

Centre for Aboriginal Studies

**Marr Mooditj Foundation:
Three Decades of Aboriginal Health Education**

Marie Joan Winch

This thesis is presented for the degree of
Doctor of Philosophy,
Curtin University

November 2010

DECLARATION

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

.....

ABSTRACT

This thesis presents a history of Marr Mooditj Foundation, the Aboriginal health worker training college that has for the past thirty years provided culturally appropriate education in primary health care and training for Indigenous staff involved in delivering and managing health care and community service programs. It traces the development of Marr Mooditj from its origins in the context of Indigenous health in the 1970s through to its current achievements and challenges.

This auto-ethnographic study, which focuses on my central positioning as an advocate and leader of Marr Mooditj, documents the history of how Marr Mooditj emerged from a context of 'dis-ease', where government legislation and the introduction of strict and repressive policies and practices regarding Indigenous people determined an outcome that resulted in a disruption of lifestyle, separation of children from families, serious illness, and an on-going, poverty-stricken separation from the rest of the population. It explores the wide-ranging ramifications of the appalling state of Indigenous health in Western Australia, and the part played by all those involved in establishing and running Marr Mooditj and the Perth Aboriginal Medical Service in working at changing this for the better. The thesis argues that Marr Mooditj Foundation is now deeply embedded within Aboriginal culture, is responsible for delivering culturally safe programs, and can be proud of its contribution to closing the gap between Aboriginal and mainstream health care in Australia.

Acknowledgements

I wish to thank:

My faithful dog Jester;

and the following people for their support during my research:

My supervisors: Associate Professor Frances Crawford, School of Occupational Therapy and Social Work,

Rosalie Thackrah, Senior Lecturer, School of Nursing and Midwifery,

Dr Rick De Vos, Senior Lecturer, Centre for Aboriginal Studies;

and

Assoc Prof Anita Lee Hong

Assoc Prof Margaret Quartermaine

Jean Boladeras

The Staff of Marr Mooditj

Assoc Prof Pat Dudgeon

Jeannie Morrison

Jane Jones

Jennifer Garlett

Rachel Humphries

Vanessa Riley

Debbie Cherry

Rod Carpio

Lorraine Morrison

Christine Clinch

Robert Indich

Sophie Hills

Cheryl Phillips

Tracey Lawrie

Stephanie Carroll

Jessica May

Michelle Webb

Cheryl Taylor

Stuart Crowe

Damien Webb

Dr Christine Cameron

Dr David Paul

Ken Hayward

Prof Fiona Stanley AC

Prof Ian Wronski

Prof Ernie Stringer

The Staff of Curtin IT Services;

The Staff of the Centre for Aboriginal Studies;

and all the others who saved my sanity.



Lillian
Oct 1957 - Jan 2005



Joan and Jester Winch
2005

Table of Contents

Chapter 1	Introduction.....	1
Chapter 2	Nyungar Boodja: A Cataclysmic Change	15
Chapter 3	My Story – Nursing and Education: Travelling a Spiritual Road.....	31
Chapter 4	Aboriginal Medical Services in Perth: Opening New Doors	57
Chapter 5	Marr Mooditj 1983 – 2006: Small Beginnings, Big Hopes.....	94
Chapter 6	Conclusion: Where to From Here? Closing the Gap and Opening New Doors	133
Appendix A	Responses from Marr Mooditj Graduates to Questionnaire conducted in September 2010	148
Appendix B	Letter from Professor Arthur Kaufman.....	158
Appendix C	Letter from Professor Robert Staples.....	161
	Bibliography	162

Chapter 1

Introduction

This autoethnographic study traces the development of the Aboriginal Health Worker Training Program known as Marr Mooditj College, from its origins in the context of Indigenous health in the 1970s through to its current achievements and challenges. The research is driven by my central positioning in these developments as a Nyungar health practitioner, advocate and educator. 'Marr Mooditj' in Nyungar language means 'good hands', and is a fitting description of the way this training organisation has been administered by and worked with and for Aboriginal and Torres Strait Islander people.

At the time of first settlement all available evidence indicates that we Nyungars were a 'healthy looking' race with an estimated lifespan of over 40 years, which was certainly much better than the 'new arrivals'. What happened to the Nyungar people of Western Australia where by the 1970s their life span was 20 years less than that for white society, and all measures of Indigenous health compared unfavourably with the health of mainstream society? Government legislation and the introduction of strict and repressive policies and practices regarding Indigenous people determined an outcome that resulted in a disruption of lifestyle, separation of children from families, serious illness, and an on-going, poverty-stricken separation from the rest of the population. By 1967, when all Nyungars became Australian citizens, it was hard to identify any Nyungar life not shaped by this new regimen.

This thesis will document the history of how Marr Mooditj emerged from this context of 'dis-ease' in an organisational, educational and personal sense. It will explore the wide-ranging ramifications of the appalling state of Indigenous health in Western Australia, and the part played by all those involved in establishing and running Marr Mooditj in working at changing this for the better.

Appointed as the first visiting Nyungar community nurse in 1980 by the Perth Aboriginal Medical Service, I soon became aware that Aboriginal peoples in and around Perth were not able to cope with their health problems. With other key players, I identified an essential component to progressing our health would be health education delivered on our terms. The development of this organization and how it overcame many obstacles (along the way winning the World Health Organization Sasakawa Prize for primary health care in 1987, followed by many other awards for its achievements as a training college), as well as the complexities of fighting for funding and accommodation, will be documented in this thesis.

The central research question guiding my research has been:

How did Marr Mooditj develop from 1983 to the present day in becoming a culturally appropriate and responsive health care education provider?

In answering this question I have focused upon the following objectives:

- To consider the origins of Marr Mooditj within the context of Indigenous health in Western Australia;
- To describe the beginnings of Marr Mooditj as a provider of Indigenous health education;
- To examine the challenges Marr Mooditj has faced along the way and how it has met them;
- To critically reflect on Marr Mooditj's achievements over a thirty-year period.

Background

The Nyungar peoples of the southwest of Western Australia appeared to be healthy when the Europeans came to our shores in 1829, and certainly in better health than the newcomers (Saggers and Gray 1991, 95). In retrospect it was assumed that their good health was due to their hunter and gatherer lifestyle and spiritual beliefs (Abbie 1970; Thompson 1984). '[The] estimated life span of 40 years' [was] certainly better than that of 'the new arrivals' (Cowlshaw 1978,

73). Their diet consisted largely of meat, berries, root vegetables and traditional herbs, which combined to provide a recipe for good health. The diet was devoid of refined sugar and wheat flour, and produced fit physiques in contrast to the current global epidemic of obesity. ‘Governor Phillip was so impressed with the physique and presentation of Aborigines he met, he named Manly Bay in the colony of New South Wales after them’ (Saggers and Gray 1991, 20). This early observation corresponds with the athletic build seen in early anthropological photographs (Randall 2005; Hughes 1988).

The Indigenous peoples of Australia are now 20 years behind white society in life expectancy, nutritionally depleted and bereft of belief in their own abilities. What happened to bring about this reversal in the health status of the two populations? Prior to the invasion, the Nyungar peoples lived for more than 60,000 years in a place with plentiful water, ample food and a temperate climate, enjoying an experience of everyday life that was complex and successfully organised, both socially and culturally. The key to this was a rich spiritual life derived from their Creation Ancestors, giving them laws to live by, and rules for traditional practices and beliefs (Berndt and Berndt 1980; Andrews 2004; Tunbridge 1988). Emotionally, spiritually, mentally and physically the people lived a fulfilling life.

European arrival had a devastating effect on the health of Nyungar people. Not only was the existing lifestyle completely disrupted, the colonisers also brought with them measles, whooping cough, diphtheria, influenza, and chicken pox. These diseases had traumatic consequences for a people with no immunity to them. In addition, European settlers and convicts in Western Australia spread venereal diseases to the Nyungar women at an alarming rate (Jebb 1984, 68-87).

The colonisers’ perceptions of the existing population were heavily influenced by theories of moral Christianity and Social Darwinism. Such theories supported the view that white Christians were vastly superior in every way to all others, particularly the black-skinned ‘heathens’ encountered in the Swan River Colony. The most emphatic marker of people’s worth became ‘race’ (Smith 1999; Rigney 2000).

When race was the issue, all white men stuck together, boss, worker, bond and free Protestant and Roman.... Nothing the government did called forth more contempt and greater resistance than to bring white men to justice for murdering blacks (Reynolds 2000, 133).

Where the law did legislate to 'protect' Aboriginal people? The realities of the colony worked against this.

By the second half of the nineteenth century it was generally accepted that in opening up new districts, settlers should have a free hand in dealing with the "native question". In the 1830s Protectors of Aborigines had been introduced, on the insistence of British humanitarians, to protect the interests of the indigenous population. In practice the Protectors became increasingly concerned with the protection of the colonists rather than of their Aboriginal charges. Their official title was changed in 1848 to Guardians of Aborigines and Protectors of Settlers (Crawford 1989, 7-8).

For over two hundred years, throughout the early colonial period, the 'white Australia' period and up to the present day, 'race' has persisted as the dominant signifier of difference in the psyche of the nation (Hall 1997; Hage 1998). With the racist policies and practices of the early 1900s continuing through to 1967 and beyond, Indigenous health suffered in all areas (Eckermann 1992, 98-99). People were forced to sit in camps, reserves and later missions, with nothing to do, living in deplorable conditions (Randall 2005; Hughes 1988). Spiritual and emotional stability degenerated as people were removed from their 'country'. The healthy diet of foods such as meat, vegetable, fruit and nuts had been replaced by flour, sugar, tea, tobacco and alcohol. The change from a semi-nomadic lifestyle to a sedentary one combined with these other issues to cause devastating health problems. Life in reserves and camps was destructive both physically and mentally.

With the wiping out of traditional Aboriginal social institutions, it can be argued that a state of what has been described as 'anomie' set in, an erosion of standards and values, resulting in alienation and purposelessness (see Durkheim 1964, Giddens 1972). J.P. Hartman also discussed this "disorganisation of social and personal values during times of catastrophic stress" (1958, 24).

Hartman estimated that there were 300,000 Aboriginal people living in Australia at the time of European contact, while others have provided higher estimates. Most agree, however, that by the early 1900s only about 70,000 Aboriginal people remained. Since then, the health of Indigenous people has become far worse than that of any other social or cultural group living in Australia.

After a long struggle by the Aboriginal activists of the day and their supporters (Bandler 1989), the 1967 Referendum enabled Indigenous Australians to have full citizenship alongside other Australians. This led to expectations of equal opportunities for all and gave rise to policy developments that saw the emergence of many Indigenous organizations. These organisations operated initially within a policy context defined in terms of a goal for 'integration' and after 1974 in terms of 'self-determination' and 'self-management' (Eckerman 1992). This new context encouraged Indigenous Australians to make autonomous decisions about their own futures, with new organizations run according to Indigenous terms of reference, with Indigenous ways of knowing being seen as an important element of empowerment.

In 1974 the Perth Aboriginal Medical Service (PAMS) was established through the combined efforts of Indigenous and non-Indigenous health care workers. I graduated from the inaugural Diploma of Nursing cohort at the Western Australian Institute of Technology (WAIT) in 1979 and started working as a community nurse at PAMS in 1980, an experience that emphasised, for me, the need for more knowledge and informed training in health care for Aboriginal people.

In the 1970s and early 1980s in Western Australia, the health status of the Indigenous community was appalling. Alcohol abuse was rife, infant mortality was ten times that of the wider society, and the life expectancy for Indigenous males and females was twenty years less than for their non-Indigenous counterparts. On all measures Indigenous health compared extremely unfavourably with the health of mainstream Australian society (Winch 1980, 451). Many people lived solely on welfare money, drank alcohol and sugar-laden soft drinks, ate fast foods loaded with fats and had little idea about healthy

nutrition from either an Indigenous or a western point of view. Obesity and hypertension were common, and the ugly spectre of diabetes was becoming pandemic (Thompson 1984, 943).

The measures that Federal and State governments and other non-Indigenous organizations introduced to combat this tidal wave of sickness and death were largely ineffective. Aboriginal people's contact with government institutions had been one based on oppression and subjugation, and there was little expectation of assistance and understanding from government services and figures of authority. The Indigenous community had little respect for and trust in the government and its representatives. In the midst of progress mayhem was taking over, giving the people a voice, and some power, but no education. As Aboriginal organisations were developed by the community, there were no ongoing steps in preparing these 'early day' leaders to manage them. We did not have experience in managing our own personal affairs. Consequently there were huge gaps in developing and managing the newly founded projects. The progressive steps were expected to lift us from segregation to self-determination in 1972. In many instances there were mouthed words and no action. Aboriginal people were not sure of their rights, while the white bureaucrats changed hats from the Native Welfare to the Department of Aboriginal Affairs (DAA) but were otherwise unchanged, especially in regard to their prejudices. In this new policy era many non-Indigenous 'experts' of goodwill did not understand Nyungar mentality or protocols, and without realising it, health professionals often either offended or frightened their Indigenous patients. As a result, Nyungar people avoided the clinics and medical posts designed and built at great cost to serve them. Those who did seek assistance did not trust non-Indigenous staff, particularly if they were spoken to in a degrading manner, as happened on many occasions.

By 1980 as one of the few Aboriginal people working in the area of health care in Perth, my task of addressing these problems became overwhelming. Some of the living conditions left a lot to be desired – camps with little or no running water – and consequent diseases such as gastro-enteritis and skin diseases were endemic. It was clear that Aboriginal people needed to have the education to

make decisions about their health, and that such education would need to be responsive and culturally appropriate. From this realisation grew the idea for an Aboriginal Health Worker Education Program whose graduates would be health advocates for their people particularly when they had to talk to non-Indigenous health professionals when their relations were hospitalised. The wider vision was of equipping Mums and Dads with the language and opportunity to talk to their children over the dinner table about health, and about the importance of reading the labels in the supermarket, as well as understanding hygiene in the home.

While the Health Department of Western Australia employed Aboriginal health workers, no formal training was provided for them. Some had been employed with the Department for many years as liaison officers. The training they had for this was in the main a series of workshops to deal with the problems of the day. An Aboriginal Health Worker Education programme had been set up at Koori College in Victoria in the late 1970s, but this program used the 'Medical Model', which was similar to that which prevailed within the medical profession. What I felt was needed in Perth was a program based on the Primary Health Care Model, advocated by the World Health Organization (WHO 1978). This drew on Paulo Freire's philosophy of pedagogy for adult education, which contended that adults were not empty vessels into which information could be fed, but rather that education needed to be conceived as a two-way experiential process between teachers and learners (Heaney 1995, 1-6). Such a model would not disadvantage students and health workers who did not possess formal qualifications but draw on their own lived experience and 'hands on' skills as a knowledge source. Armed with the understanding that simple practical knowledge about health was something we all could aspire to in order to help our children and old folks stay healthy, I set about developing a health care education program aimed at 'taking the magic out of medicine'. This program aimed to dispel fears and open the doors to a healthier lifestyle and teach the graduates to be health advocates for Nyungar people.

The Aboriginal Health Worker Program was established in 1983 as a community controlled health education program with financial help from the

WA Lotteries Commission and support of key persons in the community including, Aboriginal community leaders and key persons in major hospitals, particularly Royal Perth, King Edward Memorial and Princess Margaret Children's Hospitals. It was initially based at the Perth Aboriginal Medical Service. In 1990 the college was named 'Marr Mooditj' - Nyungar for 'Good Hands'. A new college building was completed in 2000. Since its establishment, Marr Mooditj has sought to enhance and develop the role it plays in Indigenous health care training and in social and cultural life in Australia. The reputation within the state, nationally and internationally has been acknowledged through the many awards the College has received since inception, the most recent being at the WA Training Awards in September 2006. Marr Mooditj was also named WA Small Training Provider of the Year in 2007.

My intention in this thesis is to document from a Nyungar standpoint the history of this organisation and its achievements, in order to inform the ongoing attainment of Indigenous health and wellbeing. While Marr Mooditj has had outstanding success, there is a lack of research on the history and establishment of this program. This thesis considers the perspectives of those participating in the development of Marr Mooditj. These participants broke new ground for Aboriginal health education in Western Australia and cut through the red tape preventing appropriate service provision, despite the struggles of the day and the fact that they were starting out in new directions. These forerunners have achieved the unthinkable, growing from those with a sparse knowledge in health care to highly qualified health workers with university degrees stretching across the health sciences.

My research is intended to complement and extend aspects of existing studies of the Indigenous 'domain' and Indigenous organisations, such as Rowse (1991), the Centre for Applied Economics Policy Research (CAEPR) at the Australian National University, selected studies by the North Australian Research Unit (NARU) and the sparse amount of literature on Indigenous health studies produced in thesis form by Smith, Lewin, McKelvie, Paul and Genat, and the valuable work on education contributed by McKeich.

Research Methodology

The methodology for the research first started with the constructing of an Aboriginal standpoint in order to understand the development of Marr Mooditj, a Nyungar organization, from a Nyungar perspective, and to provide a history for Nyungar people to read, reflect on and refer to. I used this standpoint to inform a qualitative, interpretive, autoethnographic inquiry into the contextual and lived experience of the participants, supported and evidenced by organisational records, documents and iconographies. The members of the Advisory Council of Marr Mooditj acted as a Critical Reference Group for my research project.

My autoethnography focuses on my experience as Marr Mooditj's advocate and leader. The essential core of ethnography and autoethnography is the meaning of actions and events to the people we seek to understand (Spradley 1979). Postmodern theorists contend that there is no longer an 'ultimate meaning' to be found, no form of discourse that stands above another, and no privileged system of knowledge providing the grounding for all others. Knowledge comprises whom people know, and what they know. Meaning is embedded in everyday interactions and pathways, in the way language is used and the way in which it functions (Lyotard 1988; Fish 1980; Derrida 1982; Foucault 1970). Interpretive research is therefore appropriate to a process of inquiry conducted in an Indigenous frame of reference. Research in an Indigenous context requires an epistemological and ontological consciousness that differs from other knowledge systems. The interpretive research paradigm employs a method that enables Indigenous people to articulate our own knowledge and world-view, relative to specific contextual areas.

The project used qualitative research methods, such as open-ended, in-depth interviewing techniques, to provide insight into the way that participants made sense of their attitudes, beliefs, values, feelings and behaviours. Successful qualitative research provides an understanding of the deeper meanings that an individual or group makes of lived experience, thus allowing the reader to understand what is being described (Denzin 1989; Lincoln and Guba 1985). In

my project, a selection of past graduates were interviewed, including Nyungar, Wongatha and Yamatgee people, who are now in gainful employment, in order to build a picture of how the Marr Mooditj Health program affected their lives. Other key non-Aboriginal stakeholders were also invited to share their experiences. Participants were selected from the considerable number of people who were involved in Indigenous health activities in the Nyungar community, by way of a sensitive and non-intrusive request for participation, guided by the foreknowledge of my own considerable responsibilities as a member of that community.

I drew upon Marr Mooditj's formal records and retrieved archival material from public sources. I also reviewed historical documents relating to Indigenous health in local, regional, national and international contexts.

Ethical Issues

This study was guided by NHMRC guidelines and the principles of the Centre for Aboriginal Studies' Aboriginal Terms of Reference (ATR) (Oxenham 1999), and informed by the Guidelines for Ethical Research in Indigenous Studies as recommended by the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS). ATR is a concept that acknowledges the value of Aboriginal knowledge and belief systems, incorporates the rights of the Aboriginal people to make decisions on their behalf, and facilitates the expression of an Indigenous perspective. ATR focuses on working toward social justice, recognising Indigenous diversity, and promoting positive social change.

All participants in this research were adults. They were fully informed of their rights as participants, of confidentiality issues, and their rights to withdraw from the study at any time at their own discretion. All participants were given an information sheet, made aware of a conduct of procedure, and given appropriate contact details. No interviews commenced without a consent form being properly completed. The participants were informed that transcriptions of the

data would be made available to the Supervisors and Examiners, if needed to verify the integrity of the study. Transcripts of the data were checked for accuracy, and confirmed with the participants as soon as possible after the interview.

My Research Positioning

I am writing this history of Marr Mooditj from a Nyungar point of view, so others can read and understand through my eyes. It is not intended to be put on a bookshelf and never used again. The stance I have taken is adapted from Aboriginal Terms of Reference.

Having been brought up by my parents, both of whom were Aboriginal though from different language groups, I felt home was my haven. I did not feel separate from the broader society in my childhood. However, when I became aware that my mother had been taken from her family at two years of age, I realised that I did not understand the intricacies of white society, but rather had a “fish bowl” view of life, standing on the outside looking into what contentment and healthy living could be like. I too suffered the skin diseases and chest infections of close living without knowing or understanding the practicality of healthy living. The children in the missions were not given instructions in caring for themselves or for others. Healthy lifestyles were not passed on from either a cultural or western perspective.

Forty years after I lived that life, I could see it all unfolding before me. It appeared to me that our people were caught in a time warp, with all the negativity and ill health I experienced as a child still playing havoc with our lives. Infant mortality was nine times higher than the broader society; children were still dying of gastro-intestinal tract disease; mothers were not being seen antenatally. Nyungar peoples were effectively locked out of the system. Doors would have to open to teach our people the joy of living and being healthy.

Thesis Structure

This first chapter provides a synopsis of the thesis and my research project. Chapter 2 presents a brief outline of Nyungar life and experiences prior to colonisation. It looks at early European explorers and some sightings of local people, and how Nyungar culture has evolved over the past 200 years, guided by government directives that have moulded us into a broken race, ruled and marginalised from mainstream society. Nyungar people were incarcerated in prisons, which they were unaccustomed to, while tribal leaders were either killed or imprisoned, dying alone and away from their country on Wadjemup (Rottnest Island). Western Australia still has one the worst Aboriginal incarceration rates per head of population in the world today.

The focus in Chapter 3 is on 100 years later and onward, introducing my parents and siblings, how my father struggled to keep us in the Depression years of the 1930s, and further into the war years and how it affected my life growing up in Fremantle. It looks at how the returned Aboriginal soldiers were excluded from accommodation whilst awaiting travel back to the country areas where they lived, making 'do' with a lot less money than the other soldiers they were fighting shoulder to shoulder with in the jungles of the Pacific, only to find that their children had been taken from their mothers by the authority of the day while they were at the battle front fighting for Australia. I reflect on how the loss of my mother in my early teens changed my direction from child to adult, caring for my father and brothers, and on my experiences working in hospitals. My time working at Sister Kate's Children's Home, with a child at hand, gave me insight into some of the behaviours seen in adults and children today and helped me to begin to understand why our people found it hard to come to grips with a society which wasn't ready to accept them. It was easier to live in 'hiding' in the metropolitan area and reject 'your Aboriginality' than to try to be accepted into white society. The discrimination laws against Aboriginal people proved divisive to our people. Starting formal nursing studies at the Western Australian Institute of Technology at 40 years of age was a saving grace for me, opening doors and showing me the way and the possibility of success. In turn it also opened new doors for the Aboriginal community in Perth, and led to the

setting up of the Aboriginal Health Workers Education Program at the Perth Aboriginal Medical Service.

Chapter 4 outlines reasons for setting up the Aboriginal Medical Service, and why it was important to outline the threads of traditional knowledge, passed down through the Elders, in the Perth area. The University of Western Australia played a major role with discussions in the 1968 Summer School supporting the Aboriginal peoples in developing Community Controlled Organisations. There was a strong focus on education, with the Federal Government supporting Aboriginal Students in higher education, and the role Aboriginal people played in setting up support systems for their people in the Aboriginal health field. Each AMS is a stand-alone autonomous body, which is still maintained today, so we still have a say in local affairs.

In the beginning most of the equipment for the AMS was donated by Royal Perth Hospital, while various specialists from various clinics volunteered their time. Most of the Aboriginal people gave their time free in setting up the centre. I have included a 'bird's eye view' of the Medical Service in the 1970s. Infant mortality was five times higher than in the non-Aboriginal population at that time, whilst babies were still dying of gastro-intestinal tract infections and chest infections associated with the many camps where people were living. Some were living in car bodies, under bridges or anywhere they could get shelter. I had begun to think about an education program and how I would go about teaching people who had very negative experiences in the school system. Aboriginal people are not catered for very well in the remote areas of our country and antenatal mothers are forced to come to Perth for many weeks. It is very difficult for these people where English is not their first language. The Aboriginal Health Workers Education Program was started at the AMS in 1983, which opened new opportunities for Aboriginal people, while the Aboriginal Medical Service joined forces with other services to form Western Australian Aboriginal Medical Services where aims and objectives were created and a task force was formed to inform State and Federal Governments of the Aboriginal Health Statistics. The Aboriginal Medical Services has stood the test of time after 37 years of service to the people.

Chapter 5 introduces the principal reasons for starting the Aboriginal health worker education program, providing an early history of Aboriginal health care in Western Australia. At first the program was aimed at the disempowered who had very little family support. I explore the past to look for reasons why many Aboriginal people were not participating in the general education system, and consider the negativity handed out to them. One of the challenges in the 1980s was finding proper accommodation in the community for students from rural and remote areas. Another key question was why there was a gap in the handing down of knowledge to children by their parents. Primary health care, as depicted by the World Health Organisation, proved to be the saviour of the people, and was more relevant and cost-effective than the 'Medical Model'. The next step was to encourage funding bodies to take up the cause and recognise Aboriginal health workers as a viable resource in the health field. This involved putting our case forward to dominant bodies such as the State Health Department, in order to influence them to take up the cause. A highlight was winning the World Health Organisation's Sasakawa Award for Primary Health Care Work four years after our inception. I also discuss the moving of Marr Mooditj's operations to the Clontarf campus in 1990, and developments after my retirement in 1995. Since then the net has been extended to include the development of a Vocational Education Training program in high schools, a Diploma in Management for Aboriginal Health Workers, and working in prisons and investigating more programs suitable for men.

In Chapter 6, I reflect on Marr Mooditj's current programs, and the structure of the organisation, including key people. I consider the way that it has contributed to the notion of 'closing the gap', and look at the challenges that lie ahead. It is my view that the Marr Mooditj Foundation is now deeply embedded within the Aboriginal culture, is responsible for delivering culturally safe programs, and can be proud of their contribution to closing the gap between Aboriginal and mainstream health care in Australia.

Chapter 2

Nyungar Boodja: “A Cataclysmic Change”

The truth is that the underlying foundation of national policy with respect to Indigenous people has always been about disempowerment, either by removing them from the landscape that is the source of their culture and spiritual wellbeing, or by creating a dependency on alien and disengaged processes of governance (Sanderson 2009).

The Nyungar peoples of the southwest of Western Australia appeared to be ‘healthy looking’ when the Europeans came to our shores in 1829. On the Eastern seaboard Briscoe notes that there was ‘no medical or other evidence to refute the statement that Aborigines appeared in good health and free of disease prior to and upon first contact with whites in 1788’ (1978, 13-15).

Throughout Australia, Aboriginal people appeared to enjoy better health than the average English person, who as a result of living and working conditions during the Industrial Revolution, faced greater risks of disease and mortality. It was assumed that the good health of Aboriginal people was due to their hunter and gatherer lifestyle and spiritual beliefs.

Aborigines appeared to be in good health and free from disease according to Abbie (1970, 95; Thompson 1984, 939) ... [Evidence] indicated that Indigenous Australians were physically, socially and emotionally healthier than most Europeans at that time’ ... with estimated life span at 40 years, and certainly better than the new arrivals’ [in 1788] (Cowlshaw 1978, 37).

Why were we so healthy and contented, living life within our culturally and environmentally structured mode of existence, only to become paupers in our own land?

Little interest was taken by other nations who had touched our Western Australian shores. In the first recorded instance, c589 – 618 AD, Chinese sailors

wrote that they had found a land with strange animals and people. They made a map of the west coast in 1421-22, which was given to Henry VIII of England in 1542. Others ships may have been blown onto our craggy coastline, which had become the bane of Dutch ships looking for the Spice Islands, while the English explorer William Dampier in 1688 visited the southern coast, naming 'King George Sound'. Evidence, noted by me, of sailing ships had been recorded in a cave at 'Wave Rock': when the sun shines through a hole in the cave it highlights a sailing ship. Other evidence had been noted of a cave drawing indicating a sailing ship, probably belonging to the Dutch East India Company, at Walga Rock Austin Downs Station, where I worked, in the Murchison area. Dampier wrote that he was not impressed by the Aboriginal people he saw. While exploring the north-west coast he described "a land of dust, heat, and flies, and the most miserable people" (Dampier 1927, 1697, 312).

In 1696-7, the Dutch sea captain Willem de Vlaming explored and named the Swan River (Cunningham 2005, xi-xv). In 1791, Lieutenant George Vancouver, took possession of land in the name of England's King George III, whilst Vancouver recorded native people in 'beehive-type' shelters in the area (Green 1984, 15). The French also showed interest in the south-west of Western Australia, surveying the south coast and noting human occupation in the area between 1801 and 1803.

The British then took charge of the situation, setting up a military base in 1826 and naming it Fredericks Town, later renamed Albany. It was here that the 'red coats', as they were known, represented the crown of England, and policed the area. The new Nyungar word 'monarch', referring to the King's soldiers, came into our vocabulary, and is still used today to refer to the police. James Stirling was named Lieutenant Governor of Western Australia in 1829 and was assured of 50,000 acres of land for his services. He declared the local inhabitants British subjects and subject to British laws. While this idea might have worked on paper, it was impossible to enforce 'on the ground'. The cultural barriers were far too great. The British concept of society was measured by land ownership. Because of the hunter and gatherer relationship the Aboriginal people had with the land, land ownership was impossible to conceive.

Captain Charles Fremantle, in command of HMS Challenger, anchored off at a site just south of the mouth of the Swan River and took possession of the western third of the Australian continent, establishing a new port for the colony. The port was named after him. The first prison was built in 1830 at Arthurs Head, Fremantle (Walyalup), and was the first permanent building in the Swan River Colony. This was later used as a 'hellhole', a holding centre for Aboriginal people from all areas of the state, who were crammed into it. There is still a tunnel underneath this prison, where the 'whalers' hauled their catch ashore. Today it is used by homeless people, who camp in the caves underneath the old prison.



Arthurs Head, Fremantle – Built 1830
(first prison built in the colony)

Within three years of the Colony being established, one of our great Nyungar leaders, Midgegooroo, was shot by a firing squad, as punishment for the 'payback' killing of two settlers after the death of a family member. Rottnest Island (Wajamup) was turned into a prison island for Aboriginal people in 1838, just eight years after the first takeover of our country. The mentality must have been inconceivable to our people who had no concepts of what a prison was all about. This had never happened to Nyungar people previously, as their

retribution was swift and immediate, strangely in line with the Old Testament values of an eye for an eye.

Records of the likelihood of a 'convict settlement' were examined, with the final outcome being a sturdy prison built in Fremantle in 1856. Initially the natives were reported as friendly. Then, in 1831 when the ships started rolling in with waves of people looking for a new start, there were rumblings among these new arrivals that the only annoyance to the (white) people was the hostile conduct of certain Aborigines.

Our peoples' diet consisted of meat, berries, root vegetables, traditional herbs were used, indicating the recipe for good health. The diet was devoid of fat, refined sugar and flour. The fat in native animals is stored on the outside of the muscle, whilst the fat is encompassed in the muscle of domestic animals. New discoveries have identified a high proportion of vitamin C in many of the native fruits. This was reflected 'in the athletic build' seen in the early contact photography of anthropological reports (Randall, 2005). Traditional herbs were used to treat a variety of conditions and illnesses, a custom that is still practiced today. However, according to Barr (1988, 8) Aboriginal traditional medicine played no part in the lives of the immigrant Europeans of 200 years ago. The spread of European infectious diseases to a non-immune population was often fatal.

Coastal sealers from Tasmania (Van Diemen's Land), the second established colony, according to Green, 'were working their way around Southern Australia' (1984, 34). They plundered the islands for women and female children, which caused severe disruption to the Nyungar peoples, including disease depopulation and cultural disruption, causing inevitable and irreversible change to our people. All this was in place prior to the British colony's establishment at Albany in 1826. It has been well documented that when the 'white skinned' people arrived from across the sea, the Aboriginal people thought that they were the spirits of their departed 'Djanga', and so were happy to welcome them to their shores (Green 1995, 33).

Aboriginal people lived in harmony and balance with 'mother earth' in the diverse life-sustaining ecosystems of the nature of foods, which flourished without artificial fertilisers pesticides and herbicides. In Walyunga National Park, I was shown where Wadjuk people established traditional methods of horticulture. Plants were placed at the base of large granite rocks in order to be drip fed by water through expansion and contractions of the rocks. These plants were extremely high in nutrients and medicinal values. This system of knowledge is still practiced today. The diet brought good health and an increase in life expectancy.

Green (1995, 2-3) described the diet, traditional food gathering and abundance of food in the South West, which had similarities to those described by Governor Phillips in 1788:

Governor Phillip was so impressed with their physique and presentation of Aborigines he met he named Manly Bay ...after them (Stone 1974, 20).

Hughes (1988, 8-12) confirms this:

The tribesmen they encountered were so well adapted to their landscape that their standard of nutrition was probably higher than that of most Europeans in 1788 ... they had exquisite skills as stalkers.

The plants were the silent sentinels that carried the blueprint for life and living, handed down from the 'Dreamtime'. These precepts have almost been lost in today's suburban living.

As far as what is known about Nyungar people prior to colonisation, the land was and still is 'our mother', which succoured the people. It was not a commodity to trade. The land was timeless and like the sea was not there to be tamed, whereas the British, had developed an agrarian society with 'landlords' in charge and 'serfs' as the labourers of the land, which was the absolute antithesis of life for Nyungars at that time. The newcomers brought their philosophies of life and living and imposed them on this 'stone age' group, which included the clearing and usage of the land, and the fauna and flora within. Many Acts incorporating land were passed, including dividing the land with fences and restricting Aboriginal people's entry. In 1893 the Destructive

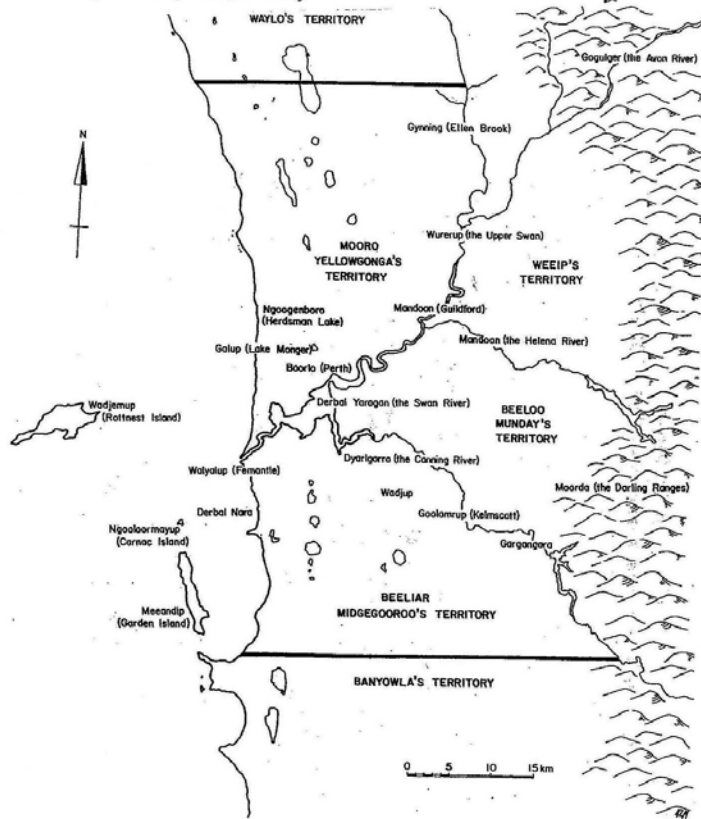
Bird and Animal Act provided for the destruction of native fauna; while the 'law keepers' continually pushed with the rule of clear felling the land despite the increase of salinity levels, which led to the land being deemed too salty for railway use in 1905 and beyond. The Department of Agriculture Handbook published details of how to remove native tree species (Cunningham 2005, xiii). It was not realised by the white settlers that xanthorrhoea (Balga bush) and eucalypt trees prevented salt from rising into the topsoil. By 1917 the evidence of dangerously high salinity on farmlands was dismissed by a Royal Commission, and farmers together with other landowners were encouraged to clear all land holdings. This has persisted throughout the past 141 years up to the present. In 2002 it was reported by the Australian Terrestrial Biodiversity Association that the land was in major crisis, due to clearing and overgrazing with over 3,000 ecosystems at risk of extinction (Cunningham 2005, x-xv). Many of the plants from the Gondwana epoch are parasitic and not found in any other part of the world. These plants need to attach to the roots of other plants to survive. In 2001 Australia was named as the fifth highest country in terms of clearing native vegetation, and the only developed nation in the top ten (Australian State of the Environment Committee, 2001).

Nyungar Boodja

The world of the Nyungar appeared to be carefree and ideal, although the country provided adequately for their needs, and the ability to survive depended '...on the understanding of the environment and every plant and creature in it' (Green 1984, i), taking in the 'Dreaming', and the establishment of laws and interdependence linked people and the environment with the Dreaming. Everything had to be memorised: the botanical knowledge including the optimal seasonal time for selection was passed on through the 'Song Lines' and observation of the seasons, and vital information was passed on through song and dance. With no written language, all information was by word of mouth. Some of the tribal people living in remote areas still use this method, though there is a fast track method in this day and age with television and the internet putting children in touch with world affairs but further removed from traditional ways of being and doing.

Though land was not 'owned', particular areas were known where plants had been left for the following season. This also happened with wildlife: "leave him - we'll come back next season when he's bigger", or "let them breed up for next season", or words to the effect of "when the plants are in flower we can catch him then". It was the way of animal husbandry and plant proliferation for hunter and gatherer peoples. I had access to this philosophy whilst working on sheep stations in the 1950s, when the Government paid a royalty for dingo 'ears' and emu 'beaks'. They never caught them all: some were left to breed up again. Not everyone knew everything. Only particular people were given information to hold and pass on through family lines.

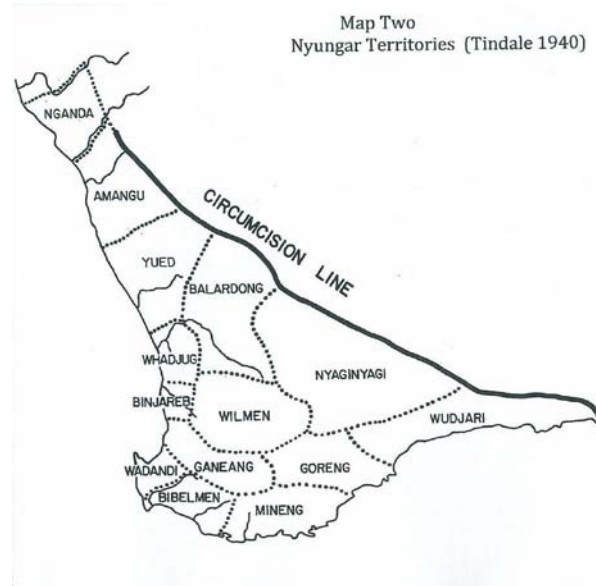
Nyungar place, names and territories as told by Robert Lyon by Yagan 1832 (Green, N 1984)



Nyungar place, names and territories as told by Robert Lyon by Yagan 1832 (Green, N. 1984)

Boys learned about men's business. This was still carried out in the metropolitan area in my childhood. My father took my brothers to the bush teaching them about bushcraft. Though we lived in the suburbs we were practically self-supporting with vegetables and fruit in the garden and fowls in the backyard. We went crabbing and fishing every weekend and Dad talked about hunting kangaroos and keeping food fresh in the bush. In our walks, we learned about 'Bush Craft', tasting all sorts of bush food, and never getting lost, by setting out landmarks in different trees. He was particular in pointing out the trees to look for and to avoid, such as those where people were buried in the early days. All this has changed as the suburbs become more sophisticated, where plants are

imported from other areas and the burial rites of our culture are discarded by the dominant society. The extinction of unique plants and animals has changed the ecosystem, and the micro and macro climate of the region. Today, in the twenty first century, governments allow for the overgrazing of sheep and cattle for export to Middle Eastern countries, and are contemplating importing beef from overseas. Past traditions of land care have been disregarded and another system imposed upon the traditional people, so that ways of being and doing are redundant under the new regime.



In the 1950s, when there was a downturn in the economy, I had a small child to support and no job. I fell straight back to the old ways I was taught, gathering greens from the sand hills with mussels and fish from the river. My father also passed on to me certain spiritual rituals after my mother died, though when I tentatively mentioned something, my brothers did not know about it. As I write in Chapter 3, my mother knew nothing of her Aboriginal background and so was unaware of most of her family's knowledge to pass on to me. I expect my father thought that it was his duty to do so. This conjecture I can only philosophise in because all of my family have now passed on.

It appeared that our people, who had evolved with no written language in the country since time immemorial, living in harmony with nature, tending to their own needs and not claiming ownership of people, plants, animals or land, were placed in a position of dispossession of all that was their world. This had happened in the Northern Hemisphere with the imposition of farming and animal husbandry under the agrarian society and was the accepted way of life for the newcomers.

The Nyungar women had a ceremony of burning the mangart (jam) tree to ash in the delivery area for childbirth, which created a germ-free place for delivery of the newborn, preceding Joseph Lister's discovery of the 'germ theory' in 1867. This place is given ownership to the babe and remained so for life. When the female child reaches menarche, she then is expected to care for that area (personal communication with tribal women). Laws to live by were timeless and meticulous. There was no need to challenge a way of life that had sustained them for centuries.

As with other tribal areas there was a system of cohabiting, which with today's understanding led to the belief that there was knowledge of genetic responsibilities, and strict matriarchal laws were developed under the 'skin group' system, which the average Australian person finds great difficulty in coming to terms with. This information was lost fairly rapidly when a policy of forced removal, taking the children away and bringing them up under the British rule, was introduced. A similar policy and outcome was described to me when I was in Vancouver in Canada in 1990. There was a very intricate method practiced by these people, which in retrospect indicated knowledge associated with prevention of relationships between two people who were genetically related:

Divisions of the South West matrilineal moieties groups:

MALE	FEMALE	OFFSPRING
Wordungmat - Crow		
Ballaruk	Tondarup or Didarruk	Tondaruk or Didarruk
Nagarnook	Tondarup or Didarruk	Tondarup or Didarruk
Manitchmat – White cockatoo		
Tondarup	Ballaruk or Nagarnook	Ballaruk or Nagarnook
<i>Didarruk</i>	<i>Ballaruk or Nagarnook</i>	<i>Ballaruk or Nagarnook</i>

(Bates 1985, reproduced in O'Connor 2001, 12)

Daisy Bates noted that no other marriages were permitted...a *ballaruk* could not marry a *nagarnook*, for they were *koota gen* (one womb)...a breach of this law meant death in the old days” (O'Connor 2001, 12). There appeared to be arranged marriages with reciprocity between groups including gifts and privileges. This all disappeared from the South West under British laws superimposed on them. Some of the decisions were disastrous at times, with cousins marrying cousins. This would never have happened under the traditional laws.

Testing the Waters

In the first instance, the Nyungars were accepting of the new arrivals that were struggling to come to terms with living in a foreign land. There appeared to be no attempt to understand the Nyungar way of life, including the ‘pay back system’. If someone died then a person was held responsible and had to pay the consequences, by spearing or attack with a ‘nulla nulla’, a hand-held wooden club. This has been recorded by many historians in other readings (Green 1994). Many of the new arrivals were in very poor health after their long journey from England. It was reported that whole families died while trying to eke out a livelihood. They were described by Hasluck (in Bolton 2008, 9) as ‘a broken down gentility’. There was no land allocated or buildings erected for them, nor any steps taken to come to terms with Nyungars.

The 'fatal impact', as noted by Alan Moorehead, was in full flight in the South West of Western Australia. The Nyungars were devastated by waves of disease epidemics upon the arrival of the infected immigrants from Britain. Upon first contact the local people were faced with a plethora of diseases, which included influenza, typhus, dysentery, and other unspecified fatal illnesses such as whooping cough and venereal diseases. New words came into the Nyungar vocabulary: *nyandyn* (unwell), *matta ngallin* (crooked legs – from yaws), and *kalbul kulbulkan* (the sound of bugles - thought to cause the cough). In 1841, 11 children in Guildford were reported dead after an unknown illness (Green 1995, 71, 235-6). Many of the illnesses were thought to have been caused by bad spirits: this concept still persists today in modern Perth (my experience in the field).

Destitution and misery were common experiences. It was declared by migrant Liza Shaw in 1830 that 'The man who declared the country 'good' deserves hanging' (Bolton 2008, 10). Large numbers of Aboriginal people died as a result of these introduced diseases and a dependency was created on introduced goods. Within a short period of time traditional resources were being depleted. The waterholes were commandeered, traditional hunting grounds fenced off, creating a dependency upon the colonisers that has continued to the present, where we have learned what has been described as a 'handout mentality'. Aboriginal families were left destitute, forced to scrounge by the rubbish tips. Death stalked the Nyungar tribes over the hills when the invaders travelled further inland. The traditional owners lived in uncertainty of where they would be banned from next. Small farmlets were allocated to selected Aborigines in Perth, Guildford, Wanneroo, and York, which proved useless because of the poor soil and lack of farming knowledge (Green 1984, 181-2).

Unrest in the Colony

According to Bolton (2008, 9-10), "there was a general unrest among the indentured labour within the new settlement." When land was confiscated from the rightful owners and fenced for the introduced pigs and sheep, the access for their food source of kangaroos, possums and small marsupials was cut off. Then

sheep and pigs were killed for food. A clash of cultures had begun. The new settlers were incensed, and relationships deteriorated with Aboriginal people, who paid the price with their lives. Within Nyungar law this meant 'pay back' – a life for a life (Bolton 2008, 1). Innocent white people and Aboriginal people were killed, both carrying out their own laws, one side claiming personal property and possession, and the other a hunter and gatherer tradition of sharing what was available, with both sides paying the penalty for ignorance of the other's laws. This culminated in the Pinjarra massacre in 1834, after a flour mill was raided and a soldier killed. As a result of conflict in the South West of Western Australia from 1826 to 1852, 38 settlers are recorded as dying, compared with 121 Nyungars (Green 1984, 203-218). Historians have recordings of mistrust and murder in Western Australia over the years since, and to this day there are still unexplained deaths in custody in our country (see for example Gribble 2009; Green 1984; Austen 1998).

Many reports of cruelty have been historically recorded, including the castrating of Aboriginal men. The Reverend John Gribble (1884) spoke out against oppression and cruelty, for which he was ridiculed and chased out of the Settlement. Other reports indicated chaining and flogging Aborigines as the only way to 'bring them to their senses'. The continual taking and destroying of traditional lands, together with the onslaught against the men and the rape of women, which had been the way of conquerors throughout history, combined with government decrees directed against the traditional owners, became overwhelming for our people.

Tom Austen dedicated a whole book, *A Cry in the Wind* (1998), to the treatment meted out to Aboriginal people in Western Australia. He castigated the 'so called white Christian station owners' for slavery and the flogging of children with stock whips. When an Aboriginal girl accused a clergyman of criminal assault (rape) she was accused of 'doubtful morality' and the Court found that the accused was 'utterly untrustworthy and therefore (case) dismissed' (*Australian Advertiser*, Albany June 8, 1888).

Most complaints by Nyungars were unprovable in English Law. A fallacy often stated in my time was that 'the half-caste usually inherits the vices of both races and the virtues of neither' (p153 WA Agent-General 'Henry Bruce Lefroy').

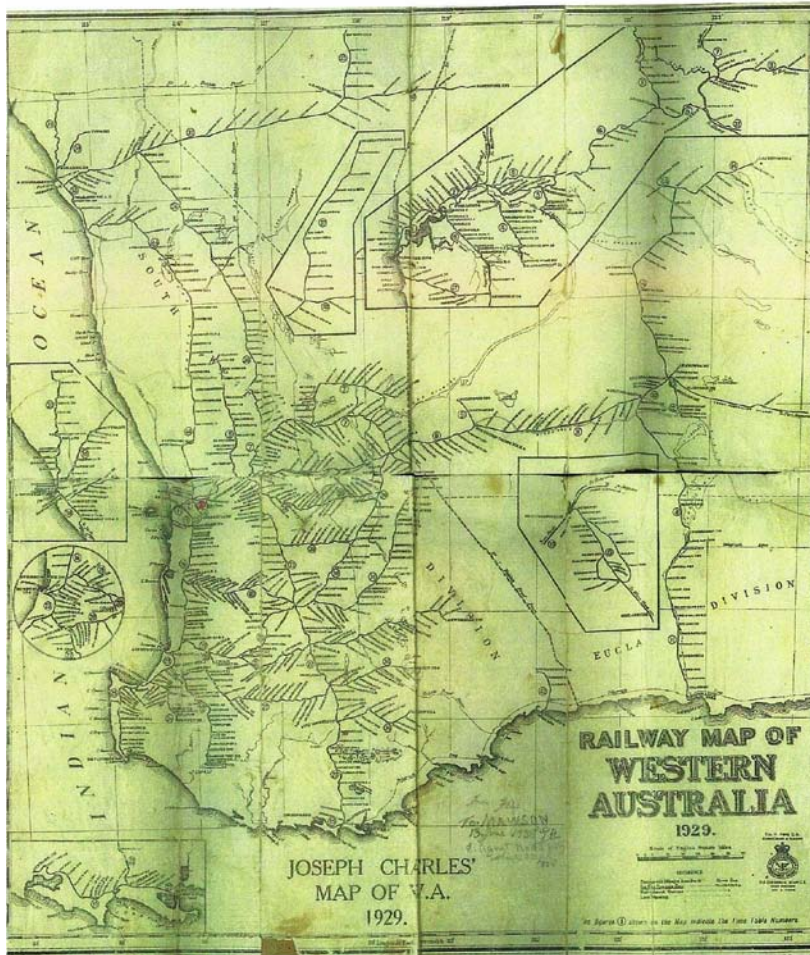
Walter Malcomeson reported in *The Times* that indentured Aborigines in West Australia were worse off than the 'old time American Negro slaves' (Austen 1998, 84).

'Shackled by the neck and handcuffed, 120 men shared 1 'water closet' ... the diet was appalling ... they died in numbers. Few of them saw their country again ...Like shocked beasts they died' (Austen 1998, 151).

Prison records showed that at least 364 deaths were recorded in the new colony. A Curtin University ground radar survey in 1993 indicated that many hundreds of people were buried on Wadjemup (Rottnest) Island. Many cases of mistreatment on the mainland were dismissed even when there were witnesses.

After sitting on the Parole Board for seven years in the late 1980s and early 1990s, I still had the feeling that there was a bias against Aboriginal people who were seeking parole. There were some members who appeared to have the need to 'convict them again'. I asked Neville Green, historian and eminent writer, what he thought was the main reason for the eventual demise of our people and he indicated that the construction of the Great Southern Railway System was the catalyst which cut the Nyungar lands and destroyed the last semblance of traditional land ownership. I believe it destroyed the 'song lines'. The steam trains took first place when competing for the waterholes. The Ngamma Holes (water holes), as they are still called by us, were the areas where the people used to gather and socialise. This is something we do not hear about in Nyungar country nowadays.

Map Two
Railway Map of Western Australia 1929
(Joseph Charles Map of WA 1929)



Paul Hasluck, while a journalist, also wrote about the appalling conditions along the Great Southern Railway with people living in tin shacks (Hasluck 1942). Ronald Berndt indicated that Rottnest Island Prison and the removal of children of mixed blood contributed to the destruction of traditional culture. From my personal view, the removal of children who were then ‘brainwashed’ to believe they were white caused a great deal of heartache. While the children were ‘cared for’, they were never totally accepted into white society. The ‘caring’ did not include educating them into being responsible adults on most occasions. This

was another version of the 'handout mentality', and the expectation is instilled into them to stand back as second-class citizens with their heads held down. Shame! Berndt estimated that from 1901, the Nyungar population had declined from an estimated 13,000 to 4,419 with practically half of these being people of mixed blood (Host 2009, 19).

Nyungar people were marginalised and excluded from a system where there was no sense of belonging to any structural organisation. Having no power to make decisions for oneself has been found to cause mental and physical stress, resulting in generational conflict and progressive mental and physical deterioration of people. Soul loss happens when we have a series of bad experiences and we feel fragmented from within: 'cut to the quick'. This has been identified in the modern psychological world and described by Robert Francis Johnson, a psychotherapist, who explains this kind of fragmentation as a condition of the modern world, and 'manifested in our culture by the crisis we are facing ... in increased drug use, violence, moral and emotional numbness' (Ingerman 2006, 90).

I have identified this during work experience in the Aboriginal Medical Service and in my experiences working in hospitals, where Aboriginal people experience high levels of worthlessness and extremely low self-esteem. Our people are sick far too frequently. Alcohol and drugs are too often their coping methods. Young boys are incarcerated where there are no cultural male supports and suicide is becoming the perceived solution to the problem.

We are now a colonised people where most of us occupy a low socio-economic status in a world of 'haves and have nots'. We have had to cope with depression, developing behaviours that support our existence. Being confined to reserves and missions, the early tribal people had no knowledge or understanding about the hygiene requirements for living in confined places, as previously hunter and gather peoples moved around with the seasons. What they left behind was naturally broken down by sunshine in the summer and frosts in the winter. Eventually with many of their leaders killed or incarcerated, Aboriginal people

were left in a state of anomie, alienated in relation to the 'new rulers', with no sense of power within themselves and no sense of belonging.

The invasion of peoples from across the globe destroyed the way of life for our people, with severe misunderstandings of cultural differences. The Nyungar peoples had no experience in dealing with the avalanche of diseases and the way of life these people brought with them. Introduced diseases such as smallpox, measles, influenza, leprosy, sexually transmitted diseases and massacres followed by the destruction of the power base, value systems and as our warriors were destroyed or incarcerated. Finally we became a conquered nation.

This has affected my whole life, as my mother was taken from her traditional family as a baby and given an English name. She had no history to share with us and died at a relatively young age with no known family support.

Chapter 3

My Life: Travelling a Spiritual Road

Family Background

My mother was born in Martu Country in 1904 at a place called Lakeway, later renamed Wiluna. She was taken from her family in 1906 and sent to the coast. My mother was not able to tell us anything about her background, because of her tender age when she was removed; not her family name, nor who her relatives were, and nothing about her culture, language or skin group. These points are very important for Aboriginal people to state on introduction to other people. My mother lived and died without knowing about these connections. I started to seek out this information 30 years later, after she passed on.

The tribal people heard via the ‘bush telegraph’ that I was looking for information about my mother, and in 1981, 33 years after my mother passed away, I had a message from the Martu people to come to Wiluna on the pretext that they wanted some health advice. It was Melbourne Cup Day when I arrived with other members of the health team from the Aboriginal Medical Service in Perth. I was asked to come by myself to the special ceremonial grounds in the morning. When I arrived there was a big circle of people waiting. I was led to a place to sit down on the ground, and about half a dozen men proceeded to shout and throw spears, yelling in language. I must have looked frightened, because a young man next to me said “Don’t be frightened. They are telling you the story of the ‘one that was taken’ as you are her daughter”. I was overwhelmed with emotion. I hadn’t felt that there was anything missing in my life, but all of a sudden I felt that a giant jigsaw puzzle had just been put into place inside me. They had kept the story in their song-lines dating back from 1906. I had always thought that had my mother known her roots, she would not have died at the relatively young age of 44 years.

My mother was brought up in various church missions - Dulhi Gunyah at Victoria Park, Carrollup (now Marribank) at Katanning, and Moore River Settlement, north of Perth. The mission girls were only taught the basics. They needed to know how to write a grocery list, read a cookery book and clean a house. I expect they had plenty of experience minding children at the Mission, while the children were incarcerated. Missions and reserves were like concentration camps. Inmates were treated like prisoners, and severely reprimanded if they absconded from the Mission. For instance, there was a tin shed at Moore River, called 'the boob'; where the people were incarcerated for any misdemeanour, real or imagined, by their 'caretakers'.

When my mother was taken from her Wongawol family, she was renamed Lena Bookett, and her first job, at fourteen years of age, was at Orton's farm, called 'Petworth Park', near Moora. At the farm, with more western food available, she was told that she was putting on too much weight to be called Lena, and so she was renamed Lily. Mum made a joke of it and said she couldn't be called Lena because she was too fat, but it was worse when she had to bring out the food to the dining tables for visitors, and out came a 'black Lily' to serve the guests. However, her name remained Lily until her death. My mother told us a lot of happy stories about looking after the children at Orton's farm, and there were a few photos showing her with the children on the farm. However, she moved on from there to work as a house girl at Darlington and in Perth.

One of the letters in her file was dated 27/1/1921 and stated that she would be working for A.O. Neville as a house girl for seven shillings and six pence per week. The money was not paid into her hand, but had to be applied for, stating why it was needed. On one occasion there were letters asking to please explain about money for dental work done. Mum sent the tooth and the account for dental treatment (by a Mr. Ralph Potts: one extraction and one filling - personal file 568) by post with a note as proof verifying that the money was for treatment. My mother was deeply inscribed and surveilled by 'The Native Welfare Act'. Her every action had to be accountable under that system. The 1905 Act legalised the removal of Aboriginal children from their natural

families, encouraged the establishment of reserves and missions, and introduced many restrictive measures over Aboriginal people's lives.

My father was more fortunate, having had a luckier introduction to life. His mother was of Nyungar and Portuguese mixture, a legacy of the sealers visiting the southern coast of Western Australia in the sixteenth and early seventeenth centuries, bore the name of Coyne. His father was a stone mason brought out from Cornwall to help build houses in the colony. Many of these solidly built houses are still in evidence today at Katanning. My father, who was born in Perth in 1900, did not come under the regulations of the Native Welfare Department. This enabled him to grow up as a free thinker, and he had a much freer childhood than my mother.

Even so, the '1905 Act', which gave the Chief Protector full control of all natives, was ever present in all Aboriginal peoples' lives in Western Australia, dictating the terms of living and co-habiting. There were many government legislative policies governing the 'natives' in Australia. In 1829 the welfare of Aboriginal people came under the direct responsibility of the Colonial Secretary of New South Wales. In 1840 the colonial government issued a directive that Aboriginal people should not be admitted to towns. This was followed in 1886 by the establishment of the Aborigines Protection Act. This new act enabled regulation and control over the entire Aboriginal population in Australia. In 1890 the Western Australian colony attained self-government, although the British government continued to maintain control over Aboriginal affairs. 1898 saw the Protection Board abolished, and the Aborigines Department under a Chief Protector of Aborigines was established, giving responsibility to the Premier of Western Australia. In 1904, after The Roth Royal Commission found that there were many abuses involving the care of natives, the Aborigines Act of 1905 was enacted. Initially it was for the protection of the Indigenous people who were overwhelmed by the new system being imposed upon them. The Act legalised the removal of Aboriginal children from their families, encouraged establishment of reserves and missions and introduced many restrictive measures. Indigenous people in Australia have always indicated that

this Bill has caused much anguish, particularly in our relationship with the foreigners.

Dad was able to make decisions about where he worked and was not answerable to anyone about what he was doing at any given time, such as being on the street after 6pm; Aboriginal people could and would be put in gaol if they were on the street after that time. Certain seats were allocated in the picture theatres, and Aborigines were not allowed into hotels and were not free to marry their chosen partner because of the 1905 Act co-habitation rules. Special permission had to be given if one wished to live in the townships. They were forbidden to speak their native tongue, and many children were banned from attending country schools from 1911 to 1944.

The Western Australian Natives (Citizenship Rights) Act of 1944 gave limited rights to Aboriginal people who could prove that they had adopted a 'civilised life' and did not associate with family members who had not been accepted into this elite group. My father was very bitter towards government policy, as he had felt the full force of in 1911 when he was forced to leave school at 11 years of age. He had brought us to Perth to evade these restrictive rules about schooling and fraternising with family. He told us to ignore these rules and do what we wanted to do, for example going to the pictures and being on the street after 6 pm, and later, going to the hotel if we felt inclined to do so.

When my parents met, Dad was 32 and Mum was 27. They applied to get married, and permission was denied because of Neville's policy on breeding the Aboriginal colour out of the people. He had complete control of all Aboriginal people in the State. Fortunately, my father was aware of life outside the 'Native Welfare Department' and had his own ideas about ways around the 'rules'. At that time my mother was actually working for Auber Octavius Neville, the Chief Protector of Natives, as his house girl, and so she was in a tenuous position as far as getting away with an unauthorised marriage.

As luck happens sometimes, Mr Neville had to go north on a State ship in 1933 to clear up some facts regarding the 'Forrest River Massacre'. This had taken

place in 1926 and there had been a public outcry about allegations of ill-treatment of Aboriginal people. It took six weeks to complete the trip, so Dad wasted no time in taking his chosen bride to St. Albans Church in Beaufort Street, Perth, to have the 'wedding banns' read. In the Church of England it is customary to give notice of forthcoming marriages for a four week period at the end of each Sunday Service. This is to give people the chance to speak up and oppose the marriage 'or to forever hold their peace'. Mum and Dad were married in St Albans Church on 18th June, 1933.

Mr Neville was powerless to reverse the situation so Mum and Dad remained married for life. Mum was released from bondage. When Dad told this story over and over again to us children, we were so proud of how he outwitted the 'Chief Protector of Aborigines'. Dad told many stories about his family and how we were related to many people in the South West of Western Australia, but the story about how he overcame the system to marry our mother was our favourite.

My father was working in the railways and this meant that he was transferred around many areas of the State. When I was born in 1935, I had a brother Brian, fourteen months older than me, and Dad had been transferred to Collie. We did not have a regular railway house, something that was generally provided for railway employees, but a tin humpy. This is what many Aboriginal people had to make do with in the 1930s.



Joan, Brian and mother Lillian
Tin shack at Collie 1935

When I was two years old, the country was still in the midst of the Depression and my father lost his job in the railways. He then decided to bring our family to Fremantle. One of the main reasons for this decision was that he saw Fremantle as having more opportunities for his children. He said that many Aboriginal children were excluded from school in the South West and he wanted us to have a good schooling.

The War Years

Our family - mother, father, and now two brothers, one older and one younger, and I were told by the authorities that we had to move out from Fremantle to Palmyra in 1942, when the Japanese were sending reconnaissance planes to spy on the land over Fremantle. It was considered too dangerous to stay in Fremantle because the Army was situated in Burt Street. When the soldiers practiced firing the cannons out to sea, many of the windows of nearby houses shattered, and the gas works in Fremantle was a prime target for bombing.

The Australian Prime Minister, John Curtin, had asked the American Government if their Naval Forces would help protect the Australian coast-line. The Japanese Air Force had bombed Pearl Harbour, an American Naval Base in Hawaii on 7th December 1941, which forced the United States to respond to protect the Pacific Ocean area. On February 19th 1942, Darwin was bombed in the same manner as Hawaii and other coastal strips including Broome and Port Hedland followed. The war was getting serious for Australia.

At the same time the British base of Singapore was captured by the Japanese. The hospital ship *Vyner Brooke*, fleeing the country, was torpedoed and sunk on 14th February 1942. Forty-three nurses and physiotherapists were killed. The female survivors made it to Banka Island. However, a Japanese patrol arrived and ordered all the women to march into the sea. All but one were shot and killed. The only one who lived to tell the shocking story was Sister Vivian Bullwinkel, a nurse and a shining example of heroism.

They were machine-gunned from behind. "They just swept up and down the line and the girls fell one after the other," Bullwinkel was to recall. She watched Matron Drummond disappear beneath the waves, and then, one by one, her friends. The bullet that was meant for her, struck her in the flesh above her left hip. The force of the round threw her into the waves, where she floated. She began to swallow salt water, then became nauseous, but she was not dead. Though wounded, Vivian Bullwinkel was the sole survivor of the massacre of the women. She knew that if she vomited, or showed any movement whatsoever, that the Japanese would finish her off. She held her breath, stealing a little air here and there and, although she couldn't swim, she floated and slowly the current brought her closer to the shore.

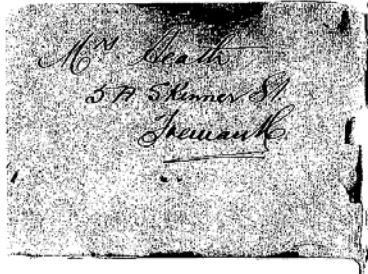
"Finally", she was to say later, "I plucked up enough courage to sit up ... I looked around and there was no sign of anybody ... there was nothing. Just me". Vivian came ashore and walked up a narrow path, away from the beach and into the jungle. Some twenty yards in, she lay down. "I don't know whether I became unconscious or whether I slept", she was to muse later. At daylight she awoke; she was hot and thirsty. She thought of the springs, but fortuitously stopped herself from moving, for just at that moment she spotted a line of Japanese back on the beach. "My heart went to the bottom of the feet again", she said. Another escape. (Angell 2010).

Because I felt at one with the nursing contingent, this affected me very deeply and made me more determined than ever to be a nurse when I grew up. I had always felt drawn to nursing when I was young. During the War there was much talk about the Red Cross and the work they were doing overseas. The government was calling for the public to join in to help the soldiers in their need for more resources. We were expected to put money in the bank for the 'war effort'. A hit song on the radio at that time was *'Nursey Come Over Here and Hold My Hand'*. I used to put a tea towel on my head and pretend to be that nurse, holding people's hands and making them feel good again. On Mondays, the children all rolled up at school with sixpence to have it recorded in their Commonwealth Bank Books or to buy War Bond Stamps. To me as a child, life was satisfying, and war seemed only a word with no real meaning of death and mayhem.



Palmyra School Grade 5
(Girls Class 1946)

It wasn't long after the 'Great Depression' and people were just getting back to regular employment. My father used to go down to see 'Paddy' Troy, the champion of the unemployed from the Painters and Dockers Union at the Fremantle Wharf. The unemployed men gathered at the 'pickup' for casual work on the wharf every morning. Paddy Troy became the saviour of the unemployed and was responsible for getting jobs for the men to help feed their families. Dad had spent some years on 'sustenance', receiving meal tickets for work done clearing the swamplands at Langley Park. On some days he spent hours pulling up onions at the Spearwood Market Gardens, and was paid with a bag of onions at the end of the day. Lucky for us our rent was only eight shillings a week. Later Dad was 'manpowered' at the Fremantle Gas and Coke Company for the remainder of the war years, because at 42 years of age he was considered too old to join the army and go overseas to fight the Japanese.



7	2-3-42	S F 42
14	9-3-42	S F 42
21	16-3-42	S F 42
28	23-3-42	S F 42
14-4-42	30-3-42	S F 42

5	to 20/10/41 S F 41	James Road Point to 20-5-41	8
1	27-10-41 S F 41	14	8
2	3-11-41 S F 41	21	16
15	10-11-41 S F 41	28	S F 41
22	17-11-41 S F 41	5 2	16
29	24-11-41 S F 41	12 1	S F 41
26	1-12-41 S F 41	19	S F 41
13	8-12-41 S F 41	26	S F 41
20	16-12-41 S F 41	9	S F 41
27	23-12-41 S F 41	16	S F 41
3	30-12-41 S F 41	23	S F 41
10	6-1-42 S F 42	30	S F 41
17	13-1-42 S F 42	6	S F 41
24	20-1-42 S F 42	13	S F 41
31	27-1-42 S F 42	20	S F 41
27	3-2-42 S F 42	27	S F 41
14	10-2-42 S F 42	6-9-41	S F 41
21	17-2-42 S F 42	13-9-41	S F 41
28	24-2-42 S F 42	20-9-41	S F 41
		30-9-41	S F 41
		6-10-41	S F 41
		13-10-41	S F 41

Family Rent Book
5A Skinner St. Fremantle 1941-1942

There was much patriotic talk between the children at school as to what we could do to help the 'war effort', such as collect silver paper, and discarded tubes from toothpaste or any other metal which could be used. Another area of contribution was the 'Victory Gardens' at school. Each class had vegetable gardens, which they maintained. While I don't know if this had any effect on the war, we all felt it was a positive achievement and that we children were making a personal contribution. Mothers and other adult women were busy knitting gloves and scarves, and baking Christmas cakes for the soldiers who were overseas. The Defence Department had requisitioned a number of properties to be used as Red Cross Hospitals for convalescent soldiers, while tracts of land, such as the now defunct 'Fremantle Trotting Track' was turned

into a vegetable garden to help feed the Australian and American troops which had begun to amass in Fremantle.

All school children had to have a blood test and wear a disc around their neck indicating their name, address, next of kin and blood group. The other wartime essential was a First Aid Kit, which we had to keep with us at all times. This was the best part for me. Every night I checked the kit even though nothing was used from day to day. We were all seriously thinking about 'the War'. Air Raid practice was a regular part of the day. When certain whistles were sounded signalling what we had to do, we ran with a 'sugar bag' to cover our heads. Most times it meant rushing outside and jumping into zigzag trenches, which the 'big' school boys had to dig. On other occasions we had to run all the way home and back. Life was exciting and school was only half a day. What luck!



Mother with her two charges
Ortons Farm

We were the only Aboriginal family in the district and we didn't see ourselves as any different from the rest of the 'school kids'. The 1905 Act was not part of living memory then, as I didn't know about being off the street by 6pm or of drinking rights for Aboriginal people. I did have some understanding about Aboriginal people not being welcomed when seeking accommodation in hostels and hotels. Mum used to send my older brother and me down to the wharf when a troop ship came in so that we could invite returning Aboriginal soldiers back

home. Large coils of barbed wire blocked off the wharf, which we had to crawl through, and then clamber over the slippery barnacled rocks to get onto the wharf and wait by the gangway for our Aboriginal soldiers to disembark. We would shout out loudly “Mum says Come Home!” I don’t know how my mother knew about the comings and goings of troop ships as shipping movements were supposed to be a military secret.

This experience made me reflect on how heart-rending it must have been for those brave men who had fought in a war zone, only to be totally disregarded on their return to their own land because they were Aboriginal. On many occasions this insult was compounded by the fact that their children had been taken away and put in missions in their absence. There were no War Service Homes for most of these Aboriginal Returned Service Men and their pay packets were considerably less than the other soldiers. They returned to their homeland to find that they were redundant and marginalised in society. I knew none of this at the time. In those days the job at hand for me was raising funds for the Red Cross, and all my attention was focused on that.

I asked my mother to help me organise a ‘Tuck Shop’ to help raise funds for the war effort. At the end of the day I had raised seven shillings and sixpence (seventy five cents), which seemed to be a small fortune, as a penny went a long way then. I could hardly wait until Monday to take the money to school and have it recorded on my card as a contribution to the war effort (strange that it wasn’t for peace). I proudly marched up to the teacher to have the amount recorded on my Red Cross Card. I had no sisters to tell me not to act stupid, so I lived in a world of make believe, and pretended that I was a Red Cross Nurse with a tea towel on my head, soothing the wounded with a kind smile. “When I grow up I’m going to be a nurse”, I thought, as nurses were my heroines. The most important thing I remembered from that time was the thought that I would be able to get coloured pencils for school after the war was over. It was 1945 and I was 10 years of age.



Junior Red Cross Certificate
1945

Post Second World War

My mother died in 1948 when I was thirteen, and my world seemed to collapse. Later my two brothers joined the Merchant Navy and went off to sea while I was left home with my father, who turned into a tyrant. Being very unhappy and not knowing which way to turn, I ran away from home at the age of sixteen. This was the minimum age required, providing a person could keep themselves both in a job and with a roof over their head.

I was getting close to my ambition of becoming a nurse when I got a job in the laundry of a private maternity hospital. It proved not such a good first job as it was a bit daunting for a sixteen year old. On the cook's day off, I had to cook the meals for the whole hospital - no mean feat. This first big step in my career was only in the next district at East Fremantle. The family dog followed my tracks and sniffed me out. Consequently, Dad found me and made threats of putting me in a 'home' if I didn't return to him. I compromised by going home

on my days off to clean the house for him. Meanwhile at work, I was enthralled with the tales the nurses told when we were sitting out on the lawn. Nursing sounded very exciting.

Reaching For My Goals

I stayed there until I was seventeen years old and then tried my hand in nursing at the Home of Peace in Subiaco. What a shock to the system when I faced a sea of grey haired old women! It was very daunting. My heart sank and I felt like bursting into tears. The matron at the time went out of her way to employ Aboriginal and migrant nurses. It wasn't long before I clobbered up with a young Aboriginal nurse, Lorna Kickett, who 'showed me the ropes' and helped me to get all the work done. I thought I would never be able to fulfil the role of a nursing assistant. Everyone seemed so clever and knowledgeable, while I trailed a mile behind the play.



Joan Heath
(Nurse Assistant – Home of Peace, Subiaco 1952)

Matron Edis was my favourite. She had been one of those 'Red Cross Nurses in the Second World War'. She was everything I could have imagined: cool, calm and offering a helping hand to all. The hospital nursing crew consisted of a mix of Aboriginal and white Australian women, and displaced persons from Europe. Some of the foreign nurses I found difficult to work with. They had 'cut their teeth' in nursing in the midst of the devastating theatre of Hitler's Europe. I

realise now that they were acculturated differently to us in Australia. It wasn't until years later that I learned about 'code switching'. European nurses were much more aware of different cultural codes of conduct than I was at the time. These nurses had to be sure that their work was noticed by the hierarchy in order to get approval and let it be known that they were responsible for the whole exercise. They were older than the rest of the nurses and we were 'nagged to death' over every procedure. This was truly un-Australian at the time. One Aboriginal girl was so hassled by the continual nagging while she was dry mopping the ward that she pushed the mop into one of the older European woman's face. The young nurse ran from the ward crying. When she told us what had happened, we all had a good laugh, saying 'good job' and 'that will shut her up'.

Time moved on. I left and went to work in a variety of hospitals. My friend went to Royal Perth Hospital to do her Registered Nurses training. I was left behind, as I had difficulty making up my mind. Besides, I was still in mourning for my mother, five years after her death. People thought that only film stars could have psychological counselling. Such therapy was not for Aboriginal people who had lost their mother and were grieving. My young brother was in denial, telling people that his mother had gone on holidays, while my older brother had joined a Scandinavian ship and proceeded to travel the world.

I was deeply unhappy and started to mooch from place to place travelling from Perth to Queensland, landing in a lot of bother as I was taught to stick up for the underdog, no matter what. I didn't realise that people did not want an Aboriginal person in their corner, and I was beginning to understand that there were different rules for Aboriginal people, especially in Western Australia and Queensland.

In 1953 things became even more difficult for me at work in the Mental Hospital at Goodna, Queensland. When I complained about certain things, a lot of my 'colleagues' wiped the floor with me and were willing to point the finger at me indicating that 'I' was the troublemaker. After being marginalised from the workforce on a number of occasions, I had the feeling of not being wanted.

Nurses who were six months ahead of me were intent on giving me all the rough jobs on the ward and reporting to their seniors that I did not want to work. This was 'justly' recorded on my ward report. "Ah, the Aboriginal girl – just what you would expect." At that time I lived next door to the Secretary of the Australian Workers Union. I called him over to the fence and told him of the discriminatory practices at the Goodna Mental Hospital. He told me how to set up a rolling strike at the hospital. What luck! I encouraged other nurses into the scheme. The hospital was in for a shock. They underestimated this little Aboriginal girl from Western Australia. The other nurses thought it was a jolly good idea, not because of the discrimination, but the excitement of civil disobedience. It was a great adventure for them, camped out on the lawn by the main office having a barbecue in full uniform. This was breaking all the rules and regulations of nurses at that time. Patients were jumping over fences and we were laughing and having a picnic.

When a group of nurses came from Brisbane General Hospital as strike breakers, the taxi driver wouldn't take them the mile or so distance to the hospital. They had to walk. They realised that psychiatric nursing was nothing like soothing patients' brows in a 'sane' hospital. After a couple of days we all resumed our places on the ward and I gained the recognition of seniority and given the appropriate jobs on the ward. The strange thing about working there was that I liked it. However, I got the wanderlust after a while and put in my resignation. To my surprise the administration staff would not accept it. I had to do a 'midnight flit' to get away.

Home to WA

In 1955, I decided to return to Western Australia and try my hand at psychiatric nursing at Heathcote Hospital. I loved the study and spent a good deal of time with books in off duty hours. However, I came to grief with the establishment after about eighteen months and was sent packing after a confrontation with the night matron who came to inspect the nurses quarters and check that all the nurses were in bed. I was up and had had a few drinks at the hotel previously. As hotels shut at 9pm at that time, it had been a couple of hours since I had a

drink, and so I felt I was travelling OK and behaving well. I was getting my clothes ready for work the next morning. I used to be very particular about having shiny shoes (a soldier I knew had very shiny shoes and told me that the secret was methylated spirits in the polish). The bottle of spirits I had was spilt and there was an implication that I was drinking methylated spirits in my room! I had to face the Hospital Board the next day. Though it was not spelled out that I was drinking methylated spirits, the implication was still there. I was asked to leave. I was heartbroken because I loved the work very much. In later life, as a professional, I surpassed the rest of the nurses who were in my group.

Changing Directions

This put an end to any study for the time being. I spent the next year at a maternity hospital as a nursing assistant. It was from here that I met and married a Norwegian seaman, at twenty one years of age. I went to work with my husband on sheep stations off the beaten track, in the first instance at a place called Barwidgee Station, 120 miles south east of Wiluna, on the edge of the Gibson Desert. This was certainly different for me, as I had spent all my life on the coast. We travelled cross-country on the back of a mail truck to Leonora where my husband got another job as a Mill Man on Minara Station. I became pregnant, so we moved back to the coast and I gave birth to a baby girl in 1957. The marriage did not last due to my husband's drinking habits. I ran off again with a six week old baby and got a job at Sister Kate's Children's Home.

Sister Kate's Home

Sister Katherine Mary Clutterbuck was affectionately known as Sister Kate, and was an Anglican nun who joined the order when she was 22 years of age. She had a leaning to help disadvantaged children in the slums of England, and later migrated to Western Australia at the turn of the century where she helped to set up Parkerville Children's Home. In 1933, when she was 72 years of age, she was asked to retire and was given a Member of the British Empire award and a pension. Not to give in easily she took some older home girls with her and set about getting a home started for 'lighter skinned' Aboriginal children.

The Aborigines Acts of 1905 and 1936 dictated that ‘quarter caste’ and ‘one-eighth caste’ children under twenty one years of age were to be removed from tribal areas. Discussions were held with the academic and public servant Paul Hasluck, later to become Governor-General of Australia, and A. O. Neville, the Chief Protector of Aborigines and now the legal guardian of all ‘illegitimate’ Aboriginal children. These children, who were mainly taken from the Moore River Settlement, were sent to Sister Kate’s Home.

Sister Kate passed on in 1946 at the age of 86 years, and the Presbyterian Church took over from the Church of England while I was engaged as a house mother in 1957. I was brought back to my roots and this gave me a deeper understanding of some of the problems associated with Aboriginal people today. I was given a small cottage, which I later discovered was “Gran’s” (Sister Kate’s) cottage, where she had retired to live out her last years. I had five children to look after as well as my own child. It was a cosy little household. The work was shared and I felt good about my role. The young girls would rush home after school to take ‘the baby’ for a walk in her pram and I settled down to a relatively quiet life.

Though we were in separate cottages, we were still subject to the overarching regime of the home. This meant that laundry and meals came from a central area and for any maintenance needed in the house we had a handyman who ‘fixed things’. There was a central area where clothes donated for the children, albeit old fashioned and ill-fitting, were kept, and we were able to get these as needed. I managed to ‘restyle’ them on an old sewing machine. The children had no idea about where money came from to run a house, as ‘the shed’ was where everything emanated from. This encouraged the ‘hand out’ mentality. To add it all up; they did not learn how to cook, care for clothes, learn about house maintenance or wait until the family could afford certain articles. All problems could be solved by someone else.

Other problems were the changeover of houseparents. This was frequent because the salary and working conditions were poor. The wages were three pounds a week and this constituted six and a half days and every night work as

caretakers. Some of the house mothers left a lot to be desired. Although I loved the job, I had to leave, as the three pounds a week just did not cover my expenses, and I was getting in debt. I applied for and got a job as a cook at a sheep station in the Murchison. This changed my resources from the lowest scale to the highest paid at the station, with twenty five pounds a week and keep. After a couple of years, I returned to Perth and to Sister Kate's Home as a cook. By this time there were 100 people to cook for and though food stores were scarce, I felt good at the home.

In 1964, I was married in the church at Sister Kate's Home. I left after this and went to back working as a nursing assistant at the now defunct Mount Henry Old Age Nursing Home in Bentley.

Stars in My Eyes

It was not until a decade later, when I had been working at a surgical hospital, St. Josephs, in Bicton, that I found out that a course for nurses was going to start at the Western Australian Institute of Technology (WAIT). I knew I could succeed there. My idea of university was of a place where people would be judged on their merits and I knew I was able to do my work. Luckily I was well aware of the racist element which operated in most Australian hospitals in the fifties and sixties. Not taking it personally, I still had my self-esteem in place.

My daughter, who was fifteen years old, had made me aware of a program for mature age entry to university at Technical Colleges. Because I had left school at fourteen years of age to care for the house after my mother died, I would have to navigate through the education system to enable me to participate in a nursing course. I found out that a Mature Age Entry to TAFE (Technical and Further Education) consisted of two units – one English unit and the other a unit of choice - plus a Scaling Test. I chose to study Human Biology, a subject I liked and which would enhance my chances if I managed to pass the Technical College Exam. This was just as well, because if I had to sit it out with a lot of teenagers, I don't know how I would have coped. At this time I was thirty-nine years of age, and it had been twenty-five years since I had done basic study at

high school, keeping in mind my 'sorties' into hospital-based nursing, where I had a few stops and starts in the general field of health.

Western Australian Institute of Technology

As a student at WAIT in 1975, my first thought was one of relief because I had been accepted at University. The next step for me was 'Give it a go for the first semester and see how I go'. I was elated to find that not only did I pass but also that I was in the top percentage of the group academically. What's more, the past twenty years must have had some effect, as I sailed through the practical side of the course.

I had a 'fire in my belly' to explore Aboriginal health and living standards. I tried to focus my assignments upon Aboriginal health, and so I was on a continual learning curve into Aboriginal health, life and living standards. After the first year there was an offer for a WAIT Abroad Study Trip to India. We had to identify a problem, which would be appropriate for each of us. I chose Mothers and Babies programs as the health headlines all pointed to India, and the vast population, and what could be done about it. With the support of the WAIT Department of Social Sciences and the Federal Department of Aboriginal Affairs, I was allocated \$600 for the six-week program.

- **Mothers and Babies Program, India, 1975**

The Indian Program revolved around mothers and babies first. This made sense to me as locally, with Aboriginal people, we had to start with mothers and babies: keep the babies healthy, support the mother and make sure that the mothers were taught about adequate nutrition and what to watch out for when things were going off kilter. This was not rocket science, just plain good management. The way to go was to start with mothers and babies as our first priority. In India I gained great insight into how we, the Aboriginal people, could conduct similar health care projects in Perth.

Excursions to the hospitals left a lot to be desired, as hospitals appeared to be under-equipped and quite outdated. At the 'All India Institute of Medical

Sciences' there were coils of barbed wire up the stairway. Our tour group from WAIT were aghast with that as well as the old and decrepit equipment in use. There were many incongruent things we found, including patient care which seemed to be carried out by the relatives, for example preparing food on a small dung fire outside the hospital and giving out bedpans to their relatives in intensive care.

A trip to the World Health Organization Headquarters (WHO) in New Delhi was an historic occasion. The WHO team were having in-depth discussions about 'the Eradication of Smallpox'. It seemed to be planned with military precision. It was found that the epidemiological trail seemed to move clockwise in a huge circle from village to village, and if they could anticipate the next step of the outbreak then there would be a good chance of working toward eradication by immunising all in the next village and so on. The groundbreaking news was that the plan did work and smallpox was declared completely eradicated in the world by 1977.

The other areas to be dealt with were malaria and polio. Malaria appeared to be an ongoing problem that would be hard to eradicate due to the amounts of stagnant water and puddles, which were everywhere in the villages. Polio was another ongoing problem, with a huge population and most of the country serviced by open drains. There appeared to be a lot of 'people pollution' in that though the people were very clean and could be seen washing themselves at outside taps early in the morning, there was just not enough ablution and toilet blocks. The Sasakawa Peace Foundation had agreed to fund a plan to eradicate polio. This Japanese philanthropic organisation had also built and equipped a leprosarium with a most impressive high quality electron microscope.

The major epidemiological problem in Australia at that time would probably have been polio. Nevertheless, it was worth my while to keep delving into the Indian health problems. For example, as the population was so vast at 548 million in 1975, there was a major thrust toward birth control. Young men were given transistor radios if they agreed to have a vasectomy prior to getting

married, while the young married women were treated with hypodermic capsules as a birth control agent.

The village programs gave me the most incentive as regards returning home to Australian practice and I felt more comfortable working in this area. The villages we visited were all on the outskirts of New Delhi. It was possible to get a 'bird's eye view' of the population through these programs. Cows are the sacred beast in that country, and you could see this in operation walking around the streets, as people side-stepped cows on the footpath and some were housed on the ground floor of houses in the winter. The Village Chief met us at each village and showed us around his town. Though they were still subject to open drains, the air was much clearer and quite pleasant in the village.

My interest was in the Health Centres. At first glance these were very basic – plain brick buildings usually placed away from the cluster of village housing. The dainty nurses in their white saris were squatting outside the building cooking on a small fire and teaching the young mothers a “hands on” experience in good nutrition, while they were waiting to be seen by the medical officer. It was a brilliant idea - a “hands on” experience. I felt that this would be the best way to teach nutrition, which is usually such a boring subject if it is taught by the ‘three Rs method’.

I was taken in by the Maternal Child Health Programs. In Australia at the time there were separate Ante & Post Natal Programs and Child Health Centres – a fragmented arrangement. In India, mother and baby were treated as a unit. Another good experience was being with the Community Nurses when they were packing their swags onto the horse and cart to go up in the hills to visit the people. This was translated into an axiom by WHO: ‘If the people won't go to the medicine, then the medicine must go to the people’. It was a happy, jolly time. I could see most of these programs being transposed into Aboriginal communities in one way or another.

One cannot go to India without acknowledging the great champion of the people, Mahatma Gandhi. He was especially the champion of the

“untouchables” who Gandhi had renamed ‘Harijans’ in 1933, meaning ‘Children of God’. He was a lawyer by profession, studying at university in England. Gandhi protested against the English colonial rulers with ‘civil disobedience’ strategies. He was an opponent of the caste system, which prevented people from climbing the ladder of professionalism. The caste system was used to define how Indians served society: ‘*a Brahmin with his knowledge, a Kshatriya with his power of protection, a Vaishya with his commercial ability, and a Shudra with his body labour*’. One has to be born into and live in this system to fully understand it, rather like the Australian Aboriginal Kinship System with specific obligations attached.

Provision was made for 2% of all student intakes in universities to be Harijans. This was certainly ahead of Australia’s way of thinking, as no such rule applied for Aboriginal people at the time.

- **The Barefoot Doctors Scheme, China, 1977**

Two years later in 1977, with the aid of a bank loan, I travelled to China to look at the Barefoot Doctors Scheme. I wanted to know the requirements of their practitioners and whether we could use a similar scheme for Aboriginal people in Australia. When we travelled to China, the ‘Bamboo Curtain’ had not long been lifted, allowing a few professionals into the country. Our Chinese guides tried to keep us under surveillance. This became quite a task as Australians were not used to being ‘hobbled’ and things were so different: we were trying to explore everywhere.

The only similarity between the two countries, India and China, was the vast population. India was still struggling to self-govern thirty years after the British had left the country, while China appeared to be getting on track with their modern and traditional health programs. The Doctors we spoke to related that they wanted to combine both traditional and Western medical practices. We attended quite a few communes where ‘barefoot doctors’ escorted us around and, through a translator, were willing to talk about traditional methods of health care. Chinese doctors have the reputation of being very good diagnosticians.

The herbal medicine factories were a great eye-opener. I expected people in tiny rooms weighing out herbs for people. It was nothing like that: the factory was on two levels and people took the herbs to the top level where they were emptied into huge vats, processed and sent through a series of pipes to be bottled at the ground level. It was very professional.

It appeared that the Chinese were very community-minded, and everyone worked to enhance their society. The Communist Party was still in rule, so people were working within the collective regimen of their politics. When I asked about orange peel on the decks of canal boats, I was told that all people saved orange peel for the medicine factory. It seemed to be a quaint idea, but when you multiply this with the population, there would be a lot of orange peel to process into medicine.

The Chinese were using a lot of herbal medicines in hospitals, particularly in the 'Burns Unit' where the Medical staff were very successful with aloe vera treatment. We foreigners were taken into a burns ward to see the patients. This would never happen in Australia because of the contamination factor. They talked about 'alligator pinch grafts', which were tiny grafts about the size of a fingernail, to treat the burns patients when there was very little good skin left. These people were 'on show' in the hospital and treated as heroes. That, I thought, was the difference between their practice and what we had in the West, as in Australia at the time burns victims very rarely lived if they had more than 75% of their body burned.

We were taken to operating theatres to observe operations under acupuncture. This was impressive for me as I had worked in a surgical hospital in Australia prior to WAIT training, and nursed footballers when they had knee injuries. This operation is called a menisectomy, which is a surgical removal of a cartilage in the knee. Footballers spent 10 days in bed after this operation. The shock in China was that when the operation under acupuncture was over, the patient got off the table and walked away. Other operations we witnessed included a thyroidectomy and brain surgery. The brain surgery made me feel uncomfortable. I thought that if it was me about to be operated on, I would have

run away. Moxibustion or heat treatment was another treatment which appeared to be effective. I asked the doctors whether they preferred Western treatment or traditional healing. Invariably they said that Western pain tablets were good for immediate effect but that in the long run they preferred Chinese medicine.

The Barefoot Doctor scheme was in full flight, with these doctors situated in factories, 'children's palaces' (child care centres), communes, schools and health centres. When I inquired about the upward mobility of the workers, I was surprised to hear that health workers could aspire to become doctors, and that the same applied to nurses. I thought that this would never happen in Australia, with our traditional English programs. Twenty years later, here in Australia we have had health workers studying medicine and a general upward mobility in higher education for health workers and nurses.

With the advent of the Aboriginal Medical Services there appeared to be a place where these 'barefoot doctors' could fit into modern Aboriginal culture. While I was still in China completing the Study Abroad program, a message came through from the School of Nursing at WAIT that I had passed my final exams. I was now a 'Professional'.



Joan Winch
Registered Nurse Graduation
WAIT 1978

Back in Perth

I gained a triple certificate rating in General, Midwifery and Child Health Nursing, and I was engaged in 1980 to work as the only Community Nurse attached to the Aboriginal Medical Service. This service catered for Aboriginal people on the edge of society in the Perth and metropolitan area.

I was appalled when I realised the Aboriginal people in and around Perth were in a time warp – the health problems I suffered as a child were running rife in the community forty years later: impetigo, scabies, head lice, together with gastro- intestinal tract and respiratory tract diseases, complicated by lack of adequate housing. There were many Aboriginal people living in tents, car bodies, under bridges, and in paddocks in and around Perth. The colourful names attached to these living quarters were very descriptive: ‘Millers Cave’ (car bodies) – named after the Charlie Pride hit tune, ‘Bull Paddock’, and even ‘The Bronx’. I knew that some positive steps had to be taken to improve Aboriginal health, and I wanted to use my experiences to work towards that.

Chapter 4

Aboriginal Medical Services in Perth: Opening New Doors

Background

The incidence of disease, malnutrition and infant mortality was very high among the Aboriginal population in Perth in the late 1950s. The problems were compounded by a steady influx to the city from outlying areas since the late 1940s. Aboriginal families had lived for many years on outback stations with the station owner supplying food, clothing, blankets and shelter for the whole family. In exchange the women helped with housework and the men worked as labourers on the station. A minimal wage was given for this work and the Aborigines regarded the 'station' as home. However, when unions began agitating for 'equal wage for equal work' and the full bench of the Arbitration Commission held that Award terms should apply to Aborigines (Couzos and Murray 2003, 34), the station owners found that it was uneconomical to support whole family groups. The best workers were kept on in employment and many of the others either were dumped with their dogs and kids in the nearest town, while others began a steady drift to country towns and city areas.

Their whole life style was changed. Aboriginal people did not have the education to face the stress of life in the city; there were no set patterns of 'norms' and consequently they were in a state of anomie. Anomie has been described by Parsons (1954, 125) as:

'the state where large numbers of individuals are in a serious degree lacking in the kind of integration with stable institutions, which is essential to their own personal stability and the smooth functioning of the social system ... the typical reaction of the individual is ... insecurity'.

This was first described by Emile Durkheim and translated into English by George Simpson from the obscure eighteenth century word "anomy" in 1947 (Durkheim 1964). Sub-cultures grew up around city areas, which were

identified to the outsider as subcultures of poverty, poor hygiene and housing conditions, poor health and unemployment.

Institutional Racism

Aboriginal people did not view health as high on their priority list and the health systems were not made use of. Hospitals were viewed as hostile places, and it was assumed that doctors, nurses and hospital administrators were racist. Some still are. Institutionalised racism was rampant and there are still thinly veiled prejudices under a cloak of propriety, and these attitudes are then passed on to new arrivals to this country, working in the health field. Ingrained prejudices cause alienation of patients and a place where they don't feel accepted. Hence, these people who abscond from the hospital feel comfort in returning to their own families.

Mooney (2008) describes institutional racism in a recent presentation at the Aboriginal Health Council of Western Australia (AHCWA), and how horrified a visiting doctor from Scotland was at a major teaching hospital in Perth.

‘[She] could not believe how racist some of the doctors were. They told racist jokes to the junior doctors and made racist comments about some Aboriginal patients. She was convinced that Aboriginal women were being persuaded to sign consent forms without knowing what they were signing.

I also have had ‘putdowns’ by hospital staff in the past. Doctors confided to me on the phone about certain Aboriginal patients, and when I confronted them about this in person, they appeared embarrassed when they realised that I was also Aboriginal. On the wards, some doctors treated me as the relative of the patient rather than as the senior nurse at the Aboriginal Medical Service, and waved me aside with their hands as if to indicate that I was of no consequence. When I spoke up about the treatment an Aboriginal man was getting in the casualty department, I was told by the Registrar to go elsewhere if I wasn't happy with the care. I replied that I would if there was some place else to go. On another occasion, when I told the doctor at the Aboriginal Medical Service that there should be some education program for Aboriginal people about health care, he replied derisively, “Who's going to run it, you?” “Yes”, I replied.

There were many such incidents I encountered in hospitals, while working in the Aboriginal Medical Services.

Living Conditions

Aboriginal people on the whole were unable to identify with large modern buildings. They would rather stay in an environment where they could feel the safety of family who understood their particular needs. The change of living patterns from hunters and gatherers to static area dwellers, with no control of their way of life and the constant pressure of living under this 'European Regime', resulted in mental stress affecting the holistic interdependence of social, spiritual and physical wellbeing. This in turn caused the deterioration of their health, compounded by a lack of understanding of the new food system. The people were suffering from malnutrition. The changed lifestyles, which led to an increased consumption of fats and sugars, caused further increases in lifestyle diseases, and was detrimental to the past, healthy practices. Poor diets in institutions also affected children's health, forcing them into the unfamiliar pattern of close living conditions, which caused the spread of introduced skin diseases such as scabies, impetigo and head-lice. Aboriginal people had no knowledge of how to cope with this avalanche of diseases.

Past Practices for Nutrition

People lived within walking distance of their food in season. The women gathered and dug for vegetable foods. This was a social occasion, where they talked and exchanged information, while the children caught small lizards, which were put on coals for the evening meal. I saw this in action when I was working as a cook at Wooroora Station north of Carnarvon in the 1950's. The women walked every day on the flat expanse of ground to dig for 'onions'. It amazed me, as all I could see was dry barren ground. Songs were sung as they walked the tracks. It appeared to be a tradition, which had been handed down from time immemorial. The men did the hunting for meat. Only at this time instead of spears, the hunting was done with rifles given to them by the 'Squatters'. Eating food was a ritual, with every part of the kangaroo, for instance, designated to particular family members.

The people looked for signs in the sky as star patterns changed, it was said that the emu has left the nest and meant that the women could start looking for emu eggs. Then as the trees blossomed, the group would go to an area where certain berries could be found, on the coast and in the South West it was time for the men to lay the fish traps when the herring came from the other side of the country (South Australia) to spawn in the area bound by Wadgemup (Rottnest Island), Ngoloor Mayup (Carnac Island), Meeandip (Garden Island) Walyalup (Fremantle) in the area of Derbarl Nara (Cockburn Sound).

Aborigines depicted the seasons in the South West according to the weather change though now a lot of the *Nome Culture* has been lost and the peoples of the North West had their own naming of the seasons. Though a book was published about this, there was some secret information, which shouldn't have been included so the information was withdrawn.

As with hunters and gatherers, the seasons were followed for food. According to the 'old men' there had never been a scarcity of food (Green 1984, 10), until their land was taken over by the invaders, and according to Green,

A total disintegration and dispossession had taken place and the native people retreated to the outskirts of towns forming fringe settlements eking out an existence by foraging and begging... the advancement of settlement had a permanent effect on the food gathering habits of the Nyungar people (Green 1984, 183).

Although the people from Fitzroy and other North West areas were not subject to absolute devastation at that time, there was a severe disruption of their lifestyle in the late 1960s, about 100 years later. When the unions ruled that the workers had to be paid equal wages for equal work and people were put off their homelands only to drift to larger towns and eventually move themselves into the capital city in twentieth century Perth. This was where the 'hunting and gathering' now took place and was paid for by the government with Social Security cheques. The people had to discriminate between good food and bad without any education in nutrition.

After the proclamation of the 1905 Act, when the children were removed from the family domain and placed in institutions, unhealthy feeding practices in institutions also affected child health. They were forced into an unfamiliar pattern of overcrowded, inside living conditions, causing the spread of introduced skin diseases such as scabies, impetigo and head-lice. Aboriginal people had neither experience nor knowledge of how to cope with this avalanche of diseases. The illnesses were thought to be caused by the magic, brought by the new comers with the sound of the bugles (see Green 1984, 7, 235).

Causes of Aboriginal Illness		
Primary	Secondary	Outcome
Invasion	Poverty	Anomie
Dispossession	Dependence	Substance Abuse
Disease: <ul style="list-style-type: none"> • small pox • measles • influenza 	Rejection from colonial settlements Lack of access to material resources	Powerlessness
Massacre and genocide	Colonial racial discrimination	Lack of political representation
Value Systems: <ul style="list-style-type: none"> • Power base • Destruction • Capitalist vs. Socialist 	Alcoholism: <ul style="list-style-type: none"> • inappropriate housing • education • lack of access to information and resources 	Malnutrition: <ul style="list-style-type: none"> • diabetes • malabsorption • foetal alcohol syndrome
Incarceration: <ul style="list-style-type: none"> • reserves • missions • stations (sheep and cattle) • gaols 	Destruction of Reserves: <ul style="list-style-type: none"> • Loss of Aboriginal cultural knowledge • Loss of traditional roles 	Lifestyle diseases: <ul style="list-style-type: none"> • circulatory/heart • renal failure • diabetes
	Loss of knowledge of traditional medicines and healthy practices	Distress and breakdown in: <ul style="list-style-type: none"> • mental health • drug abuse • suicide

Adapted from Reid and Trompf (1991)

New Era

After the 1967 Referendum of Citizens Rights for Aboriginal People, the University of Western Australia held the 41st Summer School in 1968 entitled 'Aboriginal Progress: A New Era', this was endorsed by both State and Federal Governments giving the University financial assistance to bring together prominent people, both Aboriginal and White Australians. This gave both groups support to put in place a vision for the way ahead and to put in the first steps for equal opportunities for the Indigenous people in Australia. Critical analysis of past, present and future were discussed as 'where to from now'. There were discussions about support for basic training between parents and their children and different aspects of 'one world' (Grey 1968, 89), while John Moriarty (dec), a strong Aboriginal advocate and sportsman from South Australia, put forth the idea of 'positive discrimination' for the Aboriginal plight. This was to create a level 'playing field', which was bandied about in the 1970s. There are negative conceptions about this 30 years later when the general thought is 'Why do the Aborigines get special treatment?' which could be read in many letters to the editor in local papers.

After being semi-excluded from the education system since 1911, the Nyungars' discussions surrounded support for basic training between parents and children with the different aspects of one world. Our family was one of the casualties of education, when many of my cousins were refused education in country towns. My father brought his family to Fremantle in 1937 because he was refused entry into primary school at Katanning in 1911. It makes me proud when I see the younger generation of our extended family succeeding in the broader society by showing their tenacity in education, with Graham Farmer in the football field, and including our first Nyungar Medical Doctor Sandra Eades, her sister Francine who has a degree in Applied Science in Nursing, Denise Smith who had written children's books in Nyungar language and Anne Eades who has researched and contributed to new treatments for leg ulcers at the Masters level. Many others have qualified in higher education. These are the first force of Aboriginal University Graduates whose parents were refused basic education under the previous scheme.

Running with the Flag

Though the education system has been slow to show the way for our people, the Aboriginal Medical Services in Australia have ‘grabbed the flag’ and run with it. At ‘The Summer School’ in 1968, the changes to voluntary organizations went from non-Aboriginal control mainly by the Native Welfare Department to Nyungars taking over an increased role in the running of voluntary organizations. At The Summer School, sub-committees were formed including – Health, Justice, Hostels, Community Centres, Welfare and Education. There was an agreement for the Aboriginal Advancement Council to take over these sub- committees, which laid down the foundations for Community Controlled Organizations at Perth in that era.

The New Era Aboriginal Fellowship was established in March 1969. George Abdullah formed ‘The Rights Council’, which was later changed to ‘Aboriginal Rights League’. Most of the people leading the ‘new era’ were described as acculturated in the dominant society (Howard 1981, 92). Prominent people leading the control of Aboriginal activists, now deceased, were Ken Colbung, George Abdullah, Jack Davis, Eddy Bennell, Elizabeth Hansen, Rose Pell, Lorna Hume, Joan Isaacs and Liza Isaacs, and others in the background.

The New Era Annual General Meeting took over the Health Committee under the umbrella of the ‘Young Aboriginal Movement’, which formed the core. Front runners were Gloria Brennan (deceased), Marie Bartlett, Sue Broun, Phillipa Cook, Brian Wyatt and Lorna Hume (deceased). The help of concerned Medical Officers Drs Rodger Dawkins, Green and Rigby were successful in establishing the Aboriginal Medical Service in Perth with \$100,000 from the Federal Government through the Advancement Council in 1973.

New Beginnings: Aboriginal Medical Services

Prior to the 1970s, Aboriginal statistics were not systematically recorded. While Australian health status figures overall were comparable to those of other

leading first world countries, when Aboriginal people were included, the overall health status dropped considerably. The Australian Government had to start taking stock of what the international focus on this country indicated about how Australia was treating 'their' Indigenous peoples. This set in motion the germ of an idea about programs for Aboriginal people, though the Treasury was reluctant to release money into catering specifically for Aboriginal peoples.

It was with these concepts in mind and after the death of a close friend that black journalist Bobbi Sykes (dec) and two other prominent members of Sydney's Aboriginal community formed the embryo of an idea for a medical service to cater for the Aboriginal people. Thus, in an effort to put Aboriginal health back in Aboriginal hands, the first concept of an Aboriginal Medical Service came into being.

A meeting was called and doctors were asked to volunteer their services. Just nineteen days later, on July 21st 1971, the Redfern Aboriginal Medical Service opened its doors in Sydney, New South Wales. It was run on a completely voluntary basis with everyone concerned dipping into his or her own pocket to fit out the centre. In September 1972 a Federal grant enabled the centre to employ a full time doctor. Bobbi Sykes became a public relations officer for the "Aboriginal Medical Service" (A.M.S.) and she travelled all over Australia explaining the programme to groups.

The WA Native Welfare Department was abolished in 1972, and soon afterwards the Whitlam Labor government came into power. Among its policies was a commitment to Aboriginal self-determination, and a statutory body was put in place for Aboriginal people to be involved in government decision-making. This saw the establishment of Aboriginal-run programs including the Aboriginal Legal Service (ALS) and the establishment of other Aboriginal Medical Services in Australia, as well as other Aboriginal-run organisations, all with very little funding. The National Consultative Committee was established in Canberra, which at last gave Aboriginal people a voice in Federal Government. Thus began the development of Community Controlled Aboriginal Organisations.

Career Focus

I decided early in my nursing career that I wanted to work in the Aboriginal health field. That was why I focused my research assignments and practical experience, as much as possible, on Aboriginal families in and around Perth. After twenty years of employment as a nursing assistant in the health field, I had no doubts in my mind that health and hospital care was run as a hierarchical regime. I found the egalitarian routine extremely easy to live with at the AMS. Everyone had equal say at staff meetings - from the cleaner to the medical officer. This was definitely empowering for Aboriginal people at that time, because not many people felt comfortable being constantly surrounded by a white society. Some doctors, however, found it hard to take after being treated as demi-gods in the hospital system, only to find that they had to answer to the Aboriginal Medical Service Council. For example, when a doctor took his son, who was not employed at the AMS, to look over the patient records, he was called to task.

Improving Our Health

The Perth Aboriginal Medical Service Clinic, which was opened in 1973 in an effort to improve Aboriginal health, with one doctor and voluntary Aboriginal staff, had gradually started to get the message across (Dodson 1991). The Aboriginal people in and around Perth could be seen by a doctor in a non-threatening atmosphere, whereas in an all white medical centre they would feel the cultural difference. There was great excitement, particularly among those who were taking part in the preparation of the 'new' premises. There were no stark white walls and uniforms. Very few dollars were forthcoming, however. Only the doctor drew a small salary, albeit much less than he could have earned in his own private practice. The Aboriginal people took much pleasure and excitement in painting up the old house in Beaufort Street in bright colours and generally putting in their time and effort for free. Meanwhile they canvassed key people at Royal Perth, Princess Margaret and King Edward Memorial Hospitals for disused equipment and bric-a-brac which could be utilised at the 'new clinic'. The professions were in full support of the 'new' Aboriginal Medical

Service – particularly Royal Perth Hospital who dug deep into their ‘dungeons’ for disused equipment. Their pharmacy freely supplied preparations for ear and skin infections, while a private chemist, Mrs Heaney, was only too willing to help us in any way she could.

These brave, innovative people had to contend with other very negative attitudes:

[The] attitudes we had to contend with were such as Charlie Court’s when he was Premier of Western Australia: ... ‘They are setting up a terrorist organization’ ... [even though] it was to provide basic primary health care (Turner 2008).

In 1978, the Broome Aboriginal Medical Service was first supported by the Catholic Church with accommodation and funding from ‘Brot Fiir Die Welt’ (which translates as ‘Bread for the World’) in West Germany. This organisation has a Christian base and supports the poor, hungry and oppressed peoples of the world in their attempt to combat , hunger, poor education and disease (Winch 1976).

The Perth Aboriginal Medical Service (AMS) opened its doors with the philosophy that the client should leave the clinic with whatever medication was necessary to start treatment. A script in the pocket was of no use if one had no money to have the script filled. In consultation with the community, the issues of child health – in particular morbidity and mortality – were addressed. At Princess Margaret Hospital, ward 5 was overloaded with Aboriginal children.

Staff at the Perth AMS, 1975

- **Non-Aboriginal Staff**

1 Doctor (Full-time)

2 Doctors (Part-time)

1 Trained Nurse (Part-time)
1 Trained Aide
1 Social Worker

- **Aboriginal Staff**

1 Receptionist
1 Centre Manager cum Bookkeeper
1 Welfare Assistant
3 Field Officers
1 Trained Aide
1 Cleaner

The Doctors

All the doctors were very approachable and did an admirable task trying to help educate the 500 patients who attended each month. The centre was operated as a private practice on the Medibank Scheme and the doctors were reimbursed accordingly. These people were very committed. The difference with these practitioners was that they knew the clients personally. They interspersed their advice with Nyungar words, which made the clients more inclined to share personal details about their home and family. The clients were treated very much as persons in their own right and not just a faceless number, as was the experience in large public hospitals at the time.

There was comfort in talking to the non-Aboriginal doctors because of the possibility of conflicts that may have arisen with a younger Aboriginal doctor (even though there were no Aboriginal doctors in Western Australia at the time). In the first instance, age is important, as an older Aboriginal person would feel that a younger Aboriginal doctor would be his or her inferior. Another point to consider would be if the Aboriginal people came from a rival family group. Vital information about the patient may be passed around the community. This has always been a problem at the AMS. The centre was accused time and time again of having access to the clients' records and that this access could prove detrimental to the clients' wellbeing. While none of this was ever proven, the question still hangs over the AMS to this day. In truth, the staff were, and continue to be, so overloaded with day-to-day problems that this could never be

perceived. My thoughts at the time alluded to the Aboriginal people being 'brain washed' with regard to the concept of 'white supremacy'. It was noted in Canada (Lifter 1972) that young Indigenous college graduates returning to the reserves were met with great opposition, and that after a settling in period it was found that they were accepted with respect (Winch, 1976).

Nursing Staff

There was one Registered Nurse in the clinic and a visiting Community Nurse. The Nurses Aides worked under the direction of the Registered Nurses and carried out various treatments within their capacity in the clinic and community. This was hectic at times, for instance when a drunken brawl had transpired and they all arrived to be patched up.

The Community Nurse had a triple certificate and specialised in child health. She had many miles to cover in the metropolitan area. She knew all her clients by name and spoke of them with great respect and terms of endearment. The work was very demanding and involved a lot of travel. She had to travel three times a week to West Swan, Guildford and Lockridge, as there was a concentration of Aboriginal people in these areas. Other areas which were covered ranged from Perth to Armadale and all stops in between where the people lived. North Beach area was covered with Midland Junction and the Kalamunda area on other days. There were a series of camps in the metropolitan area which, were described as 'tent city' – Midland Junction, Lockridge Camp, Benara Road, 'Bull Paddock' and car bodies along the railway line in East Perth as well as under bridges, together with the Norbert Street shelter and small clusters of people in other areas.

Office Staff

The staff were trained in business and office management and had a friendly approach to the clients. They had the advantage of knowing the families on a

personal level and this included knowing who the contact person was and where the families fitted in with each other. There was always hot soup, tea, coffee and bread for those who wanted it. The receptionists were the first line of contact for hospitals and ongoing appointments. They always seemed to know just where to track down those who had a hospital appointment or needed to come into the clinic.

Social Worker and Assistant

These people were the negotiators at the hospitals and with families. There were a lot of negotiations, which took place between the AMS and hospitals as the Nyungar people had a lot of mistrust when negotiating with the broader society. Many of the clients thought the Social Workers were the 'Gods' who handed out money to pay accounts, such as rent, electricity and gas. They were forever dealing with hospital staff and were the go-betweens for our people in hospitals and their homes in the community, making sure that the family at home were being cared for as well.

The Field Officers

These people all had First Aid Certificates. They transported people to the AMS and then home again when they had been attended to. This included collecting prescriptions at the chemist. Other transport jobs included taking people for physiotherapy and delivering specimens to the laboratory. They were a happy-go-lucky lot and the clients had full confidence in them, as they told stories about various happenings within the community and helped the clients get in and out of the cars. They had to have a good knowledge of where the families lived as a lot of the older people could not read or write and could only direct 'as the crow flies.' In the early days, staff who owned a car did a lot of the transporting, often running their cars into the ground without any reimbursement

The Cleaner

This person was very sociable and knew about the families. She was the messenger between families. People used to seek her out for 'grapevine news.'

Her work was constant as the clinic had to be kept impeccable for both morning and afternoon sessions. The Cleaner was responsible for providing tea, coffee and soup in the clinic. The old adage was that the cleaner was always in touch with the people: this was the case with the cleaner at the Perth AMS. She knew if there had been any trouble in the community and problems with children and babies. She was a very likeable person who made us feel very comfortable.

Dynamics

Being a small group, the staff all had a good relationship with each other. The doctors gave weekly lectures on diseases to the team and the Field Officers took turns to repeat these using colloquial language. The atmosphere among staff members was a happy one.

Operations

The AMS operated on a Federal Grant, which was quite meagre. The Community Nurse was paid from the 'Bush Nursing Budget,' which meant that to get any returns of money everyone had to sign a paper to say that they had been attended to. This was difficult as in the first instance many could not read or write. They were suspicious of signing any paper because in the past they found that when they did this their children were taken away. The trick was to get them to sign prior to the procedure because after the event they would run away. We missed out on wages because of this practice.

Work Experience

This was the place where I was first engaged to do 'work experience' when I was a student nurse at the W.A. Institute of Technology' (WAIT). In 1975, on my first practical experience at the AMS, I was shocked and appalled at some of the living standards I encountered when I went into the community. I realised that the Aboriginal people in Perth and suburbs must have been caught up in a time warp, as I could picture my childhood of thirty years previously. I experienced a lot of the problems which I saw in the community, including chest and skin infections and overcrowding in houses, for those who had a roof over their heads. Others were living in tents with rudimentary toilets and washing

facilities, including only one tap and trough for all of those in one camp. Others who slept under bridges had to roll up their possessions in their blankets in the day and hide them, or else the Town Council workers would burn them. It was not until 1980, when an Aboriginal housing village was opened at Cullacabardee, that there was some respite, although this could in no way accommodate the amount of Aboriginal homeless people in Perth at that time.

Later on when Medicare came into practice, I asked about what would happen with the lost and homeless people. The doctor decided at the time that the Perth AMS would have them registered at the Medical Service address in Beaufort Street. It was heartbreaking for me to attend these people – some were desperately ill. I would try to encourage them to come to the hospital with me. They lived in the shadow of Royal Perth Hospital and yet felt so alienated from white society. When I took them in for treatment at the hospital some pulled out their intravenous tubing and ran off to the safety of their people's company in the paddocks, where they knew they would be accepted for themselves, only to die in the cold, wet paddocks. It was heartbreaking.

Statistics

Infant mortality was five times that of the broader society with Aboriginal peoples at 76.9 per 1,000, while non-Aborigines were 14.6 per 1,000 live births. Studies by Shannon and Gracey (T Shannon and M Gracey 1977 'Aboriginal children in hospital' *The Medical Journal of Australia* Vol: 1, Issue: 4 Suppl, Pages: 11-13) indicated that babies were still dying with gastro-intestinal tract diseases and the high disease pattern was mainly due to malnutrition and infections. The health status of children reflects the health of the nation. These statistics reflected the cavalier attitudes of Governments at that time.

Norbert Street Shelter

This was one bright spot for homeless Aboriginal people in Perth. The shelter was run by two Catholic nuns: Sisters Bernadine and Bernadette. These 'plucky nuns' moved out of their convent to set up a place where the homeless

Aboriginal people could have a shower, a feed and a warm bed if they wished. The nuns were truly angels who came forward to help 'the lepers', people who were shunned by the rest of society. The two Sisters spent a great deal of their time canvassing companies to give them leftover perishable food, clothing and also bits and pieces of furniture, so that the homeless could be fed, clothed and housed to some degree in inclement weather.

Situated behind Norbert Street, where the present AMS stands, was a huge shed, which was used as a contact base for other Nyungar people coming to Perth. This was prior to mobile phones. I thought of it as a clearing shed for all information coming from the South West of the State. Sister Bernadine used to hand out food and furniture to the people who slept there at night, to bring a little comfort to them.

Sister 'Trish' Young, the Community Nurse engaged at the AMS was the mainstay for health care of these people. No job was too hard for her to tackle. She managed to get an old caravan from somewhere. I helped her to do a makeover of it, converting it into a First Aid Post. We worked over a whole weekend to set up the 'clinic', which included laying down a brick pathway from the gate to the 'clinic'. The 'Park Mob' loved it. Despite all the negativity passed out to them, they were always cracking jokes and laughing at themselves. One Monday morning when we arrived for work, the clinic had disappeared lock, stock and barrel, and so that was the end of that. Someone had scored a caravan for themselves. We had to resort to attending to people under the trees at Norbert Street.

The other accommodation, run by Ivan Yarran, was in Newcastle Street, West Perth, and was called the Nyungar Shelter. This mainly catered for the Wongais from the Kalgoorlie district. The two tribal clans traditionally were unable to live under the same roof, as there were always cultural tensions, which are unresolved to this very day. Ivan's wife Gladys ran a women's shelter in Aberdeen Street, catering for mothers and babies. These accommodation shelters were very few and far between as Aboriginal people were not welcome in mainstream accommodation at that time. Some of the people were

desperately ill. At least there was some acceptance for them in the last days of their life.

Edward Street, East Perth

I was officially engaged as the Community Nurse Practitioner in 1980. The premises at Beaufort Street, East Perth were becoming increasingly overcrowded and negotiations had begun for a larger premises to give us more space to manoeuvre. This was identified as a warehouse and two-storey office space at the corner of Pier and Edward Street, East Perth. The premises appeared to be a massive space after the small cottage in Beaufort Street. At that time there were plenty of private houses in the area. In the early 1900s it had been an area where Aboriginal people were designated to live. Claisebrook in particular was a traditional food source area for long-necked tortoises. People were familiar with the area and were comfortable coming there. Many of the Aboriginal people still called it home, and itinerants gathered at the traditional camping area, colloquially known as 'The Bull Paddock', and in abandoned cars near the railway line at East Perth. However, housing was being replaced by modern offices, and Aboriginal people were being pushed further into the outer suburbs.

With the change of base, The Aboriginal Medical Service began to direct their efforts into forward planning for a comprehensive health care program for their people.



Perth AMS 1980 s
Top: Joan – Community Child
Health Nurse
Left: Florence Springs (dec)
Enrolled Nurse
Right: Norbert St – East Perth
AMS Service. Delivery under
the almond tree
Bottom: Young Dr David Paul



The Yellow Submarine:

When I was officially engaged to work at the Perth Aboriginal Medical Service, I had a small four-cylinder Hillman Station Wagon. This was upgraded to a modern Mobile Medical Clinic, which allowed much more privacy in the field and space to carry our equipment and stores. The Nyungars named the new Mazda van the 'Yellow Submarine'. The wagon had a raised roof and bench space for us to carry out medical procedures. This was particularly handy when visiting young mothers in the field and weighing the babes and assessing the postnatal mothers, including having access for the elderly, infirm and young children. A small three-way refrigerator, which held the medications, injection drugs and specimens for laboratory analysis was essential for warm weather travel. The Aboriginal people could easily identify with the familiar yellow van as I was travelling my rounds in the suburbs, and they would put their hand up for me to stop and ask me some health advice. They felt more solidarity with their own service people: it was more culturally approachable, as it was our clients who had named it the 'Yellow Submarine'.

I began to contemplate a program to teach the clients about 'mums and dads' teaching their children about health care in the city. To do this, one has to understand how we teach our children. This is tied up with child-rearing practices, as we learn by imitating our parents. This is complex, involving what they have to say, together with the appropriate body language. The complications of the children, who are removed from their parents and grow up in confusion about the right and wrong way to respond to various commands and body language, creates a chasm that can only be overcome with great difficulty. Some children never can understand either the Aboriginal way of life, or come to grips with white society. There is an area of ignorance that never seems to be bridged. Later, some of these people came forward to enrol in our health education program. I could not have hoped for a better response. Now their children and grandchildren are lining up to enrol.

The Nyungar Child:

Child Rearing Practices

To understand how Aboriginal Children learn, one must investigate how a child is brought up. To work in this area, one needs to know and understand the workings of the young mind and how they come to their reasoning about life and where they fit into the picture. Independence of action is important to 'small hunter and gatherer groups', where each person has to work individually, while, on the other hand the children brought up within the 'agrarian society' and later subject to the 'industrial revolution, led to the need of working together and for obedience to authority conducive to larger structural groups. Hunter and gatherer people need individual activity by adults for successful survival, as also seen in the Kalahari Peoples of Africa; therefore independence of action and interest in self-determination, rather than direction by others has been their educational mould, though this is never acknowledged in areas such as the schoolroom.

White Australians have almost always been reared in a system similar to the teacher. Words, cues, and body language all bear meaning to the young white Australian child, while the behaviour would seem strange and at times frightening to the young Aboriginal child. The mutual misunderstandings mean that the Aboriginal child has no idea about their expectations and what is likely to be approved, whilst the teachers' view of the children is likely to be negative. Within the Aboriginal culture, babies are seen as individuals, feeding on demand, where the babe makes the decision when he/she needs feeding. This works well with breastfeeding, but works in reverse with bottle fed babes and causes overfeeding.

Children are treated with indulgence by all, to be part of family interaction, even if it's one o'clock in the morning. Babies are held upright and are often astride the hips of the carrier, and rarely do they have 'clicky hips' (as told to me by Dr Fiona Stanley). In many instances older children take over the guidance role when younger children are away from their mothers, which gives the children a wider play range than the average 'white child'. The average Aboriginal child is

physically skilled and they rarely have accidents when they play, though they tend to speak later than their white counterparts because others pre-empt their needs. Instead of unquestioning obedience they follow by example. This is cause for much worry in young children: as they get older they express the belief that they haven't made it until they have 'done time' in some detention centre. It appears to be some type of rite of passage.

Australia has one of the healthiest nations in the world, while the health of Aboriginal Australians can be described as fourth-world. This is the plight of Indigenous people left behind in a modern society, with lower life expectancy, higher disease rates and lower quality of life expectations, including education, housing, employment, and high infant and maternal mortality rates. This is combined with the highest incarceration rates per capita in the world (Australian Institute of Health and Welfare 2008).

Pregnancy and Infancy

The overall fertility rate has declined over the past 50 years both in Aboriginal and non- Aboriginal families, probably due to the introduction of 'the birth control pill' and Depot Provera birth control injections in the late 1970s and 1980's. Overall, the age of the Aboriginal mothers are younger at 15-24 years compared with than their white counterparts peak at 25-34 years and perhaps older. The high values placed on motherhood is a significant factor with Aboriginal mothers encouraging their daughters to 'make them a grandmother'. Prior to the advent of the Aboriginal Medical Services, our women failed to get adequate antenatal care. This still persists today, though 'ultrasound has become a fascination for early viewing of the babe.

Aboriginal women are hospitalized for longer periods in the antenatal period, though now James Cook University in Queensland is educating Aboriginal women from remote areas in ultrasound procedures and Maternal Health Care, which is guided by Royal Australian College of Obstetricians & Gynaecologists, who help in decisions about hospitalization. 1 in 5, possibly higher in 2010s, Aboriginal people are potential diabetics, which has to be taken into account in pregnancy and the follow up and availability of antenatal care, while teenage

mothers are more likely to have medical and obstetric complications during pregnancy including pre-eclampsia, ante-partem haemorrhage, diabetes, genito-urinary tract problem and sexually transmitted diseases, which affect the foetus. Neo natal deaths are twice that of the non-Aboriginal mothers. Infant mortality is still 3X higher than the wider society.

The School Experience

The autonomy, which has been learned from early childhood comes to a halt when the child enters school. Children now have to learn different rules. Those who are successful learn to code switch with different rules for home and school, while others spend their whole school years in limbo. As a child I learned very quickly that comparisons with the teacher and home was not to be mentioned. School was school and home was home and each had its place in my upbringing. The Aboriginal child in the urban setting has a lot to learn about family relationships within their group.

Funerals

The importance of compulsory attendance at funerals is fundamental because that is the place where one learns about the whole extended family. It is the main time when family gets together as all relatives must pay their respects. Children meet up with their relatives both close and distant and learn who will not be eligible for partnership when they are older because of family relationships. Loud wailing and special handshakes are exchanged to pay their respects. Children are sometimes absent from school until the next pension day as there is no money to travel back to their homes. This nonattendance is frowned upon by teachers who often give up when a series of funerals keep the children away from school. I was told that if I wanted to see an Aboriginal child at school then don't come on a Monday or Friday.

On the home front, children of all age groups mix and mingle with each other, in particular helping to look after the younger ones and become influential in directing various behavioural patterns. This style of behaviour can lead to

negative peer pressure as they get older. Children then think it's smart to get out and about with the older siblings. This is how the 'street kid' mentality is developed. Some of the health problems associated with the children include injury, poisoning, gastro-intestinal problems and upper respiratory tract infections. The school experience can make or break an Aboriginal child.

Teen Agers:

Education Retention Rates

Retention rates are higher with girls than boys, and the peer pressure is in great force at this time. There has to be conformity with peer group, and those who don't conform are scorned, bullied or ostracized. Males 18-30 may come under police attention and harassment, while teenage females are left to bring up their babies with their fathers in gaol and the children grow up not knowing their fathers or that there is a lot of disruption when he comes home. Major problems erupt around this age group including police attention, drug addiction and overdoses, which is not conducive to holding up regular employment.

Positive Outcomes

The positive aspects are that there are education programs that can get them back on track, which are at the TAFE and Bridging Courses at Universities. These days there are more job opportunities within Aboriginal Organizations, particularly in the Management Sector.

Non-Conformists

A few non-conformists stay at school and these do very well, including Dr Kumina Perkins, Dr Sandra Eades, her sister Francine Eades RN, Dr Pat Dudgeon, Dr Dennis Bonney, Dr Michael Wright and others who have found their way through the education maze and paved the way for others to follow. In 2010 there are many more Nyungar peoples in professional positions than the previous decade.

Integrating Services:

Western Australian Aboriginal Medical Services (WAAMS)

The collective Aboriginal Medical Services (AMS') applied for funding to host a joint meeting in Perth. This historic meeting took place from the 16th to the 18th of May, 1984. It was here that Western Australian Aboriginal Medical Services (WAAMS) evolved. A collective policy statement of aims and objectives was created, which was inclusive of all AMSs, although each service was to retain individual autonomy and decision-making within its own service. A Task Force was formed dealing with Aboriginal health to inform State and Federal Governments about Aboriginal health statistics.

Dr Ian Wronski, past Medical Director of Broome Medical Services, was the key person to form Western Australian Aboriginal Medical Services into a cohesive group. I had continual phone and fax discussions identifying problems facing the AMSs. It was mentioned at a meeting in Queensland that the Eastern States did not have an equivalent over-arching Aboriginal organisation such as that in Western Australia. This contact method started between Perth, Geraldton, Carnarvon and Kalgoorlie. As new AMSs were inducted, they were included. Alice Springs was accepted onto the Committee as their Centre took in the desert people because they were of the same language group. Regular discussions were held at Broome or Perth. This was the forerunner to Western Australian Aboriginal Community Controlled Health Organizations (WAACCHO) and National Aboriginal Community Controlled Health Organizations (NACCHO) to advise State and Federal Governments on Aboriginal health issues.

It is important to think in terms of a 'time and context bound philosophy', particularly in Western Australia because we are dealing with different language groups and their world view, which means that what works this year in a certain place does not necessarily work next year in the same place. This also encompasses 'blanket directives' from a distance, e.g. State or Federal directives.

The idea, developed through Western Australian Aboriginal Medical Services (WAAMS) in the 1980s, was to develop principles for action and then for each Medical Service to translate it into a workable program in their own area. As I have described earlier, our principles evolved from an egalitarian society, and is one with which we are in tune. According to Stringer (1996) organizational diagrams are often represented as hierarchies or systems of superiority and subordination, with the most senior person on top. Rather than have a top down system, it is better to reflect the intent of equality and unity rather than superiority, subordination and division: co-ordination and support rather than control and supervision.

Aboriginal Education Programs

The need for educating our people became apparent, and through WAAMS we came together to begin to sow the seeds for Community Controlled Aboriginal Health Education Programs. A career structure was set up through the WAAMS Certification Panel, including salary, conditions of employment and a description of the role of the Health Worker (see Chapter 5).

There were 23 recommendations, including a discussion to be established between WAAMS and the Health Department of Western Australia, a Certification Board to be established, a description and framework setting out the role of the Health Worker, and a career structure put in place, which included: salaries, conditions, promotional opportunities, separation from the nursing stream, and employment of educators for health workers. This eventually went before the Arbitration Court in 1988 and was accepted.

Planning - Our Vision for Health Care

The next step was to work as a combined force to make inroads into improving Aboriginal Health. It was likened to key people developing plans to attack the enemy, 'disease'. Various problems were targeted where we could form a cohesive front. Diabetes, renal failure, liver disease, chest infections, heart disease, hookworm, trachoma, hygiene, nutritional problems, AIDS, alcohol and drug abuse and the like were all on the list to be addressed. Though the

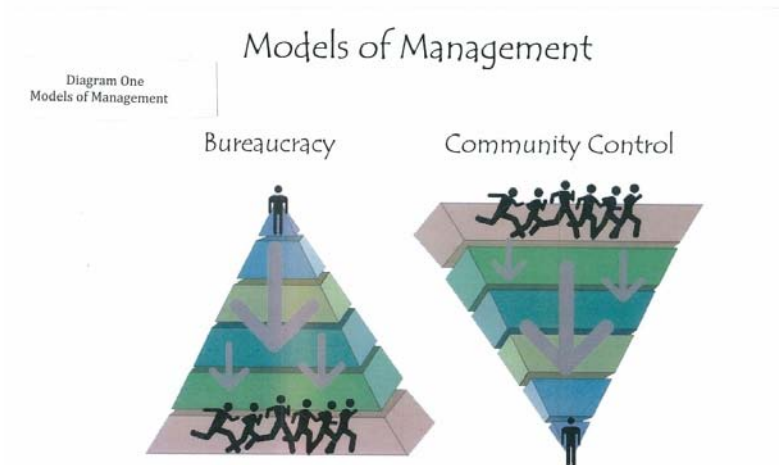
Community Health Services have ploughed millions of dollars into something named 'Aboriginal Health', most of the money appeared to be engulfed by administration and infrastructure, while money was shuttled into the coffers for the non-Aboriginal administrators and Medical Personnel. The government structure is subject to tunnel vision, though directives appear to be made with good intent, one can see more clearly at the coalface. The anomalies appear to be obvious when practical application is attempted.

This reminds me very much of an incident told to me by the eminent ophthalmologist Peter Graham, when he was asking a community in a third world country what they needed the most to help clear up trachoma. A quick response was "A sewing machine!" This seemed a bizarre cure for trachoma. However, as it turned out, when they had sewing machines they could make personal face cloths and towels for everyone. If they all had two sets of towels each, one in use and one in the wash, it would help to stop the disease.

They won their case.

Dynamics of Community Control

From its early days, the Aboriginal Medical Service has proven to be an effective program developed to encourage and assist Nyungar people with their health problems. The comparison with government management and community-controlled health care can be described antithetically, contrapositioned as a reversed pyramid (see next page). Bureaucracy can be described as a triangle represented as a hierarchical system of superiority and subordination with a power base situated at the top (Stringer 1996, 134) whilst community-controlled management can be illustrated by an inverted pyramid, where the basic principle is that a group of people make collective decisions about their community. Consequently they have direct knowledge of the individual and of how families interact, for example, in relation to births, sickness, marriages, skin-groups, deaths and the interactions therein.



By 1984, people were taking notice of the Perth Aboriginal Medical Service, particularly after a letter was sent to the Chairperson, Dean Collard, by Professor Arthur Kaufman, a visiting Fulbright Senior Scholar, and Director of Family Medicine at the University of New Mexico. He sang the praises of the Medical Service, emphasising how effective it was in leading the way in the Aboriginal health field (see Appendix B). He later wrote to me outlining a similar visiting program for the Pueblo people, with an outfitted caravan including a laboratory and X-ray equipment, which he took into the mountains in New Mexico to take the medicine to the people.

By 1986-87, many bridges had been crossed in addressing Aboriginal health problems. In that year, the Perth AMS Annual Report indicated that current services consisted of a comprehensive Health program encompassing a Medical and Child Health Clinic, Welfare Support, Transport System, Interpreter Service, Aids Awareness Program and Hostel Accommodation for itinerants.

Throughout the existence of the AMS, there was a continual struggle to meet health demands with limited funds. However, the vision was still strong and far-reaching, looking toward the future and the decentralisation of services. Small successes were sweet. According to Professor Fiona Stanley,

Improvement in health appeared to be taking effect and the educated health workers in the community were making a mark. There was a lowering of figures for low birth weight and small for dates babies in Aboriginal mothers in 1983. No other group of people showed any marked improvement before or since. (Stanley 1986, 50).

The Final Shift

By 2002, the expansion of services was obvious with over 10,000 clients registered with Clinical Services and staff dealing with a wide variety of health problems. Outcare services were in place at Maddington, Mirrabooka and the Elizabeth Hansen Autumn Centre in Bayswater, as well as Home and Community Care Programs in the suburbs, including day care, home help, shopping trips, home maintenance, and community visits, medical appointments, transport and recreation for the frail aged and young disabled clients (Annual Report 1999-2000). Primary health care certainly prolongs life and is always more cost effective than secondary and tertiary care. The Derbarl Yerrigan Medical Service has made its mark in Perth as the major community care organisation for Aboriginal people.

Aboriginal Lands Trust

In 1988 Ken Wyatt was the Chairperson of the Aboriginal Lands Trust. I sought Ken out when a general meeting was held in Perth to put in a submission for the land where our outdoor clinics were held in the 1970s, where Sisters Bernadine and Bernadette ran their shelter for the homeless. The Sisters had moved on to Port Hedland and buildings had been bulldozed down. East Perth was getting ready for a 'makeover' by Government departments. To my surprise and elation, the Land Trust Council made a decision on that day and I was granted the land to develop a separate college in place of the warehouse, which had been our home since our inception in 1983.

Meanwhile the Health Education Program appeared to have run out its time under the umbrella of the Aboriginal Medical Service. Try as I might to get other departments to indicate what their needs would be in the new building, I came up against a blank wall. Some of the staff were hostile toward me for trying to encourage them to make a decision about a building at Norbert Street.

I was getting nowhere and our education needs were not being met. When things like this happen in my life, I centre myself and ask my guiding spirits to show me the way. I felt I was going about things in the wrong way. However when I get stuck, I give the problem to the universe and get on with the job on hand.

Shortly after that time I had the occasion to go to Clontarf for something. The place was so calm and peaceful. The Chairperson, Tony Lee, happened to be there at the same time. I enquired if there were any spare rooms I could use as a school. The spirits had turned me in the right direction. He said “Yes, there are two dormitories upstairs, which could be used”. My prayers were answered. On that day in 1990, when I went over to sign the lease papers at Clontarf, I saw a double rainbow in the sky over Clontarf and knew instinctively that it was the right decision.

We used some of the invested funds I had won in 1987 to transform the dormitories into classrooms and office space. The staff of the health education program then set out to prepare the upstairs dormitories to enable us to move over to Clontarf to carry on with the health education of our people. Meanwhile our salaries continued through the Aboriginal Medical Service until we had prepared a submission to the Department of Aboriginal Affairs to become autonomous. This came about in 1990, after all legalities had been completed, and we became an education centre in our own right.

I then reimbursed the salaries, which had been covered by the AMS for the interim period, and handed over the land in Aberdeen Street to the AMS for their development. This is where the Derbarl Yerrigan has built its permanent home.

Derbarl Yerrigan 2010

A lot of water has gone under the bridge since 1973, and the Aboriginal Medical Service in Perth has travelled through many makeovers by various Directors.

The mission statement for the new millennium is:

[To] provide a wide range of health services [for Aboriginal peoples] and work in partnership with other agencies and services to improve access to health care services.

The staff now consists of 120 workers, with 70% Aboriginal employment. Reading through the Annual Report, I can recognise many names of graduates who have passed through the Marr Mooditj College. The Aboriginal Medical Services have certainly made their mark in health care for our people.

The catch cry is 'Why is Aboriginal health so bad?' In retrospect when the AMS first began, people were dying in paddocks in Perth, unknown and unaccounted for. Now, with many of our people educated as professionals through universities we have the expertise to run our own services, with our own doctors, nurses and social workers, and our people qualifying in management and other professions.

The Nyungar people learned to live in harmony with the land, to enhance and protect it. Then came waves of invasion, and the people were pushed off the land and herded into concentration camps called reserves. The third stage was when the children were taken from their families and brought up in an alien culture.

Stolen Generation

One problem that has touched us all, one way or another, has been when our children were taken away from their parents, never to know their 'real' name, or family line. They grew up thinking white and looking like mixed-race children. They tended to be rejected by both societies, with no sense of belonging in any society and no clear patterns to follow. Disharmony followed. Their goals were not attainable and the tracks to follow had been lost. New tracks had to be made if they were to get themselves together. In a similar way to an anthill that had been carefully built and then destroyed, new tracks had to be made, and after 200 years we are still trying to get our 'ant nest' together again.

This very action has been on top of the list for a raft of health problems, which can be recognised in our people today. Farr (1859, 155) indicated that unmarried

people suffer from undue disease, more so than those married. The horrific psychological problems are revealed where the nadir is suicide (see Causes of Aboriginal Ill Health table, 36) and the victim is single or widowed, they appear to be more vulnerable (Durkheim 1952, Gove 1973), with similar results of homicide, motor accidents, cirrhosis of the liver, lung cancer, and diabetes, and other medical problems have been identified within the Aboriginal Community.

Class difference was also found to be a deciding factor, which was imposed upon an egalitarian society with the imposition of British culture upon the Aboriginal people. This law of 'divide and conquer' was not part of how we understood the preservation of life. Though we did not fit into the indicators of occupation and education as recognised in the Western World, our traditional world was torn asunder. Another calculated strategy of class was the banning of our children from the education system. As ownership of property and education was the way classes were separated in England, this separation was transposed onto the Nyungar peoples of the South West.

We were faced with the experience of unemployment, ill health, and living through grief. We were pushed into the lowest social class, leading to low self-esteem, which is described as a critical intervening variable in the etiology of depression. Bibring (1953, 82-3) suggested that social factors influence alcohol consumption, cigarette smoking, drugs and sexual behavior. Distressing behavioural events and major difficulties are social stressors seen to increase particular diseases. Many older Aboriginal people spent the whole of their lives having no access to money and living in squalid settlements on the fringes of towns.

Peter Jackson

In Palmyra, where our family lived, there was a 'full blood' Aboriginal family living in the bush, which is now identified as the cross roads of Stock Road and Leach Highway. The elder male was known as 'Peter Jackson'. As far as I know he and his family spent their days cutting down small saplings, which were made to prop up clothes line wires and then the family walked the district selling these 'props' for sixpence each. He was the only 'full blood' person I

saw in my childhood. My mother used to buy a prop and offer him some scones she had cooked. I wanted to run and hide when I saw them coming up the road, but my mother held me back with the words, 'He won't hurt you, he is trying to get some money to live'.

The place where the family camped was on my school friends' family's small farm, where he caught possums and kangaroos for sustenance. This was in the 1940s, when child endowment payments were first introduced for Australian families with children. There was no such money for full blood Aboriginal people, who had to survive as best they could on the fringes of white society. Years later I was told by my brother that Peter Jackson was granted full citizenship for himself and his family, and that he was totally accepted into the community.

When I went to work at the AMS in 1980, forty years later, I found many Aboriginal people hiding in our society, who had no money at all, and just depended on their family to feed and shelter them.

Housing

In Western Australia there was a big improvement in the metropolitan area in the late 1970s, when the State Housing Commission began to build houses for the fringe dwellers. There was an immediate improvement in the health of the children. Problems arose, however, after they had been living in the houses for approximately 12 months. After surviving in the camps all their lives, most of the people had no idea of house maintenance, and the cost of brooms, buckets, rakes and various other garden bric a brac was beyond them. Handles fell off doors and stayed off, and toilet systems were blocked. No one took responsibility for educating these people about living in and maintaining houses.

The Housing Commission, Lands Trust, and the Department for Aboriginal Affairs were contacted, but all denied responsibility for helping these people to live in houses. At a later date 'Homemakers' was introduced by the Native

Welfare Department in partnership with the State Housing Department in order to give the people some education in caring for their accommodation.

There was an outbreak of salmonella poisoning, and though 'no one' could find out where it came from, there were dead birds in the water tank, toilets blocked, water pipes broken, no rubbish collection and a buildup of soiled disposable nappies, whilst the houses were overcrowded and poorly constructed. It could have been caused by any one of these things. People who were used to living in car bodies and small boxes were set up in houses with electricity, gas and pot-bellied stoves with flimsy guards. It did not take long for casualties to occur: burns, electrocution, infections, and added to this 'mountains' of unpaid bills.

The comfort of an open fire called, and people dragged furniture into the yard to sit around the fire bucket to yarn, get warm and boil the 'billy'. Kalgoorlie showed more imagination, with roller doors on their buildings, which could be opened in the summer and the houses warmed in the winter with an open fire. The Perth Nyungars left their hotplates and ovens on all day to heat their houses, and their electricity bills were enormous.

Instruction was not given on the use of the new technology. Health hazards were created by well-meaning welfare officers providing 'stick on' carpet tiles, which soon lifted and became germ traps for young children. Flywires were in tatters and refrigerators proved to be a breeding ground for fungi, salmonella and other bacteria. Hoses in washing machines were germ traps; boils and other skin infections cleared up when 'bleach' was used to wash out the hoses in the washing machines. The old ways of moving around with the sun and frosts, in order to kill off the bacteria, were over. Wherever numbers of people live together in one place there is a danger of bacterial infection. When there has been no instruction in house dwelling, people don't know about different ways to cope with living.

I found this out when I went to work in the bush and was camping out when the sheep were being mustered for shearing. The traditional people kept their camping area spotless, while it took me all of my time and effort to cope with

the dust heat and flies. I was taught to clear all around the camp so that we could see if anyone or any animal visited the camp in our absence.

Learning for life

Young girls on “supporting mothers’ pensions” struggle to bring up our next generation with very little formal instruction on safety measures. Before the destruction of our culture every girl and young man was given explicit education in all areas of survival. All of this education ceased when our children were taken from their parents and brought up as ‘lesser human beings’.

In the 1980s, the people of Wiluna put their foot down and did not want their girls to go to Perth High School for education. They said that they did not make ‘good’ mothers and could not care for their babies properly when they returned to country. This was the time for them to learn about traditional motherhood. Worse still, some were introduced into the drug scene and lived out their short lives on the town fringes in and out of gaol. These young people were lost, ignorant of the rules of either society.

In the 1950s, when I was working out on the edge of the Gibson Desert, the tribal people were healthy, empowered people. They were still practicing their rituals, singing their songs and feeling at one with nature. The more contact with white people, the more seepage of white values prevailed and the more tribal values were lost. Rules of gathering and eating food were cast aside. Fire as a method of sterilisation was no longer employed, and the use of water is now fraught with danger because of ground pollution.

Communities are becoming larger and people are staying longer in one area. What happens to the refuse of modern society? In the past everything was biodegradable; now disposable nappies can be seen dotted around the countryside attracting flies and spreading disease. We were locked out of the monetary system for many years and are now expected to budget to buy food, clothing and cleaning materials, and live in a society that has practiced these

ways for hundreds of years. Now after 200 years of destruction by white society we are constantly being told we are not capable of getting ourselves together.

Compensation

We have no economic base, our resources have been exploited, and we have been effectively locked out of the Anglo/Saxon system. We are entitled to a percentage of all the resources of this country to build our broken society, empower our people and build a strong support system back into this modern culture of Aboriginal Society and become spiritually whole again.

Thirty years ago we were asking the Government for 2% of the Gross National Product as compensation for loss of land and cultural traditions; keeping in mind as citizens of this land we were entitled to the same respect as all citizens. When the Aboriginal people at Saunders Street were first housed after living for many years in tents, the Swan Shire neglected to supply a regular rubbish collection in their area, and consequently there were complaints of rubbish buildup. After meeting with the Council it was agreed to empty the bins on the collection day. The shock came when they were expected to take the bins about a kilometre down the road for collection. The misunderstanding was discovered when the bins were left at the end of their street for collection and not picked up even though someone had emptied the bins all over the road. It appeared to be a deliberate attempt at sabotage against the Nyungar people of the Swan Valley. This negative attitude demonstrates that attempts by our people to strive for a sustainable way of life, and to 'get up and go', seem to be thwarted on all levels.

Programs at Derbarl Yerrigan Health Services

Persistent medical problems have been given special attention. One of the questions often asked is 'Why do you duplicate services?' The answer is another question: 'Do you have Aboriginal people failing to go to appointments?' The Aboriginal Medical Service found that it was more efficient to have a program that specifically served the Aboriginal people, including transport to and from the clinics: "If the people don't go to the medicine, then the medicine must go to the people."

It was decided that a one-stop health organisation would be more appropriate and efficient and probably cost effective to serve the Aboriginal people. The AMS have gradually added to the clinics as funding has become available to conduct appropriate programs to close the disparity of morbidity and mortality, which still exist between the Aboriginal and Western society today.

The Clinics include:

- Ear and Eye health care, with interaction between school health programs where there is a predominance of Aboriginal children;
- Health Promotion: Maternal and Child Health /New Born Health Service;
- Environmental Health supporting clients in the community with housing maintenance;
- Visiting Health Worker Program;
- Dental Services;
- Physiotherapy;
- Podiatry;
- General Clinic;
- Chronic Disease Program
 - Responsible for Major Renal Failure clients from the Murchison, North West and Eastern Goldfields;
- Welfare Service
 - Emergency Relief and Financial Assistance;
 - Transport for clients;
 - Home and Community Care;
 - Patient Assisted Travel Scheme;
 - Housing Liaison with Centre Link;
 - Resource Liaison;
- Suburban Clinics
 - Mirrabooka;
 - Maddington;
 - Elizabeth Hansen Centre;

- Peel District - new Aboriginal Medical Service Nidgalla Waargan Mia;
- Social Outings
 - These are held for clients on a fortnightly basis. Residents are taken shopping and to various places, with a barbecue pack or picnic lunch for a day out.

At last we have a Medical Service, one that has stood the test of time and which was established by and available for our people, to get professional care by people they know and trust. Our people can be recognised as having addressed their education problems through study and getting involved themselves as parents and family members encouraging higher study in the health field and in promoting healthy living standards. Our own health professionals are a testament to this (*Annual Report 2008-9*).

While changing our traditional ways of being and doing is a slow and drawn out process, which only time will remedy, the 'bad old days' have gone forever.

Chapter 5

Marr Mooditj 1983 – 2006: Small Beginnings, Big Hopes

Health does not just mean the physical well being of an individual but the social, emotional, and cultural well being of the whole community. This is a whole of life view and it also includes the cyclical concept of life-death-life. Health care should strive to achieve the state where every individual is able to achieve their full potential as human beings, and thus bring about the total wellbeing of their community (From the Declaration of Alma-Ata, International Conference on Primary Health Care, USSR, 1978, quoted in Eckermann et al 1992, 22).

In 1980 when first employed at Perth Aboriginal Medical Service, I was totally shocked at the physical and sometimes mental state of some Aboriginal people I met and visited as the Community Nurse in and around Perth. Organizations such as the Aboriginal Legal and Medical Services were quite often used as a target for expressing the frustrations of these people. It appeared that these identifiably Aboriginal community-based corporations were being targeted, culminating in fights between Wongi and Nyungar peoples. Our windows were being smashed on weekends, as we were the first line of attack for them to vent their frustrations. There was a long line of clients to be patched up after such events. Some of them just wanted a bandage for their hands, though they appeared to be all right. As a social critique of identity, their struggle could be exemplified by their worship of Aboriginal boxers - a kind of power play where they could ask for and receive something for the expression of self. Despite their behaviour, I thought it was also because boxers in the films often had their hands bandaged. It was a status symbol and spoke to their self-identification as 'fighters'.

One of the areas where the community nurse visited daily was the 'Bull Paddock' at Claisebrook near the old East Perth Gas Works. This was a *kalleep* (Nyungar for own traditional camping ground), a 'sit down' place by the fire where *kilon* (Nyungar for long-necked tortoises) used to breed. This was told to

me by Lizzy Ugle (deceased), a gracious old lady who stayed at the Bull Paddock and spent her young life there with her family.

One of our community nurses, Jessica Bujevich, had to take blood from the arm of one of the men in the area. The client's female partner took umbrage to the attention paid to him and jumped on Jessica's back. She was shocked. Back at the clinic, when Jessica relayed the event, the staff all had a good laugh at our morning tea break. The sense of humour between the clients and staff was probably a key factor in keeping us all buoyed up in those days. The staff was predominantly Aboriginal and new to the idea of Aboriginal community control, so there was a sense of the empowerment that went with decision-making, leading to self-fulfilment carrying us along to success. This has been described by Hawe as 'choosing winnable issues' (1982, 94; see also Coombs 1983, 109).

Many of the Aboriginal people in Perth were so oppressed by the broader society that there was a lot of mistrust between the two groups and a general sense of not belonging, described by Kelsall (1984) as 'social stratification', which allows different access to power, privilege and status based on income and wealth.

Included here has to be the issue of racial discrimination. Discrimination due to colour has been a driving force in social attitudes in Australia, exemplified by the Western Australian government with the 1905 act, enacted after the 1904 Royal Commission led by Dr. W. E. Roth into the administration of the Aborigines Department found many abuses of 'these people' and then legalised their removal for their own protection (Haebich 1988, 76-79). The Royal Commission of 1936 resulted in the enactment of the Native Administrative Act, and among its provisions were:

- The imposition of a permit system for living in towns;
- Penalties for being on the streets after 6 pm; and
- The taking of children of mixed blood to be brought up under the European system of childcare.

At the same time, however, Aboriginal people were being discriminated against in many contexts, for example, when it came to land ownership. Aboriginal people were not allowed to buy land and other commodities on 'time payment.'

It was envisaged that we could not aspire to higher education, and though it was not a written law, Aboriginal children were not encouraged to continue school after the legal leaving age of 14 years. In 1948 I was one of those children prevented from entering into a 'professional class', which was only available to those who were 'earmarked' for university. This action of preventing Aboriginal children from fully participating in the education system was first proffered by pressure from the Parents and Citizens Association in 1936.

Many positions in the workforce were denied to Aborigines in terms of education and Aboriginality (Haebich 1988, 260-261).

My brother 'sailed' through schoolwork and ended up in third year high school at barely 13 years of age, vying for top position in the class of 1948 at Fremantle Boys School, with another boy, Julian Ford. They were both from working class backgrounds, but only one was from an Aboriginal family. Julian received a scholarship into higher education and university, while my brother was offered a job in a wood factory, getting the lunches and being a general 'dog's body' and office boy. Others were left behind altogether and were subject to discriminatory racial attacks against the 'park' people. This caused a general sense of not belonging amongst them, as the majority had been released from welfare homes or had come from an assortment of Aboriginal church homes, and had lost their connections from their family roots. Others had their children taken from them. They were shunned and prevented from accessing housing in the white society. The 'outcasts' gathered in small groups where they could find shelter and comfort in each other. This could mean under bridges, in condemned houses or in caves or old car bodies. The generally accepted belief among Aboriginal people in Perth was that housing was not available to them.

Frequently Aboriginal people are confronted with a very negative looking-glass from others who have considerable powers over them. Consequently there is considerable insecurity about self (Fay Gale, quoted in Eckermann *et al* 1992, 130).

Around that time, my daughter Lillian Passmore and Dean Collard started up an Aboriginal housing organisation. They did the negotiations for rental housing, while making it possible for rental monies to be taken out of the peoples' pension money. Many non-Aboriginal and Aboriginal people were reluctant to have them as tenants because they had not learned the protocols of suburban living. These people were labelled as antisocial. What made it worse for me was that a lot of the people were my kin. They were people with little hope or trust in white society. One young fellow, Paul Farmer, from Albany, came to the Bull Paddock. The weather at the time was shocking, with gale-force wind and constant rain. When I asked him what he did to keep dry over the weekend, he told me that he had sheltered under a piece of corrugated iron. Later I heard that he had died in custody in Albany Prison, committing suicide by hanging (information from the Aboriginal Legal Service, Perth), indicating to me the last overwhelming resort of self-control.

How could one go home and have a restful sleep? I couldn't, and kept thinking that something had to be done about the terrible state of affairs. There was a shed behind Sister Bernadine's Shelter in Norbert Street in East Perth where people could rest and have nourishment. Sister Bernadine passed donated food over the fence to those hardy souls who were camping there during the night. They had to move on in the day time or the police would charge them with trespassing or for having no visible means of support. The shed was later dismantled and replaced by a used car sales yard. However this shed certainly helped to keep 'the homeless' sheltered in inclement weather. In the days prior to mobile phones, Nyungars did not make use of public phones: they were still following oral traditions where news was transferred by 'word of mouth'. It was very effective, too, and information travelled like a 'bushfire'. The shed was used as a clearing centre: the people coming from down south went there to find out where their relevant relatives were living in and around Perth. All of the latest news and gossip was exchanged at that place as well.

Education Needs

In my travels as a community nurse with the Aboriginal Medical Service, I could see that there was a great need for simple ‘word of mouth’ education, where Mums, Dads, Grandparents, Uncles and Aunts could talk to the younger generation at the meal table about some knowledge of our heritage, and what had worked previously, enabling them to combine past traditions with Western Medicine. This began as a germ of an idea, but something I believed could happen in practice.

When my mother was taken away from her people, she was too young to have learned and understood her parents’ language and ways of healing through traditional ways. Consequently, I suffered throughout my school years with all the ills likely to befall a group of people living in close proximity with each other, such as scabies, impetigo, head-lice, and chest infections. We simply did not know the basic steps that could be taken to eliminate these close contact diseases, which were the cause of anguish, shame and stigmatisation at school. Seeing this happening with other Aboriginal people in my adult life helped me to form the nucleus of an idea, which I believe could help people learn in a positive way.

Primary Health Care

At that time, the Director General of the World Health Organisation, Halfden Mahler, was flagging the concept of ‘Health for all by the year 2000’ and was searching out village programs which could fill in the gaps of health care for the ‘have nots’ (Mahler 1981, 7). Primary health care was a way of achieving this goal. Mahler’s concept encompassed the idea of preventing health problems before they caused major illness, and promoting good health and providing services run by local people. Health care must be part of the holistic way we think about total human development – social, educational and economical - a way of life and living. This appeared to be the case with the Nyungar people prior to contact with the British.



Halfden Mahler, Chair WHO
Shirley Lowden – Health Worker(deceased)
1987

Health care means providing those things needed for a healthy life, which includes water, food, shelter and sanitation. The care has to be acceptable to the community and relevant to the main health problems in the area, in other words, 'prevention'. The British had brought with them the 'medical model', which assumes that if you get sick the doctors will make you better by treatment. This model depends on medical expertise. In contrast, primary health care basically works on prevention by healthy living.

Health care systems are predominantly based on the 'medical model', with treatment and hospitalisation as the main focus, whilst the aim of the primary health care model is to change the focus to prevention rather than cure. The medical profession has forced the issue for funding this model. Millions of dollars have to be available to support such a system, which works out to be very costly, whilst a healthy lifestyle is very cost-effective and can prevent most everyday health issues. Primary health care should be for everyone, not just the few that are able to afford it. Preventing health problems before they begin should be a part of total human development, and accessible to the community.

Relevant health care should be appropriate to address the main problems in a particular area.

When travelling as a visiting nurse to various areas where Aboriginal people clustered, I took note of how people came and described their problems to me. At the time there were tent camps at Benara Road, in Midland Junction and Saunders Street in the Swan Valley. Lord Street in Lockridge had transportable housing. For community events people usually gathered at the church grounds in Guilford Park, drawing on the large community residing in rental homes and nearby suburbs. Usually a spokesperson came forward to give me a short medical report on their group about medication and who needed their urine tested for 'sugar'. Some mothers reminded me about their children's appointments at the hospital so that I could make provision for transport, or else I reminded them about their appointments. This behaviour has been described as affiliation and group-orientation intensified by socio-economic circumstances, and Fay Gale stated the situation as based on 'values within obligations to kin in need associated with family' (quoted in Eckermann et al 1992, 131).

In particular, my idea about health education came from my observations in 1980 when I was visiting the Kelly family, colloquially referred to as 'The Kelly Gang'. Things were in disarray in the front room, where people were drinking alcohol, while the second eldest son, David, was in the kitchen with the youngest children. I began to observe the dynamics between the groups and families. He would have a young babe in his arms and a toddler hanging onto his legs, while trying to cook a meal for the children. I told him I was going to get a program together for people like him, who were trying to cope with families in distress. However, I had a busy job and found myself writing up the daily records at about nine o'clock at night. Time escapes one in such cases and there were not enough hours to get everything done. A few months after I first talked about a health program, I had not taken one step toward achieving this. Young David, aged 15 years, came to the Aboriginal Medical Service and asked me about when the program was going to be started. I immediately had pangs of guilt about my tardiness, and began to get myself into gear to start the

program. I spent my evenings putting ideas down; focusing on steps I thought would be helpful to get the project, an Aboriginal health worker education program, off the ground.

The differences between the medical model and primary health care have been somewhat of an enigma for both Aboriginal people and the health profession. Medicos tend to put Aboriginal people in the box of 'lesser beings' in the field. When one thinks in terms of Joseph Lister and Louis Pasteur who suggested a theory of germs in the 1860s, fifty years after the British settled in Western Australia, the medical model is barely 250 years old. In contrast, Aboriginal people have lived since time immemorial using herbs and elements in their environment to keep themselves healthy. For instance, Barr (1988) describes use of Ant Hill therapy, where minerals are used by Aboriginal women to maintain their strength during pregnancy. Analysis has since revealed that those minerals held the same ingredients, such as sodium, potassium, magnesium, calcium, and iron, as medications used today to treat pregnant women.

In the South West pregnant women delivered their babies into a hollow where *mangart* leaves were burned to prepare a sterile area for the babe to be born into. This method was considered barbaric and the traditional women were made to go to hospitals for their babies' delivery - not into the hospital wards but in the verandas and tin sheds in the backyards of hospitals. At the time there was very little knowledge about how people contracted diseases. It took years for this information to be filtered out to the Antipodes.

Cost Effectiveness

The aims of the Aboriginal Health Worker Program were to educate people to recognise illness and initiate appropriate management, including preventative steps, so that such measures should result in significant savings to the community. This would also decrease the load on hospital casualty departments, community general practitioners and the associated costs for minor problems.

In 1982, hospital costs were running at about \$500 per day with intensive care treatment in the vicinity of \$2,000 per day, while patient visits to a general practitioner averaged about \$15 per visit with the added cost of prescription drugs. A patient may be seen three to four times for a particular illness, which incurred costs of over \$60 without prescriptions. In contrast, health organisations such as the Aboriginal Medical Services are a very cost-effective way of health delivery to the people. In June 1983 total cost per head annually including medications, dressings, home care and transport was estimated as \$32.55 with a slight increase to \$32.68 in September 1984.

<u>Item Costs</u>	<u>Daily</u>	<u>Yearly</u>
Hospital	\$500	\$182,500
Intensive Care	\$2,000	\$730,000
Perth AMS	8.9 cents	\$32.55
(providing 24-hour Doctor call services, including transport, visiting Nurses, dental care, optical services, physiotherapy and medications.)		
<i>(AMS Financial Statement, 1984)</i>		

In February 2009 the *Koori Mail* published a statement by John Paterson, the Executive Officer of the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), in which he called on the Federal Health Minister Nicola Roxon to take responsibility for Indigenous health funding and implement a needs-based population grant funding program:

A robust primary health care system that is adequately resourced will reduce demands on the secondary and tertiary sectors, and thereby save hundreds of millions of dollars around the nation.

Dr Mick Adams, Chairperson for the National Aboriginal Community Controlled Health Organization (NACCHO) stated that Aboriginal people's full participation in the health service design, delivery, monitoring and evaluation was integral to improving health outcomes (NACCHO media release, 16 February 2009). This statement was still being tabled 25 years after the argument regarding the cost-effectiveness of primary health care was put

forward in the 1983-4 Marr Mooditj Annual Report. Aboriginal people can be noted as having made beneficial changes for their wellbeing for decades, while statements are bandied about by politicians and health professionals such as “We want you to tell us what the best way to change the status quo is”. Like John the Baptist’s experience, we are “a voice crying in the wilderness ... they are listening but not hearing what we say” (Matthew 3:3).

I was lucky to have three enthusiastic staff members, Dennis Hayward, the Director, Dr David Paul and Pat Haynes, the Secretary, who gave full support to my seed of an idea. David donated some of his salary to put up a partition in the warehouse to make a schoolroom and then set about helping to write a curriculum that would address our needs analysis, based on the knowledge of the clients he came in contact with at the Medical Service. At the same time Pat set about typing up a syllabus and contacting funding bodies to get us started on the project. This was early in 1983.

New initiatives sweep people off their feet and all one can see are positive outcomes down the road. The path, however, was not so smooth, as the funding bodies did not accept the new program. The Health Department, the Aboriginal Affairs Planning Association and the Department of Aboriginal Affairs all agreed that the program had some merit but that they could not provide funding. Ever resourceful, Pat Haynes was able to get \$35,000 from the Lotteries Commission in June 1983 for infrastructure in the classroom, with desks, chairs, and office equipment. We were still holding our breath for program funding to make use of this equipment.

The Commonwealth Department of Education came to our rescue with \$10,975 to fund our Health Education program, and we were recognised as a part of ‘Adult Aboriginal Education’. Consequently we could offer a student allowance for Aboriginal people to attend a 12-month Primary Health Care Program for adults. This led to the Department of Aboriginal Affairs providing us with funding of \$41,900, which then set us on the road to success.

Income May 1983/June 1984

Lotteries Commission.....	\$35,000.00
Department of Aboriginal Affairs.....	\$41,900.00
Commonwealth Dept. Education.....	\$10,975.88
Fund Raising by Students.....	\$749.70
Donations	\$800.00
Bank Interest	\$178.05
Total	\$89,603.63

At last the train had left the station and we were away on an exciting journey into a better life for our people. There were still people in power, however, who wanted to stifle our efforts to combat Aboriginal ill health. Though I did not get outright opposition from Health Workers who were members of the Health Department in Western Australia, there was a general undercurrent indicating that I was muscling into areas which belonged to them; this also included some Advisory Council Members at the Perth Aboriginal Medical Service. When I asked for time off to develop the course, I was told in no uncertain terms by the Council that I could not return to my previous position. This made me more determined than ever to succeed.

Our Oath:

We endeavour to give people education:

- *to assess, treat and provide them with the ability to make their own health decisions;*
- *to implant in them the motivation and incentive to aim for optimal health for themselves and their communities;*
- *to evaluate health problems and understand when to refer on to other health professionals.*

Generally, the Community Health Department Health Workers did not go out of their way to wish us well. I did get calls from people at the Nurses Board worried that with this new program, health workers would eventually take over from nurses. Twenty five years later they are throwing out the 'welcome mat' to join in and follow them. I will enlarge upon the Enrolled Nurses Program later.

From the Summer School at the University of Western Australia in Perth, community controlled programs began to be developed in Western Australia, and by 1972 a National Aboriginal Health Plan was adopted to raise the standard of health for Aboriginal people to the levels enjoyed by their fellow Australians and to increase access to existing services. The Health Department of Western Australia (HDWA) engaged Aboriginal people as “inaugural Health Workers” in 1973.

Dr Holman from HDWA was an early advocate for the appointment of Aboriginal Health Workers to act as links between medical professionals and the people. It was not envisaged that Aboriginal Health Workers (AHWs) would have a direct role in the provision of a primary health service. There was a historical perception that doctors and nurses were the most appropriate providers of primary care, and that any changes to the long standing arrangement would have ramifications for the demarcation between nurses and health workers. Old habits die hard and pockets of this philosophy still existed (in 1993), with some health professionals still not recognizing the AHWs as an equal team member (Winch 1993).

In the first instance they were used as ‘door openers’ to get into the Aboriginal community. The health workers were such in name only, as there were no formal education programs. Training and education depended on workshops on various subjects being delivered to the health workers on health problems within Aboriginal communities when specific health problems were present, which depended on the seasonal fluctuation of epidemiological diseases. Training was given on a ‘need to know’ basis. No accreditation was given toward upskilling.

Getting Started

The program was based on the World Health Organisation (WHO) process:

Health Care must strive to achieve the state where every individual is able to achieve their full potential as human beings and thus bring about the total wellbeing of their community (Lyman 1961, 13).

It is essential that the learning process comes from within. Studies by McKeich at Deakin University have shown that for programs to be effective an active role must be taken by members of the community.

According to WHO Nursing Education Programs 'to have effect one must understand the cultural patterns, family structure and roles of the family and extended family, together with the expectations of the people and the changes, which have taken place within the community and prevailing customs must also be considered. Differences in geographic language groups must be respected as well as the rituals of births and deaths and what health practices affect such rituals (Crowley 1970, quoted in McKeich 1961, 12).

I approached people from the Aboriginal community and health professionals who worked in the field of Aboriginal health to participate in the program. At that time we had to ask them to donate their time and expertise as our budget was very meagre. A quarter of a century ago people were not so hung up on remuneration: it was more or less an exchange of knowledge. I used to do a lot of speaking to health professionals and the broader society about Aboriginal health problems.

I was lucky to have obtained the WHO '*Working Guidelines for Training and Adaptation – The Primary Health Worker*'. It is hard to remember where it came from, but I expect Koorie Kollege in Victoria sent it to me together with other material helpful in training primary health workers in the field. They were established at the Victorian Aboriginal Medical Centre and their philosophy of 'putting Aboriginal health in Aboriginal hands' aimed to give help and encouragement to the establishment of Aboriginal health care in Australia. The book consisted of general guidelines to be adapted into local conditions as a working document for developing countries. This was written on a problem-solving basis to be adapted for local conditions.

Generalisations of common problems were included, as well as applicable information, such as:

- Frequency of disease;
- Public demand for care;

- Dangers to the community and the individual;
- Technical feasibility and economic consequences;
- Self determination in decision-making; and
- Listening to the inner dialogue as the key in effective learning.

From the guidelines of the Primary Health Manual each country has to translate an activity into a problem-solving exercise. The problems determine the outcomes for ongoing care and treatment, whether it be First Aid or ongoing referral to the medical officer at the AMS or hospital assessment.

The principles followed were:

- Recording the history and outcome.
- Report to the Medical Officer at the AMS.
- Promote community activities.

(This was done admirably by a student in the first school when she organised afternoon tea and dance groups for the elderly at Clontarf Campus. People who lived in the next district had not seen each other for years and had a great reunion. It was a wonderful experience, and the happiness overflowed. Gloria Walley achieved an Australia Medal from the Federal Government for her innovative idea.)

- Act with common sense and devotion to duty.
- Always complete the activity with a follow up of care, record and report back to the doctor and family about the outcome.
- Work as a team and have contact with other professionals in the area, e.g. Social Workers and Health Department Workers in the area.
- Be aware of problems associated with men's and women's business and act accordingly.
- Remember your aim was to achieve their full potential as human beings and bring about the total wellbeing of their community (Katz and Snow 1980, 10).

In 1983 Ron Cacioppe, a psychologist from the Western Australian Institute of Technology, was contacted to teach the students about the psychological

breakdown in Aboriginal health. He told me that this was the first time that this had been recognised by psychologists as an ongoing problem for Aboriginal people in Australia.

Planning for Future Development

A few years later I was invited to Broome by the Minister for Health, Keith Wilson, where he gave special thanks to and congratulated Elsta Foy, a Health Worker, for her 10 years of service with the Health Department. She was a well-respected health worker in the field. People looked up to her for advice on health care though no health award was formally given to her. The positive part about the meeting in Broome was that Mr Wilson announced that the Health Department would like Marr Mooditj to upskill their health workers. This came to fruition in 1991 when official arrangements were made between us and the Department of Health to run a block release program at the Health Department, for Health Workers who had over five years' experience in the field and wished to gain an award in health work.

The program was named 'Dubakiny Koorliny', meaning 'Going with Precision and Purpose'. Two blocks were developed, one to start in September and the other in November. This would enable the graduates to enter the career structure and progress through the various levels. Fifteen students were enrolled in the first course for 1992 and another 25 applications were received for the following year. These students were required to complete their practical experience in the community. This was the program that laid down the pattern for our future development with a block release program, which has now become recognised as the preferred teaching method for our people. We could organise for health workers from throughout Western Australia to come to Perth for a two-week period and then return to their community to engage in practical experience three times annually. Jane Jones was in the first graduation from the program, and she went on to complete a Degree in Applied Science through Curtin University's School of Nursing.

The engagement of 'Health Workers' within the Health Department was not a sudden inspiration to pave the road with a softer approach for Aboriginal people living in Perth. What was important was providing education for Aboriginal Health Workers to attain at least the same standards as their non-Aboriginal colleagues, and for this to have an impact on the health of Aboriginal people and communities:

[L]ittle attention was paid to Aboriginal health prior to World War II ... Mr Stanley Middleton, Chief Protector for Native Welfare, ... reflected in 1977 that during World War II more attention was paid to Aboriginal health because service men worked side by side with Aboriginal people; thus if the latter were diseased this would affect 'our fighting men's strength', although little thought was given to Aboriginal health until the Aboriginal health organisations in the Eastern States began to agitate publicly for better conditions for our people (Eckermann et al 1992, 92).

Schapper (1969) has argued that the statistics on Aboriginal health reflected a history of neglect, describing the health status of Aboriginal people as

dependent poverty, with most Aborigines suffering from anomie, apathy, depression, fatalism, self-depreciation, passive hostility, resentfulness, mistrust, absence of ambition, unwillingness to work and unreliability, and a far greater proportion of them than us suffer from anti-social behaviour leading to court appearances ... Initially they were responses to treatment from the white man (Schapper 1969, 20).

Reaching Out

Advertisements were placed in local papers and information was sent out to as many communities as possible. We envisaged involving people from both remote and urban areas of Western Australia. We spelt this out as a positive program so that people could understand that it was going to be a program for empowerment. It was to be set out to cover all aspects of health and that the skills that graduates could obtain would help them to become key persons in preventative and curative health care in their own communities. The program was designed to complement existing structures such as Aboriginal Medical Services and Community Organisations in Western Australia. Although we envisaged having candidates from both local and remote areas of Western Australia, the first few years involved 12 months of fulltime study, sitting in

classrooms from Monday to Friday in Perth. The remote area students would have to live in Perth during the school terms and only return home for school holidays. The Commonwealth Education Department funded fares home for holidays and/or compassionate leave. They would then be able to fulfill the role of teacher and pass on the skills to their communities.

One unit in the program was to include 'Public Speaking'. It was essential to be able to be the clients' advocate in the health scene. I found that, in my role as a community nurse, that often Aboriginal people were disregarded as patients relatives and given the 'brush off'. We needed the right approach to get recognition. Our 'mainstay' was a very strict Ms Connie Herbert (dec), a champion Penguin Speaker and friend of all. The students all adapted well with her method of teaching 'Public Speaking.'

Getting the Soldiers Ready

There was a big problem getting Aboriginal people into the work force because the education standards required to commence training were below the requirements of the Nurses Board. We would have to put in the infrastructure needed to achieve a sound knowledge in health. The first necessary step for training was for the community to choose the person they wanted trained to look after the health of their people. Whatever was lacking in terms of literacy and numeracy, we would fill in the gaps. This included engaging a teacher from an adult education college to teach these subjects.

The program placed an emphasis on personal development and practical skills, whereby students could achieve sufficient status on completion to be considered for further tertiary studies and increased employment opportunities at higher levels. The pressures of work in this area demonstrated the need for the employment of our graduates, and there clearly appeared to be a need for our people in the areas of alcohol rehabilitation, sexual assault referral, and home and childcare. Many people were frightened to go out of their communities to get assistance in health care.

I noticed when I was working in the community that while some people had bad wounds which needed suturing, they did not get anything done until infection had set in. Minor suturing had to be included in the training. Another big problem was getting people in for blood tests, to combat sexually transmitted disease. It was imperative that taking blood was also included in the training. The program was geared towards participants talking about their needs in the community, and then addressing the problems as they were presented. After discussion with community members and the medical personnel at Perth Aboriginal Medical Service, particularly Dr David Paul, the general scheme of the education program was decided upon (see Appendix). The first program consisted of one year of fulltime study including:

- Health Worker Certificate
- St John Ambulance First Aid Certificate
- Holyoake Alcohol and Drug Abuse Centre Certificate
- Interpersonal Skills Certificate
- Nutrition Certificate
- Environmental Health Certificate
- Personal development courses for Aborigines seeking employment, which aimed to increase self confidence by improving literacy and numeracy, learning employer expectations, and understanding the responsibilities within the workforce.
- Practical experience in various community organizations.

Lectures were conducted by various community personnel, which included 23 members from health professional and welfare organisations; while 18 culturally appropriate Aboriginal lecturers made up the remainder.

The training included minor house maintenance, such as maintaining and replacing flywire, safely changing electrical fuses, the dangers of and safe operation of heaters, and health and hygiene in relation to carpets and dogs as pets. There was also instruction in the dangers of dry-well overflow, as well as general home hygiene. The inclusion of this training was very important, as many people were coming into houses after having lived in tents for most of

their lives. This practical training was included as an interim program to help participants get started in the course.

Student Selection

Twenty-five students were selected to begin studies on the 5th of September, 1983. They came from various places including Derby, Leonora, Carnarvon, Geraldton, Pinjarra, Mullewa, Kalgoorlie and Perth. The students ranged in age from 18 to 51 years, and their education backgrounds were equally diverse. Some had fairly recent study backgrounds while others had not been to school for over thirty years.

My philosophy for self-esteem was to punctuate every attainment with a celebration. This was in contrast to the mainstream education system, which tended to highlight the failures and create a 'crime and punishment' mentality, which made one want to run away and hide from the disgrace of ignorance and failure. I often heard teachers say to students, "You had better pay attention because this is going to be hard to understand". From my point of view, the philosophy of teaching and learning should be, "The sky's the limit and nothing is impossible". Make it sound easy. "If I can do it so can you" was my favourite one-liner.

The first item I thought of that could provide a positive outcome was First Aid. This was a three-day course and in such a short time participants were able to save a person's life. This set the students on the road to success and a positive outcome. Some of the older students, who previously could have claimed nothing but failure in the education system, were elated with their success in such a short period of time.

From very quiet and retiring people unable to communicate with each other the students became outgoing positive health workers able to conduct meetings and give lectures on health matters in the community. It was so enlightening to see the metamorphosis and imagine the effects on the communities in the future. The method of teaching was in tune with the 'hunter and gatherer' model,

whereby students were taught to move out of the classroom and 'have a yarn' about what they had learned. I found that the whiteboard and classroom situation tended to block the intake of information. I aimed to make learning fun and celebrate every success so that it would be remembered. My thinking behind this is that you can recall all the action at a party, and you don't need a pencil and paper to help you remember the good times.

Preparing Our School

In 1983 when we were starting out, we did not have the amenities for the students that other education centres had. I spoke to community members about the need to accommodate country participants. There was plenty of support from the Aboriginal community. Rob Riley (deceased) was the National Aboriginal Conference representative in Perth, Lenny Colbung (deceased) headed up the Aboriginal Legal Service, Dennis Hayward was the Director of the Aboriginal Medical Service, and Robert Isaacs, apart from being our Chairperson, was also involved with the Aboriginal Section in State Housing Commission. These leaders all supported our push to be able to accommodate students from outside the Perth metropolitan area. After much negotiation with the Department of Aboriginal Affairs, Aboriginal Hostels Limited., various estate agencies and the Blue Army, the Gnoorda Hostel opened its doors on the 30th of March 1984, at 317 Pier Street East Perth, with accommodation for 14 students. With their help and support we were able to furnish the house, which was placed on a large block, and a transportable unit was placed on the site for a married couple, Clive Hayden and his wife Wendy, to live and supervise students in the hostel. The pride in the people stood out like a beacon.

In Newcastle Street, Sister Laurel Yarran (deceased) opened a child care centre, Gurlongga Njininj, for the participants' children, and this proved to be a blessing for students doing their practical experience in child care.

Over the years many sacrifices were made by students, staff and family to travel through the curriculum to cover the first year with success. Twelve students followed the highs and lows of a rigorous course and they were very proud

students when they came forward to receive their award. Their relatives and lecturers were equally proud. One graduate of 40 plus years, who was still in the workforce, burst into tears and said that the health worker program was the first education program where she had been successful in her whole life.

Evaluation

Out of the 25 students originally selected, there were five non-starters and one student who left after the first week. A further group of 8 students were selected after this. Out of this group of 26 students actively undertaking the course, 14 dropped out along the way and 1 failed before completion. The remaining 12 students graduated.

The main reason for students leaving appeared to be family pressure because of the distance from their homelands. A few were unable to cope with class dynamics. One person was unsuitable. The main absentees were from the metropolitan area. Some country participants did not return from their holidays. I assumed they may have been homesick or had family pressure to stay home. The most single factor appeared to be stress-related illness, followed by inadequate housing, internal family problems, inadequate childcare, alcohol-induced illness and an inability to cope with the course content.

As there was one coordinator for the program, plus one secretary and a series of guest lecturers, the task was enormous, having to attend to the psychological problems of the students. Many problems went undetected until there was a serious breakdown with absenteeism and prematurely leaving the course. With more paid staff, progress could be monitored more closely to discover early signs of stress related to the course.

It was affirmed from the beginning that the reason for the program was to take their expertise back to their communities and if the interest was only in up skilling for personal use, then there were other areas to pursue, which included Technical Schools and Nursing. Later a similar program began for health

workers at the Centre for Aboriginal Studies, Curtin University. This program allowed autonomy for the individual accomplishment to aspire to a higher education.

Goals for Graduates

Our main aim was to get our graduates into the workforce whilst their enthusiasm was still in place. Some of our graduates had made arrangements to work in their own communities, whilst others had contracts with the medical services where they did their practical experiences. At that time there was a Commonwealth Employment Program in place to get employers to engage people in the workforce. It fitted our graduates perfectly, which meant that they could assess clients, and formulate an ongoing health care plan.

I put in an application for a program to bring health care to the Aboriginal people at the grass roots level in Perth. This would include:

- Home care for the elderly;
- A child health program;
- Health visits to the grass roots people;
- The day-to-day communication between health workers and professionals.

The Aboriginal Health Workers Education Program as we were known then was granted funding for eight health workers. This included four small 'Colt' cars to transport the clients and was a perfect program to get our name on the map for Aboriginal health care of our people with an increase of 600% in the workforce.

We endeavoured to give the people the education to:

- Assess;
- Treat;
- Refer and evaluate health problems and provide them with the ability to make their own decisions; and
- Have the motivation and incentive to aim for optimal health for themselves and their communities.

Broome Regional Aboriginal Medical Service

The Broome Regional Aboriginal Medical Service (BRAMS) began an education program under the direction of Dr Ian Wronski in 1984. Where the Perth Medical Service had a twelve month course, Broome students graduated after six months. However, we joined forces and developed a program of basic health education principles, which would generally cover both programs with variations of care for remote areas. Perth had access to more medical expertise, while Broome had to learn how to sustain life while preparing patients to be flown out with the Royal Flying Doctor Service. Amongst the areas we focused on were prevention of hookworm infection, care of community dogs, and mosquito-borne diseases. Later, BRAMS created a renal dialysis unit for ongoing care for their clients, something which was taken care of by the major hospital systems in Perth.

Communications

Regular correspondence and phone negotiations, together with conference meetings kept us in touch with each other. The Perth program was then known as the Aboriginal Health Worker Education Program AHWEP. Many Aboriginal people found it difficult to interpret some of the teaching methods of the English-speaking world and were more in tune with graphic descriptions, body language and oral traditions with hand-eye coordination. At that time in history, Aboriginal people were expected to keep out of sight and were more or less not expected to be able to form an opinion on any subject.

When I introduced ways of teaching and learning from an Aboriginal point of view, sitting outside of the classroom in a relaxed way and talking or 'yarning' to each other and sharing their knowledge and experiences, there was an outcry from many who claimed that I was teaching students to cheat and that some of the students were holding others back. They could not understand the 'hunter and gatherer' method of survival. The tutors were engaged to introduce aspects of literacy and numeracy, but were judging the cohort as a 'mini nursing' course, and although certain aspects of the course involved procedures which

could be termed 'nursing practice', the goal was to educate people in the field and learn how to refer clients on to the medical officer or community nurse if necessary. It appeared that the nurses could not divorce themselves from the 'hospital mentality'.

In 2009 The Congress of Aboriginal and Torres Strait Nurses (CATSIN) Conference tabled a new and innovative program called 'Yarning' run at Newcastle University for Aboriginal students. This entailed the same concept of 'hunter and gatherer' information transfer that I had been castigated for twenty-six years previously. The Centre for Aboriginal Study at Curtin University has embedded the 'yarning technique' into their academic programs in the form of Aboriginal Terms of Reference (ATR).

Preparation in the course was reflected in understanding nutritional practice within the whole extended family and social groups. This included social issues that I was privy to when I was a community nurse. I was always in touch with Dr (now Professor) Fiona Stanley, who was my main adviser and a recognised researcher into problems associated with mothers and babies. Other areas of expertise were provided by Holyoake Alcohol Rehabilitation Group, the Alcohol and Drug Authority, Dr Kim Stanton, Royal Perth Hospital, the Diabetic Association, the Aboriginal Affairs Planning Authority and our own doctors within the Aboriginal Medical Service (AMS). There was still an undercurrent of unrest, however, about me running the course: "How could an Aboriginal person really know what to do?" This was despite that fact that I had a Diploma of Applied Science in Nursing and Midwifery and a Child Health Certificate at the time.

The reason why the AHWEP was implemented in the first instance was to put Aboriginal health in Aboriginal hands, and take the 'magic' out of medicine. Many of our people were afraid to go to hospitals or seek assistance from doctors and 'white' nurses if they were sick. Those who needed the most help were the ones with the least education, particularly when living on the fringes of our society. If we could have 'made it' under the Western system then there would have been no need to start the program. Neville Green (1984, 188)

reflected that Nyungar society was shattered and its culture irreparably damaged 80 years after the first settlers arrived in W.A. This was also reflected in Hasluck's observations (1988).

In 1985 a review of the health workers education program in Western Australia was held by the State Government, with the aim of looking at:

- The philosophy, aims and objectives of health work in Western Australia;
- The need for statewide arrangements assuming the cessation of Commonwealth funding and support for the program;
- Establishment of new AMSs in WA;
- The scope of existing training;
- The adequacy of staffing and resourcing of courses;
- Accreditation of courses; and
- The outcomes of courses to date.

The review certainly improved the prospects for health workers, although BRAMS had the most gains with new classrooms, twelve new staff, office accommodation and rental subsidy for staff, while our Perth program struggled in the back warehouse and still under a cloud of misrepresentation.

There is one thing stronger than all the armies in the world, and that is an idea whose time has come!
(Hugo 2005).

Somebody Up There Liked Me?

In Perth in 1986 someone was taking notice of the AHWEP, as we had been nominated for a World Health Award in Geneva by the Women's Advisory Council of WA (WACWA). I was dumbfounded when I received a letter from the World Health Organisation informing us that the Perth AHWEP had been nominated for the Primary Health Award, as WACWA had not indicated that they were nominating our program for consideration. I was so excited; I ran into the classroom and said, "Stop the lesson we have to celebrate because we

have been nominated for an award for our program!” Staff and students were equally excited; we were all laughing and felt so proud, but as time went on we fell back into the routine of lectures and getting on with ‘the business’. However, six months later, in 1987, we got another letter to say that the Perth Aboriginal Health Education Program had won and I was to be the recipient of the prize. We were all speechless as it was too incomprehensible to understand. Although no funding was available for fares to Geneva, we were invited to attend the presentation. This caused a flurry of activity in trying to raise funds to get to Geneva, with barbecues, garage sales, quiz nights, appeals to the public and any other way we could think of. Eventually we had enough money for five of us to go for the great occasion. We were indebted to Mr Stephen Hitchins, the Managing Director of Quality Builders Pty Ltd: we called him ‘Our Knight in Shining Armour’. He came forward to fund us when both State and Federal Governments did not come through with any funding, even though it would give the Australian Government a world focus with such a prestigious award coming to Australia.

I was the first person to win the World Health Organisation Sasakawa Health Award for Primary Health Care outright, and the first person in Australia to bring the prize back to our country. I felt so proud when I gave the acceptance speech in the League of Nations Building to 152 nations of the world. Each country had about seven representatives. It was over whelming. The only pang of sadness I felt when I gave the speech was that I had included a written response from the Director of Aboriginal Medical Services, which I had written as he did not feel obliged to do so. Our contingent was beside itself with joy. From there the World Health Organisation made arrangements for me to go to many third world countries to encourage them to get primary health programs up and running in their own villages. The time for empowerment had come.



Sasakawa WHO Award
Geneva 1987 – Joan, Halfden Mahler, Director General,
WHO and Delegates

Trachoma

Prior to Geneva, 1987 was also the year that marked the excursion into learning about trachoma. In my nursing studies had I learned very little about this scourge and the implications of blindness in the outback for Aboriginal communities. It was not until Professor Fred Hollows (dec), a high-profile ophthalmologist, began bringing this disease to public notice and training Aboriginal Health Workers in these areas that I realised that we had to include Trachoma Studies in the Health Worker Program. Fred Hollows notified the Aboriginal Medical Services in Western Australia that he was interested in doing a Trachoma Survey in the Western Desert in April and would be making the base at Wiluna during the April/May school holidays. He would conduct an education program in 'Basic Ophthalmic Assessment and Care' under the direction of the University of New South Wales in the first week, and the second week would be spent assessing the Wiluna Community for eye problems.

It is difficult to remember all the participants who took part in the trachoma education program, although Aboriginal Medical Services were in operation in Perth, Geraldton, Broome, Carnarvon and Kalgoorlie. Well known health workers such as Margaret Colbung and Stanley Nangalla, both prominent people in Aboriginal health, were in attendance and prepared the food while taking notes from the kitchen servery. Shirley Lowden (dec) accompanied me and the school headmaster, Len Hayward (dec), Professor McCallister from the Lions Institute, and others who I can't recall were all gathered together under the meticulous eye of Professor Hollows.



First Trachoma Field Trip
Debriefing 1984

When the theory was accomplished and we had passed the examination, we were let loose into the community bringing in four-wheel-drive loads of clients to be assessed at the school for eye problems. It was a brilliant way to assess teamwork and the practical aspect of assessing a whole community. This included being mindful of traditional protocols, identifying the eye problem and instigating an ongoing treatment plan. This information was to be passed on to the Medico in charge of the community. It was a full-on exercise with no let up until the finish. Fred Hollows drove himself and all before him. He was a man with a mission.

At the end of the week, Fred had coerced the powers that be in the local 'lock up' to have the men in the prisoners' band put on some tunes at a barbecue held for us. Only Fred could do it. We all had a good night under the ever-watchful eye of the police officers guarding the men in the band. The next day we collected our certificates and made our way home, armed with the knowledge we had gained and determined to put into practice all the information that had filled our heads for the past week.

Moving On

In my acceptance speech at Geneva I vowed that the money won from the Sasakawa Prize would be used as the cornerstone for a new building. However, when I arrived back in Perth I was asked by the AMS to hand over the \$40,000 prize money. I refused, and placed the money in a special account to contribute to a new building fund. This response was met with dissatisfaction, and I was constantly harassed for the money. At that time our program funding was included in the overall accounts of the AMS. I had no say in the 'comings and goings' of the funding. I was never given a statement of expenditure. In fact, we had spent most of our Lotteries Commission money setting up the student hostel, with a small amount going to investment in office and classroom equipment.

The Hostel and the house-parents' accommodation had dissipated under the past Director without any discussion with me, so I understood that to have no say in the finances is to be powerless in any program. In the meantime I had applied to the Aboriginal Lands Trust for land where Sister Trish Young and I had conducted clinics under the trees at Sister Bernadine's Shelter 'Winyarn House', in Norbert Street.

I tinkered with the idea of setting up the school at Gnangara after we conducted a Trachoma Survey there when we consolidated the Environmental Program. The students spent a cleanup day there, painting the toilets and generally doing an outdoors cleanup. While we had a happy time there, it did not come to fruition. Later I negotiated with Tony Lee, Chairperson of the Clontarf School Complex, for the lease of rooms for our Health Worker Program. It seemed so peaceful by the river and it was becoming harder going into Perth by car in the mornings. I was offered two disused dormitories upstairs. We used the funding from the Sasakawa Prize to do the necessary changes to develop the area into school and staff rooms.

Setting up the classrooms together with putting in place the legal requirements through a law firm was an exhilarating experience, particular after this was settled and the Department of Aboriginal Affairs had approved the school. We became an autonomous organisation under the Aboriginal name of Marr Mooditj (meaning good hands) Foundation, Incorporated 1992. It was later proclaimed as a college.

From the time of moving to Clontarf Education Complex, the MMF has grown out of all recognition from our lowly beginnings in 1983. The escalated demand for health education emphasises the hunger for knowledge in the health field by those brave souls attempting to turn the tide to self-determination for Aboriginal people.
(MMF Annual Report 1991-2, 1)

I handed over the land that I had been granted from the Land Trust to the Perth Aboriginal Medical Service (PAMS). This took place in 1991 at PAMS. As I handed the letter involving my intentions, I was asked to see the Auditor about the Sasakawa monies. When I showed him a copy of the cheque I received, which clearly showed my name, he agreed that the money was mine as it carried the name “Marie Joan Winch”. There was much pain in my heart at the time, because I had put many years into supporting the Aboriginal Medical Service and I did not get a ‘thank you’ or any written response regarding the land where the Derbarl Yerrigan now stands. I felt like I had lost a good friend. At Clontarf we prepared to come of age and set up an autonomous school in the old dormitories.

First Aid Instructor Training

In 1991, I was approached by Ken Ford, Director of First Aid Training at St John Ambulance Association, to participate in the training of First Aid Instructors. St John allocated a specific project officer to guide us through and make sure that we were adhering to the guidelines of the organisation. This qualification would qualify the graduates to teach their own people. Early starters who became Instructors included Christine Cameron, now a general practitioner at Hollywood Hospital in Perth, and Margaret Quartermaine, who has held the position of Director of Marr Mooditj College since 2000. In 2009 Margaret had an Associate Professorship conferred on her by the School of

Nursing and Midwifery at Curtin University, in recognition for her work done in the enhancement of Aboriginal Nurses Training. Many more went back to their communities to teach their own language group. By the end of 1992, the records show that 400 people had been instructed in First Aid Methods (*MMF Annual Report 1992/93*). The mainstay of teacher/ student contact was a dedicated teacher Liz Gray, who had the responsibility of keeping the students in a cohesive group and making sure that they knew their work before moving to other projects.

Marr Mooditj deviated from the traditional method of teaching and revised the method to fit into the 'hunter and gatherer' way of collecting knowledge, including sitting outside on the lawn. We broke new ground in teaching people who had never previously expected to be able to save lives. Among them were street kids and others with learning disabilities, as well as prisoners, day care centre staff, students from Curtin's Centre for Aboriginal Studies, Aboriginal Medical Services staff and Community Development Employment Program participants. In 2009, Margaret was still going to country areas to give First Aid Instruction when requested to do so.

First Aid in the Field

In 1992 I witnessed a traffic accident outside the Perth AMS. The new graduates worked professionally as a team to help those injured in the accident, and order was restored. The graduates were very proud of themselves.

Some of our early graduates were at the New Year Celebrations in Hay Street in Perth, when an Aboriginal person had an epileptic fit. They took charge of the situation, keeping the crowd at bay and restoring order so that all was well. In another incident an enrolled student nurse and her friend were first on the scene of a motorbike and car collision. The bike caught fire with the rider trapped underneath, while the pillion passenger was thrown some distance. They managed to prevent further burn injuries and called the police and ambulance to the scene. Though the injuries were serious, there was no loss of life at the scene. Later, after a series of operations, the lady pillion passenger died.

1993 Milestone

After settling into its new role of self-management, MMF launched into developing a set of standards to promote primary health care through education and empowerment for and by Aboriginal people. These standards included ways and means of lifting the people through education, including holistic care and incorporating art, music, dance and storytelling, inclusive of spirituality. The belief at that time was that it was vital to make our people feel proud of their Aboriginality and to provide the ladder to success through their culture and knowledge of traditions and customs. MMF saw the college reaching out to State, national and international networks. At the same time it was important to keep in touch with the grassroots people at home, and promote and preserve cultural differences between Aboriginal communities.

The criteria for evaluation and registration of the Health Worker program were changed in 1993. This included a revision in the area together with preparation for accreditation and registration on a state and national basis, to be paid for by money held in trust at East Kimberley Medical Services. Though we shared all steps of the development with the other Western Australian Aboriginal Medical Services, the money was never paid to us, and apparently there was no such record of the agreement recorded about development of the curriculum: another lesson learned about negotiations with other organisations.

A curriculum writer Margaret Hallam was engaged to develop and write up the competencies for the curriculum. The final document was completed and accredited by State Education Skills Standards and Accreditation in 1993. Successful completion of the second year gave students an Associate Diploma and third year graduates gained a Diploma.

1994 Outputs

In 1994 a new revision in curricula took place. The Certificate in Aboriginal Health returned to the earlier times of more infrastructure devoted to numeracy

and literacy in the foundation studies, with a further unit associated with their employment. Students had to complete Health Studies 1 and an optional unit within their own area to enable them to work within the Western Australian Aboriginal Medical Services (WAAMS) career structure and articulate with the Advanced Certificate and Diploma where full recognition of prior learning was given.

The 1994 College Year			
Course	Enrolled	Awards	Employed
Advanced Certificate in			
Aboriginal Health Work	82	76	72
Diploma in Aboriginal Health	26	5	16
Senior First Aid Course	440	435	not known
Maternal Health	10	10	10
Medication Certificate	20	20	20

(MMF Information Booklet 1995)

An agreement with the Health Department was made for the Health Workers to upgrade their certificates at MMF. Sixty of these HDWA students participated in the Advanced Certificate, Associate Diploma and First Aid Certificates. Some of the graduates enrolled at James Cook University in Queensland to participate in a Public Health and Tropical Medicine Diploma. While we were unable to negotiate for recognition of prior learning at the Health Worker Degree Course at the Centre for Aboriginal Studies at Curtin University, Professor Ian Wronski at James Cook University was willing to accept our graduates.

Students who demonstrated skills and knowledge obtained through formal training, work skills and life experiences were eligible for advanced standing. A change of attitude was introduced into MMF education programs. Previously, the programs were focused on taking information back to families for healthy living. The new thrust was toward the participants' own professional standing and their capacity to succeed in higher education. Younger candidates were seeking to climb the ladder of success in the health field. Tertiary level

competency-based training was sought after to enable the successful candidates to gain access into recognised career paths in the health field.

In 1994 MMF also developed a National Trachoma Screening Video, for use in rural and remote areas to assess Aboriginal people for the eye disease.

1995

In my retirement year, 1995, MMF had been in education for twelve years. Many changes had transpired since our inauguration, and 1995 continued to be a time of change.

The Industry Requirement at the time included the completion of the following modules:

- Epidemiology
- Health Promotion
- Introduction to Management
- Alcohol & Drug Issues
- Mental Health
- Sexual Health Medication.

The program had become quite dynamic, with enthusiastic staff delving further into the needs of our people. One of the sticking problems that had been sadly neglected by health professionals was that of Mental Health, as in earlier days when we started the Stress Management for Aboriginal people. Reid and Trompf (1991) had recognised the primary and secondary causes of Aboriginal ill health and the eventual outcomes if nothing was done to address the problems. This information was available over the past twenty five years and began as causes of Aboriginal ill health, beginning with 'invasion, poverty and final outcomes', to mention a few.

Primary	Secondary	Outcome
Dispossession	Dependence	Substance Abuse
Disease	Rejection	Powerlessness
Incarceration	Loss of Knowledge of traditional ways	Distress and breakdown in mental health Drug abuse and suicide.

The Diploma in Mental Health, started by MMF in 1995, was the first accredited mental health course in Australia for Aboriginal people.

We had settled into the school at Clontarf College quite happily and had turned the two dormitories into effective classrooms. I was feeling the weight of my age and knew I had to stand aside and hand over the reins to a new Director. The decision was made by me not to interfere with the internal workings of MMF under a new Director and to let them find their own feet.

1996 -2000, and beyond

Within two years there had been a series of managers at MMF. Elizabeth (Liz) Hayden, Social Worker, put in a lot of the groundwork for the new buildings. Given the situation it was no mean feat, as Liz was ‘Acting Director’ while the previous managers had been left floundering when faced with the task of setting up the new premises.

Recognition was given to MMF to extend themselves as a regional centre, including a Centre for Social Wellbeing – Training and Support Centre. In 1998 MMF had been reaccredited by the Department of Training to practice as a Health Education Provider, and continued to consolidate its position in the provision of Aboriginal health training with the Diploma in Primary Health Care. From the Regional Centre, a Consortium of Members was established comprising of members of MMF (host organisation), Derbarl Yerrigan Health Services, the Noongar Alcohol and Substance Abuse Service (NASAS), Manguri (Sister Kate’s), Yorgum Aboriginal Corporation, Aboriginal

Psychiatric Services, and the Centre for Aboriginal Studies at Curtin University (*MMF Annual Report 1998*).

New Directorship

In 2000, Margaret Quartermaine was appointed as Director and saw the new building to completion. It was opened in October of that year. A lot of preparation had to be made by staff, which included workshops on roles and responsibilities and the development of a Policy and Procedures Manual. The stress of shifting into the new building was overridden by the excitement of 'making it' at last. Because of the funding arrangements, three masters had to be appeased: the State and Federal governments and the Aboriginal communities. The College staff were stretched to meet the 'Performance Indicators' set by their funding bodies.

Bush Medicine

In 2005 another new and innovative program, the Advanced Diploma in Herbal Medicine, started. The program was instigated and run by Noel Sherard, a herbalist. Later, the course was converted to Herbal Medicine Certificate IV. The course proved to be a resounding success with mature age students. Candidates gathered plants from their homelands and brought them to Marr Mooditj for study and instruction in extracting the oils and developing products such as soaps and lotions. Students owned the plants and the specific, local information. Lectures were given on marketing the product, enabling them to set up a cottage industry at home. Older people, who probably did not want to get into the workforce within the health field, were able to use their knowledge and acquired skills to cater for the tourist industry with sales of their products. The star graduate was Vivian Hansen, who was the first Aboriginal person to become a member of the National Western Herbalist and Bush Medicine Association.

Awards

In 2003 Marr Mooditj received an award as Training Provider of the Year for Western Australia, with the award recognising its programs addressing community services, youth work and aged care. The following year MMF 'came of age', marking 21 years of training provision since its inception in 1983.

In 2006 Marr Mooditj won both the State and Federal Training Provider of the Year awards. It was seen as recognising their professionalism in providing the Aboriginal people of Western Australia with an education program of such prestige, and gave staff a sense of pride in their work.

The accolades of success began to reverberate within the Aboriginal community and our people were lining up to enrol in such a diversity of Aboriginal run programs. With the avalanche of new students it became obvious that more classrooms were needed to cope with them. An application for two new classrooms was made, and in the interim two transportable classrooms were leased to accommodate the students.

Advisory Committee

Throughout the years, Marr Mooditj has had the guidance of an Advisory Committee to set the goals and vision for the future. This committee is elected by MMF members for a two-year period and is comprised of Aboriginal candidates who have had success in enhancing Aboriginal education in the workforce. Under the constitution, the council must meet once a month to discuss current issues and developments within the organisation and give advice to the Director regarding plans for the future. In 2009 all the goals set the previous year were achieved successfully by MMF, and another list of possibilities was set for the following year.

The elected committee holds the legal responsibility for the management of MMF under the direction of the elected Director. The Committee and the Director must meet the requirements of 'Duty of Care', honesty and good faith

in the performance of their roles. The Committee members reflect its public management, working to maintain credibility with the funding bodies, partners, students and the community. Minutes are recorded as evidence of their responsibilities, as required under the Constitution. Professional positions are filled within the specific requirements of the position in the workforce. All Financial reports are presented at each monthly sitting, with an accountant overlooking the accounts prepared by a qualified bookkeeper, who gives an oral account of program funding and forward estimates every quarter. The role is to prepare all accounts for the Annual Auditor's Report. With this guidance, MMF has always had clear and 'above reproach' reports since our separation from the Aboriginal Medical Service in 1990.

Policies and procedures are regularly reviewed and updated as necessary. There are many rules and regulations revolving around students and staff with all participants having full insurance coverage in their day-to-day business. Student insurance is over \$1,000,000 because of their practical experience in the community.

Over the past ten years Associate Professor Margaret Shaw (Quartermaine), in her role as Director, has led MMF with great vision, with all programs growing vigorously, and has helped to consolidate the organisation into a vibrant and respected Health Education College.

Chapter 6

Conclusion: Where to from here? Closing the Gap and Opening new Doors

In this chapter I reflect on Marr Mooditj's current programs, the structure of the organisation, consider the way that it has contributed to the notion of 'closing the gap', and look at the challenges that lie ahead.

Health education should be a normal part of the work of all health and related workers (WHO 1965) with emphasis placed on the special needs of developing countries. Though Australia is classified as a developed country the plight of Aboriginal people can be described as "fourth world", which implies that Aboriginal people are living under third world conditions in a developed country. Preventative measures then must be applied to those in need, which includes appropriate teaching in the health field, including a positive and appropriate approach in community management.

Health Education Objectives

The principal objectives for a suitable health education program are to lower the existing morbidity and mortality rates, and to improve the health of the next generation. The best and most effective way is to teach people practical methods in which to overcome this state of affairs. Normally the pattern of existing health services reflects a heavy concentration of resources in the main cities, whereas the people with the most needs often live in outlying areas. The top priority therefore should be directed to rural and remote areas.

The present 'catchcry' is closing the gap for Aboriginal people in the health field. However, the major thrust is still bigger and better facilities in the city, while many country hospitals have been closed down over the past two decades. Aboriginal people have been forced into leaving their own remote areas to travel hundreds of kilometres to the city, where the language is unfamiliar and they have no relatives with whom they can converse. Within the range of primary

health care, treatment of minor injuries, advice and instruction should be the prerogative of the local language people and they should give their own education instruction. Consequently these are the people who should be educated in basic skills to give the primary health care prior to intervention by medical staff.

Primary health care integrates at the community level all the elements necessary to make an impact on the health status of the people. It calls for measures that are effective in terms of costs, techniques and facilities that are easily accessible and improve living conditions. Local resources should be used including manpower as well as essential resources provided by the Government. Community development programs can be taught by 'Block Release' Education Programs in negotiation with major education centres in larger towns or cities. Local Aboriginal Medical Services situated in the community can teach basic health care, and where possible in the local language, with emphasis on environmental health and the devastating effects of drinking alcohol, especially during pregnancy.

Rural and remote populations and Aboriginal populations share some characteristics that can include

- Geographic isolation
- Unfavourable environments, with exposure to communicable diseases and probable malnutrition
- Inadequate health facilities and lack of sanitation
- Poor educational opportunities
- Lack of knowledge about the devastating effect of alcohol, particularly to pregnant mothers.

The repeal of prohibitions after the 1967 Referendum allowed Aboriginal people to occupy the same spaces as non-Aboriginal Australians, including drinking spaces. However, there was no basic education about the effects of alcohol and unknown effects of what it could do to the unborn child ((Wilson et al 2010).

Too often health personnel are preoccupied with superimposing a health program which appears to have no relevance to the recipients, but which fits into the prescribed government programs for funding. I saw this in operation in 1980 in Perth, when Cullacabardee Village was set up. Nyungar people who had spent all their lives living in tents were shown pictures of furniture and fittings for possible inclusion in their houses, from a homes and garden book. It was a total disaster.

The WHO committee acknowledged that a well organised nursing system and education program should go hand in hand when setting up these programs to orientate the people in use of equipment and the effect on their community. One is of no use without the other if nursing practice is to achieve results. This is one of the reasons why the program instigated by MMF was judged the best of its kind in 1987, where we elected to educate these people from remote areas. Even so I was castigated at the time because these graduates did not have a 'city' grasp of the English language. I explained to the nursing staff, that teaching the locals about health care was much easier than sending nurses from overseas into the remote areas where they had to get a grasp on flies, heat and dust, let alone the local language and cultural obligations. On the other hand, I told the Aboriginal students that they knew their culture and we had the easy job of teaching them the basics of health care. We had a lot of success in the early days.

In 2008 a community nurse from Katherine tabled a program at CATSIN (Congress of Aboriginal and Torres Strait Islander Nurses) called the 'Sunrise Program', as a best start program for people in the area. It was a heartening program, only to be overridden by a superimposed Federal Government directive, which lost the effective essence of enhancement, something that happens when programs are developed at a distance from the recipients. This also happened to the Marr Mooditj program in 2001 when the Federal Government took control of the programs and deleted or downgraded some of the essential environmental health programs. They required a vast amount of written reporting to be done before more funding could be received. This has

become a hassle for the teachers, who are constantly complaining about the amount of paperwork which has to be completed if programs are to continue.

It is vital that the local people be given the expertise, rather than the services of non-Aboriginal workers, who are only there for a short time, whereas the locals are there for the future development of their community. Marr Mooditj education program works on this premise when educating Enrolled Nurses from remote areas on a Block Release Program, taking into account that these people had their own ways of being and doing long before western society came to this country and imposed a program, that was totally unsuitable for them.

It is very necessary not to lose sight of the contribution of grass roots people. Services would be more efficient if ideas were borrowed from India, where 'Village Dias' (traditional midwives) were trained in basic health care. They can then liaise with the visiting nurse and a greater understanding could be fostered between the two cultures. The carers must retain the culture of the people delivering the care. These are important issues, which must be addressed before foisting alien ideas onto the recipients. Aboriginal people are well schooled in body language and the slightest prejudices can be detected. These points were raised in a joint paper with three other nurses and written for the School of Nursing after a WAIT Abroad Study Tour and were the core values based on the Marr Mooditj program in 1983.

Remote Area Health Corps is a Federal Government initiative as part of the Expanding Health Service Delivery Initiative for the Northern Territory which recruits urban-based professionals, predominately nurses, for paid short term placements in health clinics and largely serving Indigenous Communities in remote areas of the NT and appears to go against all the recommendations of the WHO. When I spoke to some of the Aboriginal nurses from the remote areas, they said that they were told that they were not qualified enough for the job. Where does it leave the idea of Aboriginal health in Aboriginal hands? When I spoke to some of the nurses about the Rural Health Program, they indicated that, though they had applied for positions, they were not accepted for various regions. The presenter indicated that the nurse had to have a background in all

areas of nursing, whereas I would have thought that an in-depth cultural knowledge of the area would have been the first qualification for working in the area. The greatest teacher is life experience in the needs of people and behavioural principles are needed for promotion of good health. The whole scheme appears to be back to front. It appears that Aboriginal nursing recruitment and short term management programs given to those inducted into the program from their own communities is more cost effective and a better long term arrangement for communities in remote areas.

Where to from Here

Before starting out with any new program all courses have to be assessed for their viability and effect in the community. No funding will be forthcoming unless there has been a full report to the appropriate funding body. Some courses that were believed to be essential at the time have not been successful in attracting funding.

One very successful program for the more mature person has been 'The Bush and Herbal Medicine Program', developed by Noel Sherard, creating modern ways of plant preparation. Many older candidates, both men and women, have come forward to thank the college for the opportunity to participate in learning about the cottage industry, indicating how successful it has been for them. They have said that they were happy to learn about how to prepare their own herbs at the school; otherwise they would be sitting at home doing nothing. Presently, some of the past participants are catering for the tourist industry, especially those from Broome and the Kimberley areas. The candidates bring their herbs down from their area and the Herbalist teaches them how to prepare the plants for lotions and potions. They are also taught about packaging and management of sales without costly overheads of factories and equipment. When the students graduate they are fully prepared to carry out their own business, using their ancient knowledge of healing herbs with a western approach to the preparation, though this course has been consistently underfunded every year since its inception. All other programs have been well within their funding limits.

It would be worthwhile to have this program, Bush and Herbal Medicine, developed for the broader society as I have been constantly 'bombarded' by mature age people inquiring about participating in the course. Unfortunately the programs at MMF are for Aboriginal people and they are unable to allow others to enrol in them. There should be future initiatives to open this program up to share this and similar programs with the broader society.

Accommodation

The courses are all run on a block release system, so that students are not discriminated against by distance. Though this innovative learning package has been seen as a breakthrough for distant education students, there are enormous distractions in the city for some. The staff has had to placate the managers at the motels because of the disruptive behaviour of some students. Consequently, the time, effort and finance have been stretched to the limit in trying to please both Hotel Management and disgruntled students.

The amount of money funded by the Federal Ministry of Education over the past ten years could have bought two motels. MMF has spent a lot of time and effort to appease both parties and negotiate with Hostels Ltd to have a purpose-built facility, possibly on campus, though nothing has eventuated as yet.

In 2010 the next step for MMF is to research other areas for consideration. The Director, Margaret Quartermaine, will be contacting businesses to 'sound out' their interest in building a hostel specifically for mature age students. We are looking forward to some permanent accommodation for the country students in the near future.

New Programs

Looking to the future of the college, each section must be assessed including the effectiveness of past programs, presentation and redevelopment of areas needing improvement, community needs and availability of funding for new programs. I am proffering some programs, which I think could be possibilities for the future.

Elderly History Class

This is encompassed around the idea of 'Care of the Elderly'.

1. First and pressing program would be to have a historical account of elders' story telling for the records. Where our people could have their stories recorded for the archives.
2. Lectures could be given in anatomy, physiology, and physical and psychological needs of the elderly.
3. Each student could be allocated an elderly client or select their own clients in their 'home country'.
4. Students would keep a history of the medical and physical aspects of duty of care.
5. A Public speaking course would enable students to speak and present their findings at group meetings.
6. Elders could share their experiences by recording 'yarning' over a cup of tea or lunch.
7. Students would learn the importance of confidentiality.
8. I envisage that the elders could be paid a small stipend under the Commonwealth Education Package.
9. Outcome of the course would be to:
 - Record History.
 - Instigate a feeling of worth.
 - Serve as a learning experience for students.
10. Work towards a Memorandum of Understanding with all Universities for ongoing programs for higher education.

Focus on Children and Youth

Social Work

1. Prepare students for university study: reading, lectures and practical experience.
2. Learn about recording of case notes.
3. Confidentiality and needs analysis.
4. Work in tandem with the Social Work Department, Curtin or other education centres.

5. Community experience.

Environmental Health (EH)

An EH program should be prioritised because this is still the major factor preventing improvement in health. I envisage this package could be discussed with the Kulbardi Centre at Murdoch University, who set the pattern for Environmental Health with Professor Peter Newman in past programs with 'Appropriate Technology' for remote areas in the past and Dr Kurravilla Mathew, who ran our EH courses in the 1990s. This is one of the issues which have to be addressed first. If we don't understand about 'living safely' in the environment we will never gain much in the way of health improvement. Primary Health Care is a preventative measure, which has always been more cost-effective than secondary and tertiary care.

Career Development

This could be a short course for high school students. I envisage this would whet their appetite to find out about more options in the workforce. Other considerations are to get into the routine of preparing students for work on a day-to-day basis to get the feel of consistency with daily activity, and learning to keep a daily diary of activities, and learning about confidentiality. This would be a good program to introduce the students into different workplaces and put them in contact with employment officers.

Focus on Health Promotion

'For a better future life': One-year program.

Prior to outside investigations, one must look at self first and make sure 'you' are physically fit, if advice is to be given to others. The program would then focus on investigating the community needs and the best way to focus views on different age categories. This program could be divided into categories including teens, catering for men's and women's business, leading into the twenties to thirties age group, dealing with child care through the age groups, onto older peoples' needs. Now that we have more people living up to old age

and less younger relations to care through these age groups, some commitment and realistic plans should be made to cater for their needs.

This plan would have to be discussed at length with the recipients to see the sort of programs they would like to participate in. It requires a needs analysis to back up the plan.

A memorandum of understanding could be drawn up between the South West Aboriginal Land and Sea Council and MMF, looking at the possibility to 'Train the Trainer' as First Aid Instructors and for graduates to outreach into other areas and teach in the country. This would have to be in discussion with the St John Ambulance Association. Other Aboriginal organisations may also want to be a part of this program. The philosophy of this program is to be constructive in helping people in a positive way and this will help to break a lot of the negativity within our community today. When one is helping someone in a positive way, then negativity dissipates, and therefore much of the ill feelings which abide in the community will vanish.

A working party could be funded by the Government to travel around to the small towns teaching First Aid and passing on their skills in schools and small groups. Areas of special interest can be tabled whenever necessary, with attention to the subject on hand and appropriate programs can grow from there. This will be able to be built into existing programs, particularly dealing with youth, where the implanting of cultural awareness and a positive attitude to identity would be of considerable advantage. This will open the cultural corridors of correct 'rites of passage' and diversion programs specific to Aboriginal people.

Summer School

Funding could be sought to host Summer Schools, which could focus on Aboriginal current affairs such as self improvement for family and higher education for self and family, emphasising the importance of education for all, not just the chosen few. Visiting lecturers could introduce a national or international perspective on current affairs.

Aboriginal Studies

Many of the younger Aborigines have very little knowledge of their own history; Visiting Elders from various areas could bring to life our old ways of information transfer by 'yarning'. This type of program could expand, if need be, into a 'field trip'. It would be valuable to revisit Aboriginal Terms of Reference as a valid theory in order to write and present papers as ways of being, knowing and doing.

I have found that when adults return to an education program, they have suffered a lot of negativity throughout life, and so it is most important to make learning fun, so that they want to join in and have a good time. Some of our people have never come to terms with 'learning'. They should be shown the way with help and encouragement in 'the Aboriginal way' including a relaxed learning process through 'yarning' and getting on the road to success.

These are a few of the ideas, which could be explored in the future, which may make a big difference to Aboriginal people. Aboriginal people should be in charge of all programs, walking side by side with knowledgeable mentors to guide them. This is not the entire mind map of new and innovative programs which could be expanded and developed at a tertiary level, but rather it is a wish list, which can only happen if all areas work together to conduct a needs analysis. This would consider community needs and the capacity of Marr Mooditj to include such programs, subject to staffing and funding bodies agreeing to fund them. With the extensions of the classrooms on track at MMF there will be more space to spread our wings and look to future programs for our people.

Other Services

Broome has always been associated with education needs. Now other Medical Services have responded to community needs delivering health education programs at a community level. My greatest wish would be to set in motion an

Aboriginal University in Western Australia, where all of these cultural programs could be implemented and presented at a tertiary level.

Closing the Gap

For decades after first contact in the nineteenth century our people had suffered from health problems, which should have been alleviated by simple steps our people could understand. Little thought has been given to focus training for our people. In fact the opposite applied, as we were discouraged from entry into the health field until the second part of the twentieth century. Lessons can be learnt by considering the type of education given by the late Fred Hollows to those Aboriginal people working in rural and remote areas, who were even taught simple operations in the field that prevented blindness.

It had been reported since records were kept in the 1970s that Aboriginal ill health was a disgrace.

Australia's Aborigines have the worst life expectancy rates of any indigenous population in the world, a United Nations report says.

But it's not news to Aboriginal health experts.

They say it simply confirms what Australian health services have known for years.

Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) chief executive officer John Paterson said the findings of the report, which examined the indigenous populations of 90 countries, were no surprise.

The UN report - State of the World's Indigenous Peoples - showed indigenous people in Australia and Nepal fared the worst, dying up to 20 years earlier than their non-indigenous counterparts (*National Indigenous Times*, 15 January 2010, 7).

MMF has worked constantly to close the ill health gap by encouraging our people to participate in health education and spread the information through family and friends. The word of mouth transfer of knowledge is still widely practiced in the community. When Aboriginal people made the decision to instigate community-controlled health care in the 1970s, the hope of our people was to have some control of their care, development and implementation of programs directed to the needs in their own community. This is the way that the early development of the health care system proceeded. There has to be a basic understanding of the people and their environment to survive. Part of this

understanding involves the importance of primary health care as a more appropriate model for understanding Aboriginal health and training Aboriginal health workers than a medical model of health training. It is more effective to work on preventative health measures than merely starting to think about good health once someone has contracted a disease or suffered a health problem.

Director's position at MMF

The key person at the helm to bear the brunt of the success or failure of the whole college is the Director, whose role is to keep everything in full running order between students, staff the community and all the funding bodies. The Director has to be one jump ahead on what is transpiring in the community and the financing sector in order to come up with programs to address the community needs. MMF has always been ahead with developing and running new and innovative health programs in Western Australian.

It has been a prime function of MMF to empower Aboriginal people and set the standards in providing and promoting Primary Health Care Education for Aboriginal families. This organization provides the framework of Aboriginal culture entwined within their programs, leaning to the positioning of oneself within the health field and providing culturally safe programs for their people. This enables them to incorporate current issues into the presentation of programs, including Environmental Health, Traditional Medicine and eating patterns. First aid is promoted in all communities by the training of Aboriginal First Aid Instructors and by creating equal opportunities for graduate health workers.

Comment [FoHS1]: Not sure about heading for this section – perhaps more on the Director's responsibilities

Enrolled Nurses Program 2007

When the opportunity presented itself for funding an Enrolled Nurses Program, MMF applied to train Aboriginal people, particularly from remote areas. The aim was for Enrolled Nurses to act as ancillaries for staff in remote hospitals and community controlled health centres. Strict parameters for training were applied by the Nurses and Midwifery Board of Western Australia. Just to get

our foot in the door to train people was a 'giant step' for Aboriginal training schools. A mock ward was set up in a 'clinical skills' room, for students to practice their skills on manikins. The course takes 2 years to complete and after a further 2 years in the field graduates can apply to complete a 'fast track' with the School of Nursing and Midwifery at Curtin University, completing a Bachelor of Applied Science in Nursing, with which they can apply for Registered Nurse status upon graduation. There were 18 graduates in the first intake and I believe that it was the largest group of Aboriginal Enrolled Nurses to graduate since the inception of Enrolled Nurse Training in the 1950s. Once again doors have been opened on our terms. This College has broken through preconceived ideas of traineeship and opened doors for Aboriginal organisations to train enrolled nurses.

Extending the Education Net

Marr Mooditj has been investigating the development of Vocational and Education Training in schools, including implementing the Certificate 2 in Aboriginal and Torres Strait Primary Health Care Program. This has included the Cannington_Coalition, Clontarf College, Sevenoaks Senior College and Kent Street Senior High School.

MMF has widened their scope to offer complementary courses including:

- Developing a Diploma in Management and Certificate 1V in Training and Assessment for Aboriginal people in the Health Field.
- Continuing work with Acacia Prison, looking at ways for ex-prisoners to continue with their studies on release to open pathways for sustainable employment.
- Beginning discussions with the 'Dental Authority' and the Aboriginal and Torres Strait Islander Registered Training Organisation Network (ATSIRTON), in order to introduce a training program for Oral Health Care.

Comment [FoHS2]: In full

MMF will be opening new doors of study, where they will be able to look at men's roles in the workforce and what pre-training can be developed to enhance

their chances of a permanent career. Other areas to be addressed are case management, chronic diseases care and coordinated care workers.

The introduction of 'Management' is another empowering step into a field that Nyungars have been excluded from until the instigation of Community Controlled Programs in the 1970s. When I took a health worker overseas with me, she could not believe her eyes when she saw 'dark-skinned' people taking charge in all areas at the airports in countries we touched down in. I said that I would like to encourage as many people as I could to travel overseas to experience the lack of oppression in many settings, and release them from the thought of bondage of an inferior self. The very essence of these programs will be working in collaboration with the younger generation to set themselves up as parents and inform their children about health care and steps to take when caring for their families. Past graduates are encouraging their children and grandchildren to enrol in MMF programs.

Positive Effect for Aboriginal Health

To sum up how Marr Mooditj graduates have fared:

Graduation numbers since 1984	756
Those still in employment in 2010	585
% Working in the health field	60%
% Working in other professions	30%
% Retired Grand Mothers and Fathers	10%
Some have passed on.	

Some areas of employment of our graduates:

- Aboriginal Education Officers
- Aboriginal Liaison Officers
- General Practitioner
- Registered General Nurses
- University Lecturer

- Enrolled nurses
- Community Development Workers
- Health Research Officer
- Aboriginal Health Workers in the industry of:
 - Home and Community Care
 - Aged Care
 - Community Service.

The Director, Margaret Quartermaine, can be proud of the leadership she has shown over the past decade in leading staff and students in their development as a successful education college. Over the past thirty years Marr Mooditj has made a positive contribution to the improvement of Aboriginal health in the community. Parents are now better informed and better equipped to advise their children in important life skills. MMF can be proud of their record of turning the tide of ill health for our people. However, this is not a time for Marr Mooditj to rest on its laurels, as new problems are always on the horizon to be solved.

Appendix A

Responses from Marr Mooditj Graduates to Questionnaire conducted in September 2010

The Questionnaire

History of Marr Mooditj College

To past graduates or participants at Marr Mooditj College:

I am writing up a history of Marr Mooditj and am researching ‘Where are they now?’ I would like to know how Marr Mooditj affected your life as a person, family member, work colleague and Aboriginal. If you could spend a little time to write a brief outline – be it positive or negative, I would be most grateful.

- *What qualifications did you have prior to attending the college?*
- *Did Marr Mooditj help you into upgrading your qualifications to higher education in your chosen career or family life? Write a few words.*
- *Did the MMF program have any effect on your approach to family life?*
- *In what other areas of education have you attempted since graduation?*
- *Are you working now? If so, in what position?*
- *Write a brief paragraph of what changes you would make to the program, when you think about where you are now.*

Responses from Graduates

1. Margaret Shaw Quartermaine

Before attending I had:
Certificate IV Nursing
Certificate III Child Care
Hospitality Cert

Marr Mooditj helped me to progress with my education because it had the natural learning atmosphere and it was fun to learn, which help me with my emotional and social wellness.

Marr Mooditj gave the courage and boost I needed to find my own confidence in stepping out of my comfort zone and building onto my education portfolio I went on to Aboriginal Health Work and dabbled in Management, which I found I loved mostly as you need to work with people at all levels and constantly.

Because of my state of wellness in being a part of the College, my passion and enthusiasm rubbed off on my family at home, which created and happy and healthier family environment.

I currently have continued to developed my skills and knowledge in the Management area and was appointed the Directorship in 2000 and currently still in the seat working with the Management Committee.

The Program at the college now is no longer an accredited course, which means it comes from a training package which does lack the resources and recognition to cater to some student learning needs, such as language, literacy and numeracy skills.

These are expected to be 'picked up' along the way. It is even a challenge to understand the language used in the training packages and then to interpret and implement that in the training requires a lot of resources and time to ensure we maintain our quality.

I would secure additional funding that is sustainable over the next 5 years around these issues to meet learning needs of our Aboriginal students and produce secure results to see what really does work well.

2. Jennifer Garlett

After leaving school, I worked with my own family in the community. At home I became a carer for my mother after she had a stroke, my brother with cancer, and my husband with chronic diseases.

Learning what to do at Marr Mooditj was a great help to me with caring and gave me more faith in myself when caring for them.

Now that my children have grown older, I have the time to put into myself. Since I started at MMF, I have completed a 2-week Hospitality Course and take a pride in achieving other programs.

The MMF program has made me take a positive approach, which makes me happier and less stressed with life.

I'm still studying and looking forward to learning more about the program as it's very interesting and I've learned a lot about Aboriginal Health.

3. Rachel Humphries

I completed Year Nine at school, and after graduating from MMF, I spent 15 years in the workforce contributing to improving Aboriginal Health.

My work has been in the preventative field of Diabetes and Chronic Diseases.

Because I did the program, I was able to care for Dad at home, before he died. This also applied to Mum and other family members.

The changes I would like to see are less paper work and more 'hands on' education.

4. Vanessa Riley

Prior to attending MMF, I attended TAFE and completed a 'Mature Age' program.

The Course brought me closer to my family and I had a better understanding about what I could do to help them.

Since completing the Health Worker Course, I have worked at assessing people for health problems.

The 'book learning' gave me a better understanding to help my family.

I am still studying as a student at MMF. I would like to learn more about 'diabetes' and other things in the families and communities.

5. Debbie Cherry

I completed High school and did other jobs in the meantime, like caring for children with special needs.

Previously, I tried to do a Health worker course at TAFE in Mandurah, but due to small numbers, they had to stop running the class. After that I phoned MMF and was accepted.

I completed my Cert 3 in 2009 in Aboriginal and Torres Strait Primary Health Care and won the 'Pat Giles Most Outstanding Student of the Year' award.

Since graduating, I have worked as an Aboriginal Health Worker at South Coastal Women's Health in Rockingham and now am currently working as an Aboriginal Health Worker at 'Nidgalla Waangan Mia' Health Care in Mandurah.

Marr Mooditj has been one of the best things I've done for myself and my family.

One of the things I have found with MMF lecturers is that they explain very clearly and if you don't understand the issues, they keep going and take the time out until you understand it.

I am now working in the new Aboriginal Health Centre 'Nidgalla Waangan Mia'.

In the two week Blocks, MMF crams in a lot of information, and we have to work harder and faster, and there is a lot of pressure.

I would like to see the Blocks to last 3 weeks instead of two weeks due to the above. But having said this, the lecturers warn us at the beginning that in the two-week Blocks we have to cover a lot of ground. They give us this warning.

I would recommend MMF to anybody who wants to study Aboriginal and Torres Strait Islander Health.

6. Jane Jones

Dip. P.H. & T.M (James Cook), B.App.Sc.(Curtin), (Nursing) (R.N).

I was working at the Health Department as an Enrolled Nurse.

Marr Mooditj helped me to upgrade my qualifications to achieve the Advanced Certificate in Aboriginal Health Work. This led me to enrol at James Cook University and complete a Diploma in Public Health Tropical Medicine.

I have qualified with a B. App. Sc. at Curtin University, Bentley Campus, W.A.

I learned more about Cultural Awareness and the Marr Mooditj Program was a great supportive environment for students.

I am now working at Derbarl Yerrigan Health Services, which has a holistic health care network, which develops, promotes and maintains Aboriginal and Torres Strait Island peoples' physical, spiritual, social, emotional, economic and cultural wellbeing.

Support was given in the Mentoring Program also with Social as well as Academic support with tutoring and general literature search – library and I.T. Computer information Support.

Marr Mooditj is a great program in this community to support students to achieve qualifications to work in Aboriginal health.

7. Rod Carpio

I'm of Aboriginal descent and currently completing a Diploma in Enrolled Nursing at MMF. Prior to this I studied at MMF as an Aboriginal Health Worker.

On completion, I worked for the far North Aboriginal Medical Services in Western Australia and the Western Australian Health Department in primary health care.

Among my other positions have been: 'Mortuary Technician Assistant', SRAMW Manager, and Aboriginal Health Worker.

I have always wanted to do this and Marr Mooditj has presented me with the opportunity. I know that, as an Aboriginal male nurse, I am making a difference to my people. Marr Mooditj has enabled this to happen.

8. Robert Indich

I am currently employed as the AQTF Manager.

Before attending Marr Mooditj I had a Certificate III & IV in Cookery.

After completing my prior qualifications I had begun working as a kitchen hand in a few services around Perth for a couple of years. Whilst working I decided to enrol into a course that I had an interest in for many years, and enrolled into the Certificate III in Mental Health Work (Non-clinical) at Marr Mooditj.

Since graduating in the mental health field I have studied the Aboriginal Primary Health Care course and graduated through the pathway that was offered.

The MMF Program gave me greater insight into Aboriginal Health and how the past had affected the community and my family. So the effect it gave me was that I wanted to empower my own family members.

If there were more positions available for Aboriginal Mental Health or Primary Health Care workers, then one of the changes I would make is for the course to be traineeship based.

9. Christine Clinch

Before attending Marr Mooditj I just had a High School Certificate.

I was enrolled into Curtin University Bridging Course after the completion of my Health Worker Training. I did not finish the Bridging Course as I fell pregnant. This was my first introduction to university life, and although I didn't complete the Bridging course, I knew that I wanted to attend university at a later stage in my life.

I went on to the University of Western Australia, and successfully completed a medical degree (Bachelor of Medicine and Bachelor of Surgery MBBS). Prior to this I completed a Diploma in Public Health and Tropical Medicine at James Cook University.

One of the reasons I wanted to do the Aboriginal Health Worker course was because I was a young mum at the time and I wanted to do something positive for myself and my son and my community.

I'm a Lecturer at University of WA. This is a short term contract with the university. Prior to this position I was working as a medical officer/doctor at Sir Charles Gairdner Hospital.

There isn't a whole lot that I would change about the programme, but if a student is identified during the course to potentially go on to further education (university etc), then it would be good to encourage these ones to go on to further study.

10. Cheryl Phillips

Before attending Marr Mooditj I had a High School Certificate. The qualification I gained before attending MMF was the Nursing Aide Certificate, now known as Enrolled Nursing training.

Having gained my nurse's training, I nursed in country hospitals for some years. I then went on to trying my hand at other types of work, ending up in Geraldton as my oldest sister was working as the director of the Geraldton Regional Aboriginal Medical Service. GRAMS at the time needed a transport driver immediately and I happened to be around at the time. I was asked to drive and from that time on I officially became an employee at GRAMS.

Although I had my nurse's certificate it was not enough to work in the community as I was trained to treat people, not deal with other issues that affected people in everyday life. Another Sister and I applied to MMF to do the AHW training in order to get trained up to work at GRAMS.

The training I received at MMF helped me to gain insight on how to work with people in the community dealing with issues that affected them daily hence all AMS's Statement was to work in a holistic way of working and meeting the needs for Aboriginal people in the communities.

The effects of doing the AHW training had on my family was a positive one as we made improvements in the home and with family members on how they approached their illnesses without fear.

I attended Curtin University, studying for 3 years, and on completion received a Bachelor of Applied Science degree in Indigenous Community Health.

I am currently an Associate Lecturer at the Centre of Aboriginal Studies and am enjoying the work and lecturing students from all over Australia.

The program would not need any changes as it was developed appropriately for Indigenous students and being Aboriginal and have knowledge of my experiences in Aboriginal health I am hoping it holds me in good stead as a lecturer

11. Lorraine Morrison

In my early adolescent years I wanted to become a nurse. I dreamt of being able to help people who were in hospital. This never eventuated to anything and became a distant dream that I believe would not go anywhere. Years later the yearning to be a nurse was still etched in my soul, but with not enough education and 6 children this was really just a pipe dream. I settled in believing I would never be able to achieve my dream.

I heard about the Aboriginal Health Workers Course. This course was designed for people wanting to enter into the health sector to become health professionals in their own right. The course offered the individual the chance to fulfil their dream and not be restricted to just clinical but to expand the horizon to holistic health. This was made achievable the day I met Sister Joan Winch and Sister Liz Grey. I was accepted into the course and commence my journey to become an Aboriginal Health Worker; this was a privilege and an honour to be taught by 2 of the most amazing people. These strong women were inspirational, their support, guidance and genuine empathy to their students to achieve made learning an enjoyable experience.

After graduating as an Aboriginal Health Worker, now with 7 children, I have had the opportunity of working in a number of different roles, but have always come back to the health arena. With each experience, my achievements are attributed to Sister Joan Winch and how she worked hard to empower Aboriginal people. I have a Bachelor degree and have commenced my Masters in Public Health, and am employed as a senior project officer within health promotion.

Without Sister Joan Winch, her values and strength of her vision, so many of us would have been forgotten. We would have been just another statistic with no vision of our own. There are no words that can express the gratitude for Sister Joan Winch, of the amazing person she is, of the strength and wisdom she had displayed over the years even through her own times of sadness.

I had the dream, Sister Joan Winch showed me the vision.
I had the mouth, Sister Joan Winch showed me how to put words in context.
I had the intelligence, Sister Joan Winch showed me how to put thoughts into practice.
Sister Joan Winch had faith in me, in turn I had faith in myself.

I have been very fortunate, having the opportunity of working in remote health services in the Kimberley and in urban settings. I have witnessed firsthand the resilience and strength of Aboriginal people, the constant struggle, oppression, racism, inequality faced by Aboriginal people and their determination to survive though government intervention, dictatorship and constant disempowerment. Although there has been some improvements over the years Aboriginal life expectancy remains around 17 years less than that of non-Aboriginal people,

this will continue until the government recognise the strength and determination of people like Sister Joan Winch.

I admired Sister Joan Winch and have strived to work in her steps. The funding bodies and sad to say some of our Aboriginal people have no empathy or understanding of Aboriginal people's constant struggle for improvement and have made decisions that has negative impacts on the health and wellbeing of Aboriginal people.

Thank you Sister Joan Winch, one day more people will recognise you for the amazing person you are, they will listen to your advice and will strive to alleviate social inequalities and achieve equality for Aboriginal people.

12. Sophie Hills

For Bob

Sophie Hills

I had always worked in shearing teams or in vineyards training vines since the age of 16. My father passed away when I was 13 years of age therefore I was forced to leave school at a young age to help my Mum pay for debts that my Dad had left behind, as she started to get depressed.

My schooling had always been a negative experience as I was always told that I was dumb and the teacher would encourage me to go and get a book from the shelf and read it as I had trouble understanding the subjects. I look at the positive side of this as I am now an excellent speller and a fluent reader.

I remember working in the vineyard one day and it was 42 degrees, someone mentioned to me that a new health service was being established in Albany and that they were looking for 2 trainee health workers. I laughed at this person saying that I would never be able to do something like that. They said to me that I should give it a go, even if I applied for the position at least I would be giving it a go.

Needless to say I attended the interview and received a telephone call saying that I had the position, much to my shock and amazement.

When I started my job as a Trainee Health Worker I was informed that I will have to go to Perth and study at this place called Marr Mooditj Foundation. I almost chucked my job in the first week as I became extremely anxious about having to go back into a classroom. I was informed that the other trainee that started at the same time as me would also be attending. I decided to give it go; at least I would know someone else in the classroom.

I did not have any qualifications when I went to study at Marr Mooditj, so I did not know what to expect, I remember feeling really scared on the first day of going to class. Fortunately, all of the educators were very understanding about my schooling experience. They encouraged all of us students, I thought to myself, I want to be just like them and do something with my life and finally get a qualification.

The 2 years I spent at Marr Mooditj I went through profound changes, both personally and socially. I became over time confident in the area of health which showed in my work. I really took my study seriously and spent many hours doing my assignments, keeping Joan Winch and Margaret Quartermaine in my sight as my role models, I wanted to be just like them.

I also used my knowledge at home with my family and extended family and soon became the person that everybody came to for advice for all kinds of problems and ailments. I also had clients coming to my home after hours for advice and support. This empowered me even more and also gave me the drive to further my knowledge in the area of health. My confidence and self esteem grew greatly and over the years I started to step out of my comfort zone.

When I graduated from Marr Mooditj Foundation I was awarded the Telethon Institute Award in Child Health Education, I felt so proud that day and I remember trying to fight back the tears of joy, as I was always told that I was dumb. I also wished as I stood up on the podium that my old teachers were here to see me, they would have to take their words back.

Appendix B

**Letter from Professor Arthur Kaufman,
Director of Family Medicine, University of New Mexico
September 10, 1984**



The University of Western Australia

Department of Community Practice
328 Stirling Highway
Claremont, Western Australia 6010
Telephone 384 8188 ext. 219, 211

10th September, 1984

Mr. Dean Collard,
President, Aboriginal Medical Service,
154 Edward Street,
EAST PERTH, 6000. W.A.

Dear Mr. Collard,

I wanted to take this opportunity to thank you, the Council, the staff, nurses and doctors at Perth AMS for allowing me to participate in and learn from your programmes. I also wanted to summarize my impressions before I left to return to the United States.

I have spent the past five months in Western Australia working with the University of Western Australia (Department of Community Practice) on community oriented medical education. I did this work under the auspices of the Australia-United States Educational Foundation as a Fulbright Senior Scholar. Part of my task was to develop strategies for increasing the interest of medical students in working with Aboriginal people. Perth AMS has been my greatest ally and best teacher.

In pursuit of my goal, I have travelled throughout Western Australia, visited a variety of communities and spoken with a broad spectrum of people. These visits included Perth, Geraldton, Port Hedland, Roebourne, Broome, La Grange, Derby, Mount Newman and Jigalong. I also visited the Redfern Clinic in Sydney and an Aboriginal community organization in Albury, N.S.W. I discovered that Perth AMS is a model for many communities. For example, in Geraldton I was told the AMS has reorganized much of their programme after visiting Perth's programme.

I reviewed the new Aboriginal Health Worker programme curriculum and compared it with those in the Victoria and Broome courses. I found the Perth effort an exciting start which incorporates practical, relevant objectives. It also is sensitive to how graduates apply their new skills in the communities and is making curriculum adjustments for the upcoming class accordingly. It is surprising how well the first year effort went. I heard much praise from the staff at Geraldton and Broome about their Perth AMS students doing their practical field-work attachments.

Perth AMS clinic has also accepted many fourth year medical students from UWA on month long attachments. This has consistently been rated as one of the best clinical attachments by students. The staff at AMS

2/.

show a real caring about the students and realize that in order to break down prejudice and ignorance people need to work together cooperatively. Many students' attitudes have changed for the better because of the experience and some now show an interest in joining AMS as a career.

Perth AMS has extended itself as teachers to the University in other ways. For example, Joan Winch and Josie Boyles were invited by the Department to help prepare sixth year medical students for their month long attachment to rural communities. Most of these communities have substantial Aboriginal populations. Joan and Josie spoke with the 14 students, three of their faculty and the education coordinator in a big round circle. They created a wonderful, relaxed atmosphere as they advised students about how to become accepted in the Aboriginal community. What subjects should and should not be discussed, how to pronounce certain Aboriginal words. They gave each student a book "Working with Aborigines in Remote Areas" by de Hoog and Sherwood. It is an excellent work which (we subsequently discovered) students used extensively during their rural attachments - sharing the information with other health workers. Students enjoyed Joan and Josie's session and stayed afterwards to ask more questions. A number said it had been the first time they had ever spoken with or met an Aborigine on a socially equal basis.

Finally, I cannot tell you how much I was struck by the enormity of the health care task Perth AMS is tackling. I spent one day for example with Shirley Humphries the Perth AMS field-nurse. We made home-visits and held curb-side clinics in many Aboriginal communities in the mobile clinic caravan. Not only were the health problems severe and complex, (e.g. sex assault on a child, severe urinary incontinence, neglected post-operative wound infection), but in a number of cases other health services had refused to make home-visits.

It is within the community that preventive health services must occur, the Perth AMS is severely short-staffed for the enormous task with which they must contend. There is really no viable alternative service to AMS, no service which would be so readily acceptable to the Aboriginal community. It is critical therefore, that greater funding support for this excellent front-line service be obtained. Perth AMS is not only a health resource for the Aboriginal community, but an educational resource for the State as a whole.

I am enclosing an article I wrote for the "Aboriginal Health Worker" which will appear in December. Thank you again.

Sincerely,



Professor Arthur KAUFMAN,
Director, Family Medicine,
University of New Mexico,
Fulbright Senior Scholar.

30th September, 1986

When Professor Arthur Kaufman visited Western Australia in 1985 he rode around with one of our Community Nurses in the Mobile Clinic which was the brain-child of Joan Winch.

In a private letter to Doctor Douglas MacAdam of W.A. University he wrote:-

"I got so turned on by the efficiency and range of that mobile van that visited Aboriginal campsites around Perth that we built the concept into our recently begun project, giving health care to homeless people in Albuquerque. "

He finishes the letter by sending regards to Joan and asking that she be informed of the influence she has had in the health care field in New Mexico and adds '
"..It's important that they know their work is influencing others abroad, including health care for urban Indian people in the U.S.A."

Professor Kaufman is from the University of New Mexico School of Medicine.

Appendix C

**Letter from Professor Robert Staples,
School of Nursing, University of California
June 17, 1986**

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

SCHOOL OF NURSING
DEPARTMENT OF SOCIAL AND BEHAVIORAL SCIENCES
N-631-Y

SAN FRANCISCO, CALIFORNIA 94143

June 17, 1986

Mr. Dean Collard, President
Aboriginal Medical Service
154 Edward Street
East Perth, Western Australia 6000
AUSTRALIA

Dear Mr. Collard:

During my recent visit to Australia as a Visiting Fellow at the Institute of Family Studies in Melbourne, I had the opportunity to visit Perth and observe the Health Worker Education Program under the supervision of Sister Joan Winch. During my week in Perth, 9 March to 16 March 1986, I was present at a graduation ceremony of the Health Worker Education Program, toured their offices in the Aboriginal Medical Service and visited the site of their proposed college. I also discussed the HWEP with various scholars and health personnel throughout Australia and found a positive response to it.

The HWEP is not only an important element in the health care of Aboriginal people but an essential component in dealing with the health needs and problems of that group. As a medical sociologist at one of the leading medical centers in the United States, I am aware of research that shows that health problems reflect a combination of physiological, cultural, psychological, sociological and economic factors. As you are well aware, Australian Aborigines have much higher mortality and morbidity rates than do their white counterparts. Obviously, different and special attention and resources must be mobilized to address their unique health concerns. The HWEP does that by its training of Aboriginal people as health workers in their own community. Their utilization as health workers is designed to cope with the patient's immediate health needs by a person familiar with their cultural values and lifestyles. Moreover, the HWEP's emphasis on preventive measures requires a person who has credibility and recognition in a community that, until recent years, has experienced less than sensitive treatment from the white Australian health system. Not only does the current HWEP deserve your sustained support but its expansion should be adequately funded in order to permit its valuable work to continue. I am particularly impressed with their plans for an Aboriginal health college to be located on a separate site. It deserves serious consideration as it will allow Sr. Joan Winch and her well-trained, dedicated staff to develop the health workers and programs the Aboriginal community sorely needs. Obviously, innovative and different measures are needed to deal with the appalling health conditions of Australia's indigenous peoples. The HWEP is an idea whose time has come. I recommend it without reservation.

Sincerely,

Robert Staples
Robert Staples, Ph.D.
Professor of Sociology

Bibliography

- Abbie, A. 1970. *The Original Australians*. Sydney: Muller.
- Aboriginal Alcohol & Drug Service (Inc). 2007. *2006-2007 Annual Report*.
www.aads.org.au/downloads/reports/AADSAnnualReport0607.pdf
(accessed August 12, 2010).
- Aboriginal Medical Service (WA). 1974. *Aboriginal medical services annual reports*. Online Google Books.
- Adams, F. 1975. *Unearthing Seeds of Fire*. Salem, NC: Blair Adult Learning Styles
- Albany Advertiser. 2003. 1888-2003: 115 years of news. *Albany Advertiser*, 8 June 1888.
- Alver, B. G. 1991. The bearing of folk belief on cure and healing. In *The XIV World Health Conference on Health Education*. Helsinki, Finland.
- Andrews, M. 2004. *The seven sisters of the Pleiades: Stories from around the world*. North Melbourne: Spinifex Press.
- Angell, D. 2010. *Vivian Bullwinkel: Survivor of the Bangka Island massacre*.
<http://www.angellpro.com.au/Bullwinkel.htm#Massacre> (accessed 25 October 2010).
- Austen, T. 1998. *A cry in the wind: Conflict in Western Australia 1829-1929*.
Darlington: Darlington Publishing Group.
- Austin, P. 1988. Aboriginal languages of the Gascoyne-Ashburton region. *La Trobe University Working Papers in Linguistics* 1: 43-63.
- Australian Institute of Health and Welfare. 2008. *The health and welfare of Aboriginal people 2008*. Canberra: Australian Government Printing.
- Australian State of the Environment Committee. 2001. *Australia State of the Environment 2001: Independent Report to the Commonwealth Minister for Environment and Heritage*. Canberra: CSIRO.
- Bandler, F. 1989. *Turning the tide: A personal history of the federal council for the advancement of Aborigines and Torres Strait Islanders*. Canberra: Aboriginal Studies Press.

- Barr, A., T. Knight, M. Andrews, V. Alexander, and Aboriginal Communities of the Northern Territory of Australia. 1988. *Traditional bush medicines: An Aboriginal pharmacopoeia: Aboriginal communities of the Northern Territory of Australia*. Richmond: Greenhouse Publications.
- Bates, D. 1985. *The native tribes of Western Australia*. Canberra: National Library of Australia.
- Batt, A. 1992. *Aboriginal health workers: A guide to resources for education and training*. Perth: A. Batt.
- Berndt, R. M., ed. 1970. *Australian Aboriginal anthropology: Modern studies in the social anthropology of the Australian Aborigines*. Nedlands: Australian Institute of Aboriginal Studies, UWA Press.
- Berndt, R. M., and C. H. Berndt. 1988. *The world of the first Australians: Aboriginal traditional life, past and present*. 5th ed. Canberra: Aboriginal Studies Press for the Australian Institute of Aboriginal Studies.
- Berndt, R. M., and C. H. Berndt. 1980. *Aborigines of the west: Their past and their present*. 2nd ed. Perth: University of Western Australia Press.
- Bibring, E. 1953. The mechanism of depression. In *Affective disorders: Psychoanalytic contributions to their study*, ed. P. Greenacre, 13-48. New York: International University Press.
- Bolton, G. C. 2008. *Land of vision and mirage: Western Australia since 1826*. Perth: University of Western Australia Press.
- Brink, P., and J. Saunders. 1976. Culture shock: Theoretical and applied. In *Transcultural Nursing*, ed. P. Brink, XI-XV, 11-12. New Jersey: Prentice-Hall.
- Briscoe, G. 1978. Aboriginal health and land rights. *New doctor* (8): 13-15.
- Briscoe, N., and N. Thompson. 1986. Overview of Aboriginal health status in Western Australia. In *Australian Institute of Health Aboriginal and Torres Strait Islander health series No.1.*, ed. P. Karmel. Canberra: Australian Government Publishing Service.
- Brown, G. W., and T. Harris. 1978. *Social origins of depression: A study of psychiatric disorder in women*. New York: The Free Press, A division of Macmillan Publishing Co., Inc.

- Bullock, A., O. Stallybrass, and S. Trombley. 1988. In *The Fontana dictionary of modern thought*. London: Fontana Press
- Carter, B. 2006. *Nyungah land: Records of invasion and theft of Aboriginal land on the Swan River 1829-1850*. Guildford: Swan Valley Nyungah Community.
- Congress of Aboriginal and Torres Strait Islander Nurses. 2009. *16-18 September: 11th National Conference*. Melbourne: Australian Indigenous Health InfoNet.
- Coombs, H. C. 1983. *A certain heritage: Programs for and by Aboriginal families in Australia*. Canberra: Australian National University Press.
- Cornell, S., and J. Kalt. 2009. *Sovereignty challenges in Indian country today*. <http://www.ksg.harvard.edu/hpaied/overview> (accessed 28 October).
- Couzos, S., and R. Murray. 2003. *Aboriginal primary health care: An evidence-based approach*. 2nd ed. South Melbourne: Oxford University Press for the Kimberley Aboriginal Medical Services' Council.
- Cowlishaw, G. 1978. *Family planning: A post-contact problem*. St Lucia: University of Queensland Press.
- Crabtree, B., and W. Miller, eds. 1999. *Doing qualitative research*. 2nd ed. Thousand Oaks, California: Sage Publications.
- Crawford, F. 1989. *Jalindari ways: Whitefellas working in Aboriginal communities*. Perth: Centre for Aboriginal Studies and the School of Social Work, Curtin University of Technology.
- Crowley, D. 1970. Adult education provisions for special groups. In *Adult Education in Australia*, ed. D. Whitlock. Sydney: Pergamon Press.
- Cunningham, I., and D. Saunders. 2005. *Land of the flowers: An Australian environment on the brink*. 2nd ed: Australian Oxford Press.
- Curthoys, A. and J. Docker. 2001. Introduction - Genocide: Definitions, questions, settler-colonies. *Aboriginal History Journal*. Special section: 'Genocide?': Australian Aboriginal history in international perspective.
- De Garis, B. K. 1993. *Portraits of the south west: Aborigines, women and the environment*. Perth: University of Western Australia Press.
- Denzin, N. 1989. *Interpretive interactionism*. Newbury Park, California: Sage.

- Department of Aboriginal Affairs. 2002. A brief history of Aboriginal affairs in Western Australia, ed. Dept. of Aboriginal Affairs. Library Information Paper. Perth: Legislative Council of Western Australia.
- Derbarl Yerrigan Health Service. 1999. *Annual report*. Perth: The Service.
- , 1999. *Annual report 1999-2000*. Perth: DYHS.
- Derrida, J. 1982. *Margins of philosophy*. Chicago: University of Chicago Press.
- Dick, C., and R. Osborne. 1994. *Aboriginal terms of reference (ATR) and its importance to the educative process*. Bentley: Centre for Aboriginal Studies, Curtin University of Technology.
- Dodson, P. 1991. RCIADIC: Regional report of inquiry into underlying issues in Western Australia.
http://www.austlii.edu.au/au/other/IndigLRes/rciadic/regional/wa_underlying/index.html (accessed 16 August 2010).
- Durkheim, E. 1964. *The division of labour in society*: Glencoe II: Free Press.
- Eckermann, A., T. Dowd, M. Martin, L. Nixon, R. Gray, and E. Chong. 1992. *Binan goonj: Bridging cultures in Aboriginal health*. Armidale: University of New England Press.
- Farr, W. 1859. *Method of comparing the local rates of mortality with the standard rate*. London.
- Fish, S. 1980. *Is there a text in this class? The authority of interpretive communities*. Cambridge, Massachusetts: Harvard University Press.
- Foley, D. 2003. Indigenous epistemology and Indigenous standpoint theory. *Social Alternatives* 22 (1): 44-52.
- Foucault, M. 1970. *The order of things: An archaeology of the human sciences*. London: Routledge.
- Franklin, M. A., and I. White. 1991. *The history of politics of Aboriginal health*. eds. J. Reid., P. Trompf. Sydney: Harecourt Brace Jovanich.
- Gale, F., J. Binnion, and Australian Commission of Inquiry into Poverty. 1975. *Poverty among Aboriginal families in Adelaide*. Adelaide: AGPS.
- Genat, W. 2001. Beyond the clinic, beyond the rhetoric: Holistic Aboriginal health worker practice at the margins. PhD thesis, University of Western Australia.
- Giddens, A. 1972. *Politics and sociology in the thought of Max Weber*. London: Macmillan.

- Goold, S. 2005. *In our own right: Black Australian nurses' stories*. Maleny: eContent Management.
- Gove, W. R., and J. F. Tudor. 1973. Adult sex roles and mental illness. *American Journal of Sociology* 78 (4): 812-835.
<http://www.jstor.org/stable/2776605> (accessed February 3, 2010).
- Green, N. 1984. *Broken spears: Aborigines and Europeans in the southwest of Australia*. Cottesloe: Focus Education Services.
- . 1995. *The Forrest River massacres*. South Fremantle: Fremantle Arts Centre Press.
- Gregory, J., and J. Gothard, eds. Aboriginal education: Perth Inquirer 1842. *Historical Encyclopaedia of Western Australia*. Nedlands: University of Western Australia Press.
- Gribble, Rev J. B. 1987. *Dark Deeds in a Sunny Land, or 'Blacks and Whites in North West Australia*. Nedlands, WA: University of Western Australia Press ; Mt. Lawley, WA: Institute of Applied Aboriginal Studies, Western Australian College of Advanced Education.
- Haebich, A. 1988. *For their own good*. Perth: University of Western Australia Press.
- Hage, G. 1998. *White nation*. Sydney: Pluto Press.
- Hall, S. 1997. *Representation: Cultural representations and signifying practices*. London: Sage Publications Ltd.
- Hartmann, H. 1958. Ego psychology and the problem of adaptation. *New Doctor* 8: 24.
- Hasluck, P. 1942. *Black Australians*. Melbourne: Melbourne University Press.
- . 1988. *Shades of darkness: Aboriginal affairs 1925-1965*. Melbourne: Melbourne University.
- Hawe, P. 1994. Capturing the meaning of 'community' in community intervention evaluation: Some contributions from community psychology. *Health Promotion International* 9 (3): 199-208.
- Heaney, T. 1995. *Issues of Freirean pedagogy*.
http://nlu.nl.edu/academics/cas/ace/Facultypapers/ThomasHeaney_Freirean.cfm (accessed 18 October 2010).
- Hollinsworth, D. 1992. Discourses on Aboriginality and the politics of identity in urban Australia. *Oceania* 63 (2): 137-155.

- Host, J., C. Owen and SWALSC. 2009. *"It's still in my heart, this is my Country": The Single Noongar Claim History*. Perth: UWA Press.
- Howard, M. C. 1981. *Aboriginal politics in southwestern Australia*. Nedlands: University of Western Australia Press.
- Hughes, R. 1988. *The fatal shore: A history of the transportation of convicts to Australia 1787-1868*. 2nd ed. New York: Vintage Books
- Hugo, V. 2005. *The history of crime*. London: Mondial. Original edition, 1877.
- Hutchison, D. E. 1969. *Aboriginal progress: A new era?* Perth: University of Western Australia Press.
- Ingerman, S. 1991. *Soul retrieval: Mending the fragmented self*. San Francisco: Harper Collins.
- Jebb, M. A. 1984. The Lock hospitals experiment: Europeans, Aborigines and venereal disease. In *European-Aboriginal relations in Western Australian history*, ed. B. Reece and T. Stannage. Nedlands: University of Western Australia Press.
- Katz, F. M., and R. Snow. 1980. Assessing health worker performance: A manual for training and supervision. *World Health Organisation PHP* (72):
- Kearins, J. 1986. *Child rearing practices in Australia: Variation with life-style*. Perth: Education Department of Western Australia
- Kelsall, R. K., H. M. Kelsall, and L. Chisholm. 1974. *Stratification: An essay on class and inequality*: Longman.
- Leaming, J. 1986. *"Nearly White": Assimilation policies in practice in Western Australia at Sister Kate's Children's Home from 1933 to 1964*: University of Western Australia Press.
- Lewin, G. 1991. *Former students of Marr Mooditj: A descriptive study*: University of Western Australia Press.
- Lifton, W. M., and D. G. Zimpfer. 1972. *Groups: Facilitating individual growth and societal change*. New York: John Wiley & Sons.
- Lincoln, Y. S., and E. G. Guba. 1985. *Naturalistic inquiry*. Newbury Park, California: Sage Publications.
- Lofgren, M. E. 1975. *Patterns of life*. Perth: Museum of Western Australia
- Lubout, J., J. Smythe, K. Craft, J. Moore, A. Leslie, and J. Winch. 1978. Health and medical care in China. *Australian Nurses Journal* 8 (1): 50-53.

- Lyman, K. 1961. *Basic nursing education programmes: A guide to their planning*. Geneva: World Health Organisation.
- Liotard, J. F. 1988. *The Differend: Phrases in dispute*. Minneapolis: University of Minnesota Press.
- Mackie, R., ed. 1980. *Literacy and revolution: The pedagogy of Paulo Freire*. London: Pluto Press.
- Mahler, H. 1981. The meaning of "health for all by the year 2000". *World Health Forum* 2 (1): 5-22.
- Marr Mooditj Training Inc. 2009. *Annual Report 1991-2002*.
- McGuire, A., J. Henderson, and G. Mooney. 1988. *The economics of health care: an introductory text*. London: Routledge.
- McKeich, P. 1999. *Teaching approaches in adult indigenous higher education at the Centre for Aboriginal Studies Curtin University of Technology*. Masters of Professional Education & Training, Deakin University, Victoria.
- Meyer, M. 2001. Our own liberation: Reflections on Hawaiian epistemology. *The Contemporary Pacific* 13 (1): 124-148.
- Moodie, R. 1989. The politics of evaluating Aboriginal health services. *Community Health Studies* 13 (4): 503-509.
- Mooney, G., V. L. Wiseman, and S. Jan. 1998. How much should we be spending on health services for Aboriginal and Torres Strait Islander people? *Medical Journal of Australia* 169 (10): 508-509.
- Moore, B. 1972. *Reflections on the causes of human misery and upon certain proposals to eliminate them*. Boston: Beacon Press.
- Moorehead, A. 1966. *The fatal impact: The invasion of the South Pacific, 1767-1840*. Melbourne: Hamish Hamilton.
- Morgan, S., ed. 2002. *Echoes of the past: Sister Kate's home revisited, Project Officer: Tjalaminu, Mia*. Nedlands: University of Western Australia Press.
- Morse, J. M. 1994. *Critical issues in qualitative research methods*. Thousand Oakes, California: Sage Publications.
- National Aboriginal Community Controlled Health Organization (NACCHO). 2009. NACCHO Media Release. In *The WAMS Blog*. Walgett Aboriginal Medical Service Co-operative Ltd.

- Neidjie, B., S. Davis, and A. Fox. 1985. *Kakadu man*. Queanbeyan: Mybrood
- O'Connor, R. 2001. *Aboriginal heritage in Cockburn Sound*. Perth: Cockburn Sound Management Council.
- Omeri, A., and K. Atkins. 2002. Lived experiences of immigrant nurses in New South Wales, Australia: Searching for meaning. *International Journal of Nursing Studies* 39 (5): 495-505.
- Oxenham, D., and R. Walker. 1999. *Aboriginal Terms of Reference: The concept at the centre for Aboriginal study*. Discussion Paper. Bentley: Curtin Indigenous Research Centre.
- Parsons, T. 1954. The present position and prospects of systematic theory in sociology. *Essays in Sociological Theory*: 212–37.
- Paul, D. 1998. Colonial legacies: Aboriginal health status: historical and contemporary constraints to improvement. Unpublished Honours Bachelor of Policy Studies, Murdoch University.
- Randall, B. 2005. *Kanyini*. Film. Melbourne: Roadshow Entertainment.
- Reid, J., and P. Trompf, eds. 1991. *The health of Aboriginal Australia*. Sydney: Harcourt.
- Reynolds, H. 1982. *The other side of the frontier*. Ringwood: Penguin, Australia
- , 2000. *Why weren't we told?: A personal search for the truth about our history*. 2nd ed: Penguin Books.
- Rigney, L. 1997. *Internationalisation of an Indigenous anti-colonial cultural critique of research methodologies. A guide to Indigenist research methodology and its principles*. Adelaide: Aboriginal Research Institute University of South Australia.
- , 1999. The first perspective: Culturally safe research practices on or with indigenous peoples. In *Chacmool Conference Proceedings*. University of Calgary, Alberta, Canada.
- Rowse, T. 1991. ATSIC's heritage: The problems of leadership and unity in Aboriginal political culture. *Current Affairs Bulletin* 67 (8): 4-12.
- Russell-Mundine, G. 2007. Key factors for the successful development of Australian Indigenous entrepreneurship. *Tourism: An Interdisciplinary Journal* 55 (4): 412-429.

- Saggers, S., and D. Gray. 1991. *Aboriginal health and society: The traditional and contemporary Aboriginal struggle for better health*. North Sydney: Allen & Unwin.
- Sanderson, L-T J. 2009. Rights and Sustainability. Vice Chancellor's Oration, Curtin University.
- Schapper, H. 1969. Present needs of Aborigines. In *Aboriginal Progress: A New Era?*, ed. D. E. Hutchinson. Perth: University of Western Australia Press.
- Shannon, T. G., and M. Gracey. 1977. Aboriginal children in hospital. *The Medical Journal of Australia* 1 (4 Suppl): 11-13.
- Shor, I. 1987. *Critical teaching and everyday life*. 3rd ed. Chicago: University of Chicago Press
- Sivanandan, A. 1982. *A different hunger: Writings on black resistance*. London: Pluto Press.
- Smith, L. 1999. *Decolonizing methodologies*. Dunedin, NZ: University of Otago Press.
- Smith, N. 2002. Role and practice of Aboriginal health workers in the great southern and south west regions of Western Australia. MA diss., Centre for Aboriginal Study, Curtin University of Technology
<http://library.curtin.edu.au/theses> (accessed August 27th, 2010).
- Spradley, J. 1979. *The ethnographic interview*. New York: Holt Rhinehart & Winston.
- Stanley, F., and S. Maug. 1986. Birth-weight patterns in Aboriginal and non-Aboriginal Singleton adolescent births in Western Australia, 1979–83. *Australian and New Zealand Journal of Obstetrics and Gynaecology* 26 (1): 49-54.
- Stone, S. N. 1974. *Aborigines in white Australia: A documentary history of the attitudes affecting official policy and the Australian Aborigine, 1697-1973*. Melbourne: Heinemann Educational Publishers.
- Stratham, L. 2010. Australia's life expectancy shame. *National Indigenous Times*, 21 January. www.nit.com.au/news/story/ (accessed 21 January, 2010).
- Stringer, E. 1996. *Action research: A handbook for practitioners*. 1st ed. Thousand Oaks, California: Sage Publications.

- Temme, J. 1996. *Team power*. Kansas: Skill Path Publications.
- Thomson, N., and N. Briscoe. 1986. Overview of Aboriginal health status in Western Australia. *Aboriginal and Torres Strait Islander Health Series 1*
- Thomson, N., J. Reid, and P. Trompf, eds. 1991. *The health of Aboriginal Australia*. Sydney: Harcourt Brace Jovanovich.
- Tunbridge, D., and B. Stoecker. 1988. *Flinders Ranges dreaming*. Canberra: Aboriginal Studies Press.
- Turner, P. 2008. *2008 Communities in Control, June 17th, 2008: Closing the gap: When and how will Australia ever become truly liveable for indigenous Australians?* Melbourne: Centacare Catholic Family Services
- Vindigni, D., D. Griffen, J. Perkins, C. Da Costa, and L. Parkinson. 2004. Prevalence of musculoskeletal conditions, associated pain and disability and the barriers to managing these conditions in a rural, Australian Aboriginal community. *Rural and Remote Health 4*: 230.
- Wadsworth, Y. 1991. *Everyday evaluation on the run*. 2nd ed. Melbourne: Action Research Issues Association.
- WAIT Students. 1978. Health and Medical Care in China. *Australian Nurses Journal 8* (1): 50-53.
- West, J. 1998. Speaking towards an Aboriginal philosophy. In *Indigenous Philosophy Conference*. Linga Longa.
- Western Australian State Parliament. 1998. *A brief history of Aboriginal affairs in Western Australia*. Perth: Legislative Council of Western Australia.
- Whittington, V. 1999. *Sister Kate: A life dedicated to children in need of care*. Perth: University of Western Australia Press.
- Wilson, M., A. Stearne, D. Gray, and S. Sagers. 2010. *The harmful use of alcohol amongst Indigenous Australians*. Vol. 4: Australian Indigenous HealthInfoNet.
- Winch, J. 1976. *WAIT Abroad study tour, India*. BAppSc. diss., Health Science School of Nursing, Western Australian Institute of Technology (WAIT), Perth.
- , 1980. An exploration into problems of a breakdown in health of the Aboriginal population in Western Australia. In *Aborigines of the West: their past and present*, ed. R. M. Berndt and C. H. Berndt. Perth: University of Western Australia Press

- , 1993. CRANA Conference. In *CRANA Conference*. Broome.
- World Health Organisation. 1961. *Basic nursing education*. Geneva: WHO Publications.
- , 1976. *Working document*. Geneva: WHO Publications.
http://aei.pitt.edu/5251/01/001766_1.pdf (accessed 15 August 2010).
- , 1977. *The risk approach in maternal and child health care*. Geneva: WHO Publications.
- , 1978. *Declaration of Alma-Ata*. The International Conference on Primary Health Care, September 6-12, 1978. Alma Ata, USSR: WHO Publications.
- , 1980. *The primary health worker: Working guide; guidelines for training; guidelines for adaptation*. Geneva: WHO Publications.

Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.