and outside these communities [37, 39-51].

There are also more overarching approaches which benefit both researchers and communities when applied to a project. These include ensuring that researchers treat communities with respect, provide ample time to respond to questions or any other time-based aspect of a study, and work against Aboriginal peoples' negative historical experiences with research that was disempowering, misrepresentative, damaging, or has shifted the blame and responsibility for health crises and other community-wide health issues entirely onto those communities [52-55]. There are also many data collection, output, and knowledge translation methods which facilitate enacting these methodologies:

- Including Aboriginal peers and Aboriginal Community Controlled Health Organisations (ACCHOs) throughout the research process
- Involving Elders and Traditional Owners in the research process
- Body mapping
- Community immersion and deep engagement
- Co-writing and co-owning knowledge with community members
- Utilising language in research and knowledge outputs
- Utilising technological aides (e.g. mobile phones) for alternative means of data collection
- Yarning and storytelling
- Engaging service providers and clinicians in processes, including providing participants with clinical services
- Researcher reflexivity (e.g. journaling) as a means of curbing biases, providing further transparency around research process developing accountability to the community, and encouraging further immersion [9, 17, 19, 23, 31, 38, 45, 46, 56-80]

What needs to change?

Research, evaluation, and surveillance of Aboriginal communities' SHBBVs require increased capacity and support for more comprehensive data collection. This includes improving guidelines and protocols for how clinical data are collected and stored, and the way these data are then utilised by service providers needs to be further stratified. Additionally, in order to provide culturally competent research with Aboriginal communities, researchers need to focus on producing research projects and outcomes which engage the researched communities, emphasise those communities' capacities, and focus on alternative research approaches which may be better suited to communities' needs compared to more traditional Western research methods.

3. Priority population summaries

Incarcerated Aboriginal people and sexual health

What are the issues?

Australian Aboriginal peoples experience significant rates of incarceration compared to the general population [1, 2]. Incarceration significantly increases the likelihood of acquiring sexually transmitted infections and/or blood-borne viruses (STIBBVs), particularly for incarcerated people who practice less safe sex and drug injection methods, including needle sharing [1-8]. Incarcerated Aboriginal women are also more likely to experience sexual abuse and exploitation [16], as well as having higher rates of HIV treatment attrition [15]. Despite relatively low rates for chlamydia [9], and higher rates of hepatitis B immunity [10], hepatitis C remains a particular health risk for most incarcerated Aboriginal peoples [11-13]. It must be noted that rates of infection vary depending the prison's location and the incarcerated person's urban or rural background [14].

What's working?

Harm reduction methods, such as providing condoms and making clean needles available for prisoners through needle and syringe programs, significantly improve the sexual health of incarcerated Aboriginal people [11, 15, 16]. Preventative measures such as screening, vaccination, and substance misuse support services also significantly reduce rates of STIBBV infection and transmission [8, 14, 17]. Finally, providing incarcerated Aboriginal people who have acquired an STIBBV with appropriate treatment significantly increases their quality of life [8], and in the case of people living with HIV, treatment significantly reduces or eliminates the likelihood of further transmission [18]. Health promotion messages are also an effective tool for sexual health education within incarcerated Aboriginal populations [3].

What needs to change?

Incarcerated Aboriginal peoples remain a high risk group for STIBBVs [1, 2, 5, 7, 8]. In order to prevent and reduce rates of transmission across all incarcerated populations, prisons must instate services which provide adequate contraception, clean injecting equipment, and services which support and treat incarcerated Aboriginal people regardless of their STIBBV status [8]. This includes providing these services in a timely manner which reduces the likelihood of disrupted efficacy for treatments such as vaccines [14].

LGBTQIA+ Aboriginal people and sexual health

What are the issues?

Lesbian, gay, bisexual, transgender, queer, intersex, asexual, and otherwise gender and/or sexually-diverse (LGBTQIA+) Aboriginal people experience significant issues with sexual health [1], including high rates of sexually transmitted infections and/or blood-borne viruses (STIBBVs) compared to the general population [2, 3]. There are also issues with higher-risk sex (e.g. condomless penetrative sex), substance use, lack of education on treatment options, and insufficient testing, particularly for gay and bisexual men and transgender women, which make treating BBVs such as HIV particularly difficult [4-12]. These issues are exacerbated by the discrimination, lack of education, and shame which surrounds sexual and gender diversity within Aboriginal communities, and racial, sexual, and gender-based discrimination in society more broadly [3, 13-15]. Although some research about these communities is available, there is relatively little literature on the topic, despite this population's vulnerability and the availability of multiple support groups [16-22].

What's working?

LGBTQIA+ Aboriginal people require workers and services who are aware of the ways the intersection of Aboriginality and sexual and/or gender diversity impacts people and communities [23]. An important aspect of this intersectional approach is the use of culturally-appropriate language (e.g. sistergirl, brotherboy) [3, 24], and centring services on Aboriginal empowerment, self-determination, and traditional ways [25]. Education and healthcare which are available online may prove useful for the population in the future, although issues with confidentiality, data storage, and use of data remain barriers for participation [26]. Treatment as prevention programs which are targeted specifically at Aboriginal LGBTQIA+ people have also been effective in some communities [27], though these have yet to undergo official evaluation.

What needs to change?

LGBTQIA+ Aboriginal peoples' sexual health needs remain unmet by current healthcare services [3]. Quality of care and inclusion in education materials must be prioritised [14, 15]. This includes on-going inclusion of Aboriginal people in HIV care and health promotion, to reflect their equivalence in infection rates to the non-Aboriginal population [8, 12, 28, 29]. Stigma and discrimination against LGBTQIA+ Aboriginal people also needs to be addressed, both at an individual and systematic level [7, 25, 30]. Ultimately, the self-determination of LGBTQIA+ Aboriginal people in sexual health, as well as in health and society more broadly, needs to be prioritised at a service provision, policy, and societal scale [25, 30].

Aboriginal people living with HIV

What are the issues?

Aboriginal people living with HIV (PLWH) are over-represented among the population of people who are Human Immunodeficiency Virus (HIV) positive [1-6], with rates of HIV notification for Aboriginal Australians being triple those of the non-Aboriginal population [7]. Aboriginal PLWH experience higher mortality rates [8-11] and an increased likelihood of the co-existence of other health issues such as substance misuse [12], depression and other adverse psychological responses [13, 14]. Within the Aboriginal PLWH population, there are smaller populations who are even more significantly affected by HIV: people who have experienced childhood adversity [15], people who inject drugs (PWID) [16], LGBT+ people (particularly men who have sex with men) [17-22], and women [23-28]. Women living with HIV (WLWH) are particularly impacted, with higher rates of mortality and resulting ill-health compared to their non-Aboriginal or male counterparts [23-28]. WLWH are also more likely to avoid or receive appropriate care [29], particularly when using substances [30], which can therefore increase their likelihood of transmitting HIV to their babies [31-37].

Aboriginal PLWH experience incomplete medical care, often delivered by clinicians with inadequate knowledge of working with Aboriginal PLWH [8, 27]. This has resulted in higher mortality rates within some communities [38]. A significant factor which affects the quality of care provided is HIV stigma: clinicians who have more stigmatising attitudes towards HIV are less likely to provide appropriate treatment, and Aboriginal people who are either at risk or have received an HIV diagnosis are less likely to be tested or treated if they hold stigmatising or misinformed views of HIV, HIV+ people, and the way HIV treatments interplay with life factors such as substance use [39-49]. Aboriginal PLWH's pathway to proper diagnosis and treatment may also be influenced by other factors such as whether a clinic is designed with the community's needs in mind, the geographic distance between a person's home and the clinic, lack of community support or understanding on the topic, substance misuse, economic barriers to transport and payment for care, and other cultural and life commitments which overshadow the urgency for treatment [49]

What's working?

The most vital aspect of impactful treatment for PLWH is highly active antiretroviral treatment (HAART), which improves quality of life and reduces the likelihood of forward transmission [8, 27, 33, 50]. The same regime is also useful when used as pre-exposure prophylactic (PrEP) [51]. Culturally-appropriate information and culturally-informed services are also effective tools in reducing HIV transmission and stigma, and improving the likelihood of an Aboriginal PLWH accessing medical care [52-55]. Condom provision and use also significantly reduces the likelihood of HIV transmission [56], particularly for incarcerated people [57]. Beyond these top-down services, one of the most significant protective factors for Aboriginal PLWH is their resilience, and their capacity to navigate interactions with medical professionals and the healthcare system more broadly [23, 39, 58].

What needs to change?

One of the most significant factors which continues to affect the quality of life for Aboriginal PLWH is the stigma of HIV, both in reducing the quality of medical professionals' treatment for Aboriginal PLWH and the resulting shame for Aboriginal PLWH which decreases their likelihood of accessing treatment [39-49]. This same stigma and misinformation also prevents Aboriginal people from accessing PrEP and other preventative tools [51, 59]. Therefore, Australian health services and Aboriginal communities need to collaborate in order to be better educated on HIV diagnosis and treatment. Aboriginal people also continue to be significantly economically disadvantaged in Australia [60]. This makes financial barriers to treatment an on-going issue [49], and therefore requires a more systematic approach to making healthcare affordable and accessible to Aboriginal PLWH.

People who use/inject drugs

What are the issues?

Substance misuse, and in particular injectable drug use, significantly affects many Aboriginal communities [1-5]. Young Aboriginal people form a significant part of the Aboriginal substance user population [6-11]. Needle and syringe programs across Australia have reported an increase in attendance in recent years [12], making Aboriginal people who use/inject drugs (PWU/ID) a priority population for health services. Aboriginal people who are either actively misusing substances and/or are dependent on those substances are prone to a broad range of health issues, including risk of blood-borne viruses (BBVs), organ damage, and decreased mental health [13]. Aboriginal PWU/ID are also more likely to have difficulties maintaining consistent schedules such as Human Immunodeficiency Virus (HIV) antiretroviral treatments, hepatitis C treatments, or addiction support services [9, 14-22]. This inability to adhere to treatment or support schedules becomes more likely when Aboriginal PWU/ID also experience other systematic issues such as unemployment or underemployment, transience or high mobility between different cities/regions/states, houselessness or inconsistent housing situations, or stigmatisation and discrimination [11, 23-25].

For Aboriginal PWID who are affected by a blood-borne virus such as hepatitis C or HIV, their injectable substance use is ultimately likely to result in significant loss of quality of life and increased chances of early mortality [10, 26]. It may also affect their immune system’s capacity to suppress HIV, even when receiving appropriate antiretroviral treatment [17, 18]. Overall quality of life is again affected by the same systematic factors described above, particularly unemployment or a lack of consistent living arrangements [27, 28].

Lastly, substance misuse, especially injectable drug misuse, can often increase the likelihood of other riskier behaviours. PWU/ID are more likely to engage in less safe sexual practices, resulting in an increased likelihood of a PWU/ID or their partner acquiring sexually transmitted infection or blood-borne viruses (STIBBVs) [29-51]. Aboriginal PWU/ID who have experienced sexual abuse are particularly affected by this risk [52]. Similarly, certain PWID communities, in particular communities or individuals who have experienced living in child welfare services, are more likely to share needles than their non-Aboriginal counterparts, thereby increasing the likelihood of acquiring or transmitting BBVs [29, 39, 53-55].

What's working?

Despite some of the stigma attached to them [56], needle and syringe programs (NSPs) are one of the most important tools for reducing rates of BBV acquisition across all PWID populations [57]. These programs provide clean needles and syringes and allow substance users to inject more safely than they would with reused needles. Aboriginal PWID are significantly more likely to engage with NSPs which are also culturally competent in Aboriginal ways [36, 58, 59]. Health information resources which are culturally competent are also significantly more likely to reach PWU/ID and other equally at-risk populations [60]. Cultural competence involves the inclusion of traditional modes of healing, recognizing Aboriginal peoples' histories and the ways in which communities are impacted by shame, internalised and societal stigma, and socioeconomic factors, and a focus on relationship-building between works and community members [19, 61-87]. Finally, opioid substitution treatments have been used with some Aboriginal communities as a means of reducing rates of less safe injections, which has resulted in decreased rates of BBV transmission [88].

What needs to change?

Australian Aboriginal people who use or inject drugs are a priority population due to their risks of physical and psychological ill-health [13]. Culturally competent services and resources are a priority, as they significantly affect the likelihood of knowledge and services being delivered in a way that is accessible and appropriate for Aboriginal communities [36, 58-60]. Both substance users and the service which support them remain highly stigmatised, which leads to on-going issues with affirming Aboriginal PWU/ID's specific needs and systematically instating NSPs and similar services where they are most needed [24, 56]. In order to address the stigma associated with substance misuse, awareness and additional destigmatising education needs to be included across public, healthcare, and other systems which Aboriginal PWU/ID may encounter or work within [89].

Aboriginal sex workers

What are the issues?

Aboriginal sex workers (SWs) are significantly represented amongst Australian sex workers (three to four per cent) [1], yet they remain under-served by health services [2], despite some Aboriginal SW populations being at high risk of HIV and other sexually transmitted infections and blood-borne viruses (STIBBVs) [3-6]. These risks are significantly increased if an Aboriginal SW is a person who injects drugs (PWID), or has experienced a previous STI diagnosis, child sexual assault, and/or houselessness [3, 7-11]. Aboriginal women experiencing houselessness, or inconsistent housing situations, represent a significant proportion of the SW population [12], and are also at a particularly high risk of acquiring STIBBVs or experiencing sexual assault [13, 14]. Aboriginal women who are SWs also experience difficulties with custody [15], and street-based workers in particular have reported high rates of child apprehension, the threat of which can result in decreased access to crucial medical services [16, 17].

Aboriginal SWs remain a significantly difficult-to-reach population for researchers [18], partly due to largely working in street-based rather than brothel-based environments [19, 20], making the knowledge base on Aboriginal experiences of sex work, particularly in Australia, relatively small [15]. Similarly, research on STIBBV in Australia shows that Aboriginal SWs are attending health clinics at relatively lower rates compared to population rates (two per cent vs three to four per cent) [21], meaning a significant portion are either not properly captured by current data collection or are not receiving appropriate STIBBV testing and treatment.

What's working?

Aboriginal SWs benefit significantly from services which are proactive in attending to their needs both as Aboriginal people and SWs [22]. This provides additional depth to a service's cultural competence, which is a significant way to improve a health service's ability to address Aboriginal peoples' specific needs [23-32]. Sex work-specific, peer-based support services are also leading the way on highlighting Aboriginal SWs needs [2], and provide Aboriginal SWs with the same services that are effective for other SWs, such as condom provision, counselling, and testing [22]. Research with other sex worker populations also indicates that while SWs do experience significant health risks, it is important to acknowledge the complex balance of positive and negative factors associated with sex work [33]. This allows a strengths-based, rather than deficit-focused, approach, which is an effective tool for working with both Aboriginal and sex worker communities towards better health outcomes [34, 35].

What needs to change?

Further research on the specific experiences of Aboriginal sex workers in Australia needs to be conducted in order to capture a fuller picture of their specific health needs. It is also important to note that although Aboriginal SWs are an at-risk population, sex work in and of itself is not always a determinant of sexual health risks [6].

Young Aboriginal people

What are the issues?

Young Aboriginal peoples are at significant risk of acquiring sexually-transmitted infections and/or blood-borne viruses (STIBBVs) and experiencing Human Immunodeficiency Virus (HIV) viral rebound, wherein a person with HIV has detectable levels of the virus in their blood [1-7]. Condom use varies widely between different communities [8-11], and many young Aboriginal peoples report issues around within-community stigma and mistrust of health care providers, largely stemming from clashes between Aboriginal and Western health approaches and the history of colonisation [12-15]. These risks are further heightened when a young Aboriginal person also experiences:

- Cultural disconnect and dispossession
- Houselessness or lack of consistent housing
- Incarceration, institutionalisation, or parental removal
- Lack of access to healthcare, including family planning services
- Lack of age appropriate sexual health knowledge, including likelihood of transmission and proper prevention methods
- Less safe sex or sexual abuse
- Low socioeconomic status or poverty
- Remote or rural living
- Shame related to STIBBV
- Substance mis/use
- Unwanted or teen pregnancy [13, 16-50]

What's working?

Young Aboriginal peoples benefit from sexual health care and education services which: focus on families and whole communities; are delivered by or alongside compassionate workers who are Aboriginal peers, non-clinical workers, or both; are run by Aboriginal Controlled Community Health Organisations; and facilitate personalised, age and gender appropriate, and culturally connected experiences which prioritise young Aboriginal peoples' unique perspectives and experiences of resilience [24, 35, 40, 51-61]. These approaches can be further understood and implemented by service providers who have undergone cultural safety and sexuality and relationships education training [62, 63]. Alongside appropriate service provision, specific services such as condom machines and needle syringe programs are highly effective, particularly for young Aboriginal peoples living rurally [60, 64-66]. Sexual health education programs for young Aboriginal peoples are also most effective when delivered early (e.g. at primary school age, preferably prior to puberty), and by treating sexual health holistically through the inclusion of discussions on desire, pleasure, and relationship dynamics, as well as accurate discussions on STIBBV prevention and safe(r) sex [67-69].

What needs to change?

Young Aboriginal peoples in Australia continue to be a highly vulnerable population with regards to sexual health [2, 5, 7]. Work needs to be done both within Aboriginal communities and between communities and service providers to reduce stigma around STIBBVs, promote testing and services such as NSPs, and improve the quality of culturally-appropriate service provision [14, 15, 70, 71]. This includes managing stigma and discrimination at all levels: individually, through increasing people's knowledge of how STIBBVs affect young people and the positive impact of testing and interventions; at a community level, wherein communities are educated on the community's role in preventing STIBBV transmission and the positive effects of community-supported treatments and interventions; and at a policy level, where governmental frameworks are improved to better support the development of better healthcare services, tools, and training [27, 72]. Ultimately, service providers need to consider young Aboriginal peoples' capacity and resilience alongside the ways in which they are vulnerable and marginalised, in order to provide sexual health services which meet these communities at their level and appropriately fulfil their needs [23, 24, 73-75].

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