

**Us Speaking about Women's Health:
Aboriginal women's perceptions and experiences of health,
well-being, identity, body and health services**

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Abstract

When compared to other women in Australia Aboriginal women are considered the most socially and economically disadvantaged and have the poorest health status. Aboriginal women in Rockhampton, Central Queensland are not excluded from this lived reality. This research has explored Aboriginal women's perceptions and experiences of health and health services in Rockhampton. Drawing on these experiences, and centring the voices of these women, the study reports on findings concerning cross-cultural issues, communication, policy, practice and service delivery. Importantly, the study has built new knowledge identifying the complex relationship between identity, body and well-being.

In undertaking this study, I have developed a 'talkin' up' research process in collaboration with other Aboriginal women. That is, by asking what Aboriginal women in Rockhampton wanted me as an Aboriginal woman researcher to explore and what type of process I would work through with Aboriginal women as the participants. The research has been informed and guided by these Aboriginal women and thus has witnessed the articulations of a more accurate portrayal of Aboriginal women's perceptions and experiences of health services. I take the witnessing to be partly personally empowering, partly sharing and partly a taking of ownership of experience. As those women interviewed explained, our story here is told 'by us'. In undertaking such a research process, I needed to ask what it means to be an Indigenous researcher and what is a good Indigenous research process? These are addressed at length within the thesis.

This research process has not involved examining health services with regards to their service provision or their implementation of more empowering practices to improve health outcomes for Aboriginal women. This remains to be done. This research, has instead attempted to answer the question 'how the relationship between health services and Aboriginal women can be more empowering from the viewpoints

of Aboriginal women?’ The assumption underpinning this study is that empowering and re-empowering practices for Aboriginal women can lead to improved health outcomes.

The study found :

Aboriginal women had requirements of health services relating to cultural comfort of health service environments

Aboriginal women did not access one health provider for all their health needs, they ‘shopped around’ to meet their general health, Women’s Business and relationship and privacy requirements

Aboriginal women’s health is impacted upon by stereotypes held of Aboriginal women around skin colour and Aboriginality

Aboriginal women have an understanding of what is required to improve the interactions between health service providers and Aboriginal women

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Dedication

I dedicate this thesis to Darumbal women and to the other Aboriginal women who have resided within Rockhampton in these post-invasion times. Those women that have passed before us, those that are with us today and those of the future.

I additionally dedicate this thesis to Joan Marion Brady who passed away during the production of this research. Joan was a dynamic community activist who fought hard for Aboriginal rights, women's rights, justice and equity. Joan was a dear friend, colleague and comrade. I know that as I submit this finished thesis she is with me in spirit.

Acknowledgments

I acknowledge the Darumbal people as the Traditional Owners of the area known in these post-invasion times as Rockhampton. I offer honour to the Darumbal peoples for allowing me to reside in their precious Country and to undertake the work I do, including this research work. I give honour to the Darumbal spiritual ancestors who care for the Darumbal peoples and to those of us who also live, dwell and pass through their Country, their responsibility area.

I give honour to my grandfather and I hope that his words and those of all my ancestors flow through me to you with integrity. I ask that all my ancestors and the ancestors of the Darumbal people, allow and assist me to express in a most sincere way what I need to express within this thesis. I further ask that the words on these pages place a challenge to you, along with giving you a greater understanding of issues that not only need to be reflected upon, but acted upon. I say to you that if you are not prepared to accept the integrity, sincerity and the honour bound within these pages, then please do not consider reading this thesis for you do not come to the thesis with respect.

I would like to dearly thank Daniela Stehlik for her supervision over the course of this research. Dani 'picked me' up as a student when I was 'lagging behind'. I know that I may not have reached this point at Central Queensland University without her support and guidance. Dani provided practical advice and feedback at times when I needed it most and a prod in the arm when I needed that too. I thank Ron Labonte for his steadfast understanding and encouragement over the years. I thank Priscilla Iles for her friendship and support over the time of this research work and my time in Rockhampton. I thank Kerrie Hand and Ruth McKillop for their editing skills. I offer recognition to the Indigenous people who made the varied research tracks and footsteps ahead of me and those who have written over the years, providing a rich source of literature.

I thank the Governing Board and staff of the Bidjerdii Aboriginal and Torres Strait Islanders Corporation Community Health Service Central Queensland Region for their encouragement and support. The Bidjerdii mob provided me with space when I most needed it. I thank Amy Lester, Margaret Hornagold, Mitzi Jarvis, Sam Kawane and Edward Chubb for their supportive words along the way. I thank the Board of Management of the Aboriginal and Islander Community Resource Agency (AICRA) for their encouragement and support. Thank you Elaine Williams, Judy Tatow and Priscilla Iles.

I make special mention of Angela Leitch and Pamela Croft, two of my dearest friends, sisters, who have been with me along my higher education and thesis journey. Angela, thank you for your love, encouragement and always reminding me in subtle and not so subtle ways to finish. Pamela, thank you for your love, support and for the hours of sharing as we both spoke about our doctoral programs. There have been many, many others who have offered encouraging and supportive words via emails, voicemails, letters, cards and face to face talks. Thank you.

I make special mention of Lyn and Neil McLean for being there for me. I make special mention of Rodney Stoter who provided love, care and support during the final phase of this thesis. I make special mention of Leanne, Karen, Wayne, Bradley, Norton and Colin for always being themselves and Martin, who sadly passed away in 2003.

Lastly, but in no way least, I thank those people who dwell within my heart, mind and spirit, my family, friends and my extended family. I know some of you do not know what I do, what a PhD is, what I write about in an academic sense, but you know the essence of who I am, what I do and how I try to work. I value that you accept and support what I do and what I believe I am meant to do. Thank you for loving me in all that I am.

Declaration

I certify that the thesis does not incorporate, without acknowledgment, any material previously submitted for a degree or diploma in an institution of higher education: and that to the best of my knowledge and belief, it does not contain any material previously published or written by another person except where due reference is made.

Signed:

Date:

Glossary

Aboriginal person or Torres Strait Islander person

An Aboriginal or Torres Strait Islander person is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal person or Torres Strait Islander person and is accepted as such by the community in which he or she lives.

Aboriginal peoples

The term Aboriginal peoples will be used to acknowledge the diversity of Aboriginal peoples across the Australian continent. All have different histories, social systems, cultural attributes, geographic landscapes and lives. All have different Country that they call home and relationship to Country within the continent as a whole.

Culture

Often defined as a set of beliefs, practices, rules for living life that are distinct to a particular group or people within society. Culture is something which is passed on through a complex set of relationships involving knowledges, language, social systems and life experiences which serve to link and maintain the individuals within that group or people. Culture is not static but a dynamic process which changes over time to reflect changing environments and life's circumstances.

Country

The geographic area to which one identifies as home, place and belonging. The concept of Country ties culture and people together with a place. Aboriginal peoples talk of a sense of Country in the form of identification and the concept of belonging. The Country in which this research took place was and is Darumbal Country. That is, it is the Traditional lands of the Darumbal people.

Health services

Health services are all services that provide clinical and non-clinical services. I have used the term to apply to health professionals working in isolation who are delivering a service to people, along with people working in small groups and teams, through to large organisations such as the Rockhampton Base Hospital.

Indigenous Australian

An Aboriginal and /or Torres Strait Islands person

Abbreviations

ABS	Australian Bureau of Statistics
AGPS	Australian Government Publishing Service
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
ATSIC	Aboriginal Torres Strait Islander Commission
ACCHSs	Aboriginal Community Controlled Health Services
AICRA	Aboriginal and Islander Community Resource Agency
ARI	Aboriginal Research Institute
Bidgerdii	Bidgerdii Aboriginal and Torres Strait Islanders Corporation Community Health Service Central Queensland Region
CQU	Central Queensland University
DAIA	Department of Aboriginal and Islander Affairs
DHFS	Department of Health and Family Services

DHAC	Department of Health and Aged Care
DHSH	Department of Human Services and Health
FAIRA	Foundation for Aboriginal and Islander Research Action (Qld) LTD
FCAATSI	Federal Council for the Advancement of Aborigines and Torres Strait Islanders
HoR	House of Representatives Standing Committee on Family and Community Affairs
HREOC	Human Rights and Equal Opportunity Commission
MBS	Medicare Benefits Schedule
MOU	Memorandum of Understanding
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NAIHO	National Aboriginal and Islander Health Organisation
NATSIHC	National Aboriginal and Torres Strait Islander Health Council
NHMRC	National Health and Medical Research Council
NHSWP	National Health Strategy Working Party

OATSIH	Office of Aboriginal and Torres Strait Islander Health, DHAC, (formerly OATSIHS)
OATSIHS	Office of Aboriginal and Torres Strait Islander Health Services, DHAC
QAIHF	Queensland Aboriginal and Islander Health Forum
QATSIHP	Queensland Aboriginal and Torres Strait Islander Health Program
UN	United Nations
USA	United States of America
WHC	Women's Health Centre
WHO	World Health Organization

Chapter 1

Preparation is Everything

Introduction

Many academics refuse to acknowledge that Aboriginal people's existence and conceptions of themselves are very different from their own. Objectification does not convey a "true" picture of anyone; objectification, in fact, creates a false image of Aboriginal people, more like a caricature than a portrait. If Aboriginal people determine how the picture of them should be created, and with what materials and techniques, the final composition will more accurately depict Aboriginal people and the vitality of their lives (Wheaton, 2000:156).

The quote above from Cree educator Cathy Wheaton explains the basis for this research that explores how Aboriginal women in the Rockhampton region view health services aimed at serving women. In exploring Aboriginal women's perceptions and experiences of health services, a number of issues surfaced. These included identity and white race privilege, body image, privacy and confidentiality and concepts around empowerment. This research arose from the suggestions made by a number of Aboriginal women and what they wanted me to undertake as a Doctor of Philosophy student and as an Aboriginal woman residing in Rockhampton. These Aboriginal women and I talked about what type of research project I would undertake and the suitable process, and also what would be the most useful project for improving Aboriginal women's health. The research process was developed in consultation with Aboriginal women throughout the region and Aboriginal researchers across Australia, utilising ethics documents prepared by Aboriginal peoples and a plethora of literature across a range of disciplines. The study that has eventuated, explored and exposed some of the lived experiences of Aboriginal women when accessing health services in the Rockhampton region. Furthermore, it has enabled Aboriginal women to articulate what they see as empowering practices in health service provision for Aboriginal women.

The method in which I explored what topic to research, in choosing the area of study, in consulting with Aboriginal women and Aboriginal researchers on the research process that would take place and also viewing literature, has resulted in this study presenting an Aboriginal woman's perspective of health service provision in Rockhampton. In rephrasing the words of Wheaton, this study more accurately depicts Aboriginal women's experiences in accessing health services and what Aboriginal women understand to be empowering in that access. Using the words 'more accurately' in this instance refers to what is written in this thesis about Aboriginal women, coming from Aboriginal women and through a process suggested by Aboriginal women. This information could thus be said to be 'more accurate' than information gained from other sources.

This research process did not involve health services in these articulations nor did I ask them to depict themselves. Nor has this research involved health services in how they could implement more empowering practices to improve the health outcomes for Aboriginal women in the Rockhampton region. This remains to be done after the submission of this thesis. In essence this research has attempted to perhaps answer the question; 'how can the relationship between health services and Aboriginal women be more empowering from the viewpoints of Aboriginal women'? The assumption underpinning this study is that empowering practices for Aboriginal women can lead to improved health outcomes.

During this research process, I spoke with a range of Aboriginal women including those who are full-time carers of young children and older people, public servants, students, workers in community-based organisations, shop assistants. From my personal experiences as an Aboriginal woman, I know every day life is filled with sharing of what Aboriginal women are doing, their children, family, men, work, social activities and "catching up" with what each other is doing or news from the "Murri Grapevine" (Aboriginal community news). Discussion sometimes focuses on or touches on issues of alcoholism, battery and violence, exploitation, memories of

the past, those that have gone before, the worries for the future, for the children, grandchildren and the grandchildren of their grandchildren. There are echoes of an ancestry of racism, which continues today. There is both resistance to accepting the colonisers' ways and at times acceptance of the colonisers' ways. There is the remembering of the complex cultures with a compendium of knowledge, times when women were so very, very strong, and times when women were empowered within their own nations. There are processes in place that ensure we remember to remember.

I know of some of these experiences and of some of these conversations. I brought this to the research, the process, the analysis and the writing up. I also brought my own Aboriginality. This study could not, as Aboriginal peoples have come to describe tertiary education, be 'left at the gate of the University'. To work with Aboriginal women of Rockhampton in giving voice, and then for me not to have a voice within the research process and also within the context of the University is a contradiction. The process of giving each other voice as Aboriginal women is essential. Aboriginal peoples and Aboriginal women for too long have been silenced. We need to regain our voices and maintain our voices. In the writing of this research, I refused to write in the third person, I refused to become voiceless and silent. As Aileen Moreton-Robinson wrote when referring to her work representing an Indigenous standpoint within Australian feminism, "My role as an academic analyst is inextricable from my embodiment as an Indigenous woman" (2000:xvi). Moreton-Robinson argues that she cannot separate her Aboriginal self away from her academic analyst self. Aboriginality implies certain assumptions about how one sees the world in the same way that other cultures, including Anglo-Australians, have a set of assumptions related to how they see the world. I thus acknowledge my own Aboriginality in the same way that Aileen Moreton-Robinson acknowledges her Aboriginality as integral to her research.

This thesis may not be like other theses. This thesis may provide readers with some challenges about what they understand as knowledge, research and a thesis project.

My positioning as an Aboriginal woman will not be hidden throughout this thesis, just as the positioning of readers may be clearly defined as an Aboriginal reader or a non-Indigenous reader. My own positioning and what I bring is briefly outlined within the section in Chapter 2 titled 'Living in the Landscape'. Using my own knowledge and experiences I worked in the informal yet structured way in which Aboriginal women generally communicate with one another. My own knowledge assisted in noting the contexts in which words are said and feelings are described. This assisted in the facilitation, in the process of analysis in the thesis itself and in the overall process of this research.

This study recognises that although Aboriginal women attempted to concentrate upon an account that was truly Aboriginal women's, which deconstructs Eurocentric and Westocentric views, that we are also tied by convention to the many terms which promote the unitary vision of an 'Australia'. We are designated as Other, yet still encompassed within dominant Australian society. We are within and without, different and same. Our colonial experiences are tied to the colonisers, while still being them and us, we and you. At the same time there is multiplicity in what inside and outside represent. I know few other words to describe peoples who are not Indigenous. One is either Indigenous or non-Indigenous, Aboriginal or non-Aboriginal. I have learnt that one is either white or not-white, Anglo-Australian or Other. Hage (1998:24) addresses this issue along with the question of immigrants and where they fit in multicultural Australia. Where do they fit within language? In this, Indigenous and non-Indigenous, I acknowledge the essentialism that maintains the binary of the us and them, the same and different, the inside and outside. Some people are mixtures of the binary, coloniser and colonised within our bodies and within our cultural memories (Croft, 1999; Robinson, 1997). Aboriginal culture has never been monolithic, it is dynamic and ever changing. Thus the 'I' is also ever changing and dynamic.

I acknowledge up front that I dislike reducing myself to just Other, marginal, yet at the same time know that I cannot reduce myself to just dominant, central, non-

Indigenous, female, researcher. I know that I am not the outsider like the white western outsider or Anglo-Australian outsider, but at the same time I am like the outsider in the nature of the work and research that I am doing in gaining a formal, western education. In this I sometimes feel that I am not quite the same and not quite the Other. Almost in what Homi Bhabha would call an “in-between” place (1994). At the same time I know there is no homogenous inside and no homogenous outside (Trinh T. Minh-ha, 1991). In all of this for the Self there are sets of thinking, mixed up thoughts, ways of behaving and a finding of where one fits.

It is as though Other in some way regulates Self, like a mirror reflecting back so the dominant Self knows how to behave (Trinh T. Minh-ha, 1991). I remember a social function not so long ago, where I believed the people present were responsive to equity, equality and social justice, someone made a racist joke about Aboriginal people, and when they realised I was there, they apologised. The apology was not because the joke was based on a stereotype, a misconception of Aboriginal peoples and that the joke was offensive, but because I was present. “Sorry I didn’t know you were here, listening”. I asked where was I supposed to be, not here, or here and not listening? Thus my mere presence as an Aboriginal person, Aboriginal woman, was given the position of moderator of behaviour, of the Self. As an Aboriginal woman who is fairer in complexion, I could have over the years hidden my Aboriginality from many people. When situations such as the one I described above occurred I could have quite easily remained silent. Furthermore, with people not knowing that I was an Aboriginal woman, they would have chosen not even to speak the words “Sorry”. Thus there would have been no alteration in the behaviour. Vincent Crapanzano explains that, “... one’s sense of self is always mediated by the image one has of the other. I have asked myself at times whether a superficial knowledge of the other, in terms of some stereotype, is not a way of preserving a superficial image of oneself?” (1985:96). If we apply what Crapanzano suggests, to the stereotypes of Aboriginal women, Aboriginal peoples and Aboriginal lands including the Land Rights Movement, one gains another understanding of the way Aboriginal societies

can be and are sometimes viewed. This would not be isolated from the health arena, the feminism arena or history.

Geographic Location of the Research

In Australia, there are states and territories and within the State of Queensland there are regions known as South-East Queensland, Central Queensland, Wide Bay, the Far North and so forth. These regions alone may contain nations of Aboriginal peoples with diverse histories that are suppressed within colonial accounts. Some of the writings that attempt to detail and explore the life of people within regions, including the Central Queensland region include Bird (1999) Huf (1996) Huf, McDonald and Myers (1993) and Pattison (2000). Huf, McDonald and Myers (1993) include extracts from documents from the 1840s – 1940s as they relate to the European explorers, settlers and Aboriginal peoples.

The Rockhampton region in which this research is based is situated within what is defined as the Central Queensland region on numerous government documents. As a geographical area, Central Queensland comprises of tablelands, flatlands, plain lands, open scrub, wetlands, river and creek systems, coastal areas, islands, mountains and now cityscapes and urban sprawl. It is these environments within the Central Queensland geographical area, where peoples lived for thousands of years with their own histories, their own cultures, their own laws, and their own knowledges. There were numerous distinct groups of Aboriginal peoples, who lived within the region and who belonged and belong to very specific areas, Country. These can be sighted in the pictorial map of Australia, which depicts Country belonging to different distinct Aboriginal peoples (Horton, 1999). There may have been, and are clans within these peoples who may have different dialects, different ‘Country’, different histories and different responsibility areas and roles. Women’s experiences and men’s experiences were and are different yet shared. It is all of this that is often forgotten by non-Indigenous peoples within the region. Some of the women I interviewed are from the Country now referred to as Rockhampton and other Country

from within the Central Queensland region and are integrally linked to the region's histories, peoples and places.

The Rockhampton region that I have drawn upon for this research is located within this geographic and cultural context. For the purposes of this research, the Rockhampton region that I specifically refer to is derived from the Rockhampton Community of Interest (COI) document (Australia, 1998a) and the Aboriginal and Torres Strait Islander Health Profile Rockhampton Community of Interest document (Australia, 1998b). These documents cover a geographic region lived in by a number of different peoples or different nations. The City of Rockhampton resides within Darumbal Country. The Rockhampton region as defined within the COI, resides within Darumbal Country, Woppaburra Country and Gungulou Country. From a local government statistical local area (SLA) perspective, the Rockhampton region sits across the City of Rockhampton, the Capricorn Coast and Part B of Fitzroy Shire. It is the cattle industry that Rockhampton aligns with and the town is the self-proclaimed 'Beef Capital of Australia' (Forbes, 2001:7).

Language Usage

I note at this time, that one of the problems with the English language is colonial discourse that has become hegemonic. It has also been used, as Fesl outlined throughout one of her works, to put Aboriginal people down (1989). As a result of the colonisation process we, meaning non-Indigenous and Indigenous peoples, Aboriginal peoples as a collective and Aboriginal women, have little choice but to use the same language with one another. Australian Standard English is the language that I use in most day-to-day conversations. Sometimes I use phrases of Aboriginal English or Aboriginal words relating to place interjected into Australian Standard English. I can speak no Aboriginal languages belonging to an Aboriginal nation. I cannot speak the language of my Aboriginal ancestors. Australian Standard English is the language in which most Aboriginal women speak to one another in the Rockhampton region. Some Aboriginal women use Aboriginal English or a mixture

of Aboriginal English and interject words from Australian Standard English or vice versa. Few Aboriginal women residing in Rockhampton speak languages belonging to their own nations. Thus we as Aboriginal women use the English language with one another. We too use language that is full of colonial discourse, along with racist, sexist and classist and that continues to erode Aboriginal worldviews. Moreover, we have little choice now and I anticipate that this will remain the same in the future.

Theoretical Frameworks

In an Australian context within the discourses of health, feminism, history, Australian identity and Rockhampton regional issues, Aboriginal women are said to be within the 'margin' or 'marginal' as the dominant view is 'centred'. Often in some of the discourses, we are an appendage to the main body of work, like an afterthought that is not separated, but lost within the text of the dominant voice. For example, Hage states "I have become very aware, only belatedly, that this book fails to incorporate the problematic representation of Aboriginality within white fantasies" (1998:24).

Some of the writings in feminism, cultural studies and postcolonial studies have begun to focus on and critique the dominant worldview, dominant culture and centred culture. Some have questioned the dominant worldview in relation to what is termed 'marginal women' and 'Third World Women'. Some writers such as Spivak (1988, 1995), Trinh (1989, 1991, 1995), van Acker (1999), Gandhi (1998) and Bulbeck (1998) use the term 'Fourth World Women' when referring to Indigenous women. Fourth World is "the term used for the world's Aboriginal peoples who were literally pushed into the margins for the contemporary history and geography of the world's civilizations to be established" (Spivak in Landry and MacLean 1996: 284). O'Neil (1986) explains the fourth world sites as being where a minority Indigenous population exists in a nation wherein institutionalised power and privilege are held by a colonising, subordinating majority. Other writers are specific in their focus on what has been termed "whiteness" and these include Ware (1992), Hage (1998) and Dyer (1988, 1997). Hage argues "'White' is a far more dominant mode of self-

perception, although largely an unconscious one... 'Anglo' could not account for the many non-Anglos who relate to, and define themselves through, the 'White nation' fantasy (1998:19). Aboriginal women are now examining and writing about whiteness and colonialism in relation to Aboriginal women generally or as individuals (Brady, 1999; Croft, 2003; Moreton-Robinson, 1998a,b, 1999, 2000, 2003). I write 'examining' and not 'beginning to examine or explore', as Aboriginal women have for some time understood what can be gained from whiteness and what is meant by white privilege.¹ Numerous Aboriginal people would have heard the words:

“If you’re black, stand on back
If you’re brown, hang around
If you’re light, you’ll be right”

It was often, but not always, the fairer skinned, more “white” looking babies who were removed during the Stolen Generations years. Lighter skinned Aboriginal women, those women who may have a white parent, risked being questioned by both Aboriginal peoples and non-Aboriginal peoples regarding Aboriginality. Those Aboriginal women who may have a fairer skinned Aboriginal parent and a darker skinned non-Aboriginal parent, are not questioned in the same way, despite the same combination of Australian Aboriginal/ non-Aboriginal in their parentage. Thus Aboriginal women have learned about whiteness and what whiteness can bring from a range of perspectives. Issues of whiteness, skin colour and identity feature strongly within the words of the Aboriginal women I interviewed. Their issues are explored in Chapter 6.

Aboriginal women have been engaged in a colonial struggle that is over two hundred years old and it cannot be separated from a study exploring Aboriginal women's health and empowerment. Colonisation and the continuing struggles are entrenched

¹ Examples can be found in the works of Corbett, 1994; Daylight & Johnstone, 1986; Dudgeon, Grogan and Oxenham, 1995; Edmunds, 1992; Fesl, 1984, 1989; Goodall & Huggins, 1992; Holland,

within Aboriginal women's lives over several generations, in the experiences and stories that have become part of Aboriginal cultures. Cultures are dynamic not static, they are ever changing and become added to over time. The impacts of the past two hundred years cannot be separated from this research, nor can the theories and views of what has taken place, the lies and the truths.

American writers such as Audre Lorde (1983a,b, 1992) and bell hooks (1981, 1984, 1991, 1992, 1994) include references and analysis to a range of theories, some are named, while others emerge through self understanding from reading their works. Some of these works, while framed in an Afro-American context, provide a basis for analysing some of the issues in Australia around racism, whiteness and feminism. A number of Aboriginal women have examined the issues of whiteness, colonialism and feminism in relation to Aboriginal women generally or as individuals (Huggins, 1987, 1991a, 1994, 1998; Moreton-Robinson, 1999, 2000, 2003). When one looks from a non-Indigenous Australian viewpoint, the dominant view is Aboriginal women are away from the centre, living in or at the margin from the dominant viewpoint. If we look from an Aboriginal women's viewpoint in terms of Aboriginal society, Aboriginal women, men, children and community are in the centre, the rest of the world is at or in the margin. Thus Aboriginal women are at the margin and at the centre, within and without, inside and outside at the same time. Within this duality, there are questions such as what is this margin and the centre with regard to Aboriginal women, where Aboriginal women live, inside as well as outside one's Self? It is important to understand that Aboriginal women's theorising comes from our experiences of multiple, interrelated oppressions which include class, racism, sexism and homophobia. These oppressions operate simultaneously. James and Busia cite the work of Stimson who asserts in her analysis of Afro-American women that, "... although Black women are often characterised as victims theorising is a form of agency that provides them with opportunities to "learn, think, imagine, judge, listen, speak, write and act" (Stimson, 1989 cited in 1993:2). This provides the opportunity

1996; Huggins, 1993, 1994, 1998; Huggins & Huggins, 1996; Johnson, 1991; Moreton-Robinson, 1998, 1999.

not just for the individual to move from the position of individual to activist, but for other members of the community and society to do so too. Epistemologically, experience is crucial to Aboriginal women's ways of knowing and of being within community and within the world. It is the lives that Aboriginal women live within communities that nourishes Aboriginal women in our ability to theorise about our lives. Aboriginal women's broader experiences are essential in the analysis of Aboriginal women's experiences of health care and access to that health care. This means an analysis needs to be grounded in everyday lives of Aboriginal women. We cannot possibly understand the health care issues of Aboriginal women's lives without Aboriginal women's articulations and an understanding of the experiences of Aboriginal women.

It is an important underpinning to this research that, we, meaning Aboriginal peoples, are asked to fit within someone else's framework of health care, of community and of seeing the world. Aboriginal women are asked to fit into a dominant viewpoint of women's knowledge, the women's movement and women's health care. This research argues that these views are given privilege, status and prominence in Australian contemporary society and override all other views and systems, and we are asked to fit in with or accept these views. This is the nature of Australian Eurocentrism.

If Aboriginal women do not adopt these views and systems or work against 'fitting in', we are put further at risk of remaining sick, poor and being left in the margins. When we access health services and women's places because we are in absolute need, not because we agree with the viewpoints, we can serve to affirm the dominant viewpoint and its models of service delivery. At times it is as if we must accept the worldview from which such services operate, and at times almost place our viewpoint to the side to receive a service, while services and the staff within those services can ignore the viewpoints of Aboriginal women. We can be forced to affirm the colonialists' values and sacrifice our own in the name of receiving health care to 'improve our health status'.

As I argue throughout, the health status of Aboriginal women and any improvements to that health status are intrinsically linked to Aboriginality and the sense of well-being of Aboriginal women as Aboriginal women. Aboriginality and the recognition and affirmation of Aboriginality through every point of service delivery is vital in improving the health and well-being of Aboriginal women.

Significance of the Research

This research represents a unique study, which set out to listen to some of the voices of Aboriginal women in Rockhampton, to ask them what they see as important in health service provision as it relates to them. It begins to develop a foundation for greater understanding within the Rockhampton health community, and in particular, identify how service providers can enhance their current service provision to Aboriginal women, to better meet the needs of Aboriginal women for improved health outcomes.

The poor health status of Aboriginal peoples was widely known by the beginning of the 1970s (Saggers & Gray, 1991: 121). Books, reports, journals and articles tell of high infant mortality rates, low life expectancy and excessive morbidity. During the 1970s, health policies and strategies were established to improve the health of Aboriginal peoples. Prior to this, efforts had generally been made by governments when there was a perceived threat to non-Indigenous peoples, such as the spread of venereal disease, eye diseases and leprosy (Saggers & Gray, 1991:121). There has been throughout this time, a plethora of reports and research produced documenting Aboriginal health. I address these in detail in Chapter 4. Since the 1990s and including the period up until now, there has been a greater interest and effort in improving the health of Aboriginal women, and in more recent times there has been a range of reports on issues concerning Aboriginal women's health and well-being. I address some of these as they relate to Queensland Aboriginal women in Chapters 4 and 5.

I argue that Aboriginal women need to add to the body of knowledge as to what is empowering for Aboriginal women. Aboriginal women have articulated what is empowering and how they see health services could be more empowering. This was done through 20 interviews undertaken with Aboriginal women drawn from the Rockhampton Aboriginal community. I have selected 15 interviews from the total number of women interviewed to be profiled in greater depth within Chapters 6 and 7. I selected 15 as they represented a breath of women from the 20. The process of interviewing is explored in Chapter 2. Most of the formal interviews were taped. A number of the young women I interviewed did not wish the interviews to be taped or wished other women to be present for support and to witness the telling, sharing, laughter and tears. It was through the sharing and in the witnessing that empowerment and re-empowerment additionally took place.

Other forms of evidence gathering have come through the use of writings including articles, reports, documents, books and policy responses by Aboriginal women and men around the topics of health, well-being, health policy, practice and service delivery, forms of training and education, identity, historical and social processes, government policies and much more. There are some references used within this thesis that could be said to be autobiographical and biographical forms of literature. These are included to support Aboriginal women's experiences, expressed through a range of media, and they serve as a useful analysis of health, well-being and empowerment as they collectively document the comprehensive nature and complexity of Aboriginal women's lives. These documents in all their forms make Aboriginal people the subject of their own experiences, providing constructions of identity and identifying the issues within their lived experiences, within the Australian context. They also provide the 'bigger picture', more of the 'whole story', and not segments of the whole that is so often said to happen when an exploration of health or discussion on issues arises.

From an Aboriginal viewpoint, the process undertaken in this study was important in that it has been Aboriginal women who have guided the process and who were the

definers of what is empowering. This has not been 'filtered' through the analysis of others - particularly non-Indigenous peoples, as when this happens there can be information not given at the time of interview or lost in the interpretation of the data. I will argue that the process itself could be said to be empowering for the Aboriginal women. The process also followed the preferred style of research as articulated by some Aboriginal peoples. This is further outlined in Chapter 2.

Positioning Myself in the Research

I have brought my Aboriginality to the research process, to the process of facilitation of what Aboriginal women saw as empowering. As an Aboriginal woman I have brought my Aboriginality to this process of interpretation. As I have grown older I have developed a stronger sense of Aboriginality and have come to know more about my own place within Aboriginal communities in which I have lived. I know that in Rockhampton I hold a place as a broader community member and as an Aboriginal community member. I know that I hold a place as an Aboriginal woman. I additionally know that with this positioning not only comes placement but responsibility, obligation, loyalty and respect for this Country. While not from this Country, I know that I am given forms of human and spiritual nourishment, support and love and thus I must give back human and spiritual nourishment, support and love. Respect.

As an Aboriginal woman, I have undertaken work within communities, been involved in community development, establishing services, served on committees, assisted organisations, held positions that were representative, that were specifically to support Aboriginal peoples and been an advocate for change. In recent times I have been labelled an activist by both Indigenous and non-Indigenous peoples. I have been involved with community since I was 16 years of age, was chairperson of an organisation at 18 years of age and since this time I have held numerous positions within communities.

On reflection on my community work and life over the years, it is Aboriginal women who have primarily provided support, love and nourished my growing sense of Aboriginality. Aboriginal women have supported my on-going development and have encouraged me to continue with my studies. In 1995 when I was about to withdraw from my Masters degree at the Queensland University of Technology (QUT) due to lack of support and isolation, Aboriginal women in Rockhampton encouraged and supported me to complete my degree. In all of this, I see some of the issues of reciprocity being very much a commitment to Aboriginal women and trying to be instrumental in change processes. I have a commitment to other Aboriginal women. I have a commitment to the Aboriginal women of the Rockhampton Region who have 'been there' for me as I have 'been there' in community service, friendship and the processes of surviving, living. From a non-Indigenous perspective, I am 'other'. I live as 'other' and am bound and committed to 'other'. What I have outlined gives one of the reasons for this study. Other reasons that are part of my past experiences and associated with the health and well-being arena, will be explored in more depth in the section titled Living in the Landscape in Chapter 2. The next section will provide an overview of the chapters within this thesis.

Overview of the Thesis

There are seven chapters remaining in this thesis. The next, Chapter 2, begins with a quote from Tewa Educator Gregory Cajete describing the concept of Pathway as it relates to Indigenous education and learning. The Pathway that I created for this research project needed to recognise the entirety of the journey that I had to make in the project. The use of the concept of Pathway allowed for an exploration of the external landscape where Indigenous research rests, literature on the topic and the associated literature that influences and relates to the topic, possible methodologies, the academy in which this thesis and I have been located, and the social, political and historical contexts in which Aboriginal women are based in contemporary Australian life. The concept of Pathway additionally allowed me to explore an internal landscape in the journey of the Self, within my own learning and coming to an

understanding of myself as an Indigenous researcher within the external landscape. Cajete suggests in his work that this is the nature of Indigenous education and learning (1994:55).

Not “just a little black bastard” is the title of Chapter 3, which begins with an exploration of Aboriginality from a range of perspectives and extends beyond the usual definitions and labels, before moving to perspectives and issues that are more specific to Aboriginal women. I explore Australian feminism and show how Aboriginal women are portrayed within Australian women’s agendas. I additionally examine the historical impacts of invasion and colonisation on the concept of Aboriginality and Aboriginal women. I show how Aboriginality has been questioned, attacked and debated by politicians, policy makers, bureaucrats, academics and others over the years. This broader understanding of Aboriginality is required as it allows for comprehension of the connections between Aboriginality, ill-health, well-health and well-being. I argue therefore, that any response to Aboriginal women’s health needs must incorporate Aboriginal concepts of Aboriginality.

Aboriginal health status today is directly related to our Aboriginality and to the colonising historical impacts, which commenced in 1788 when the British invaded Australia. What is discussed in Chapter 4 is Aboriginal people’s health, the impacts of colonisation on Aboriginal health, broader definitions of health, and features Aboriginal concepts of health and well-being. I present the thoughts of others on empowerment within this context, as the term is repeatedly found in the broader health literature across the world and seen as being a way to change the health status of vulnerable peoples. I conclude with a summary and questions around notions of re-empowerment for Australian Aboriginal women.

Chapter 5 addresses some of the issues with health policy as it has related to Aboriginal peoples generally, and specifically from 1989 to the present. I ask ‘what is health policy?’ and come to some conclusions about how such policy itself relates to Aboriginal peoples. In moving from the general to the specific time frame of 1989

to the present, I detail significant events that highlight major changes within the Aboriginal health arena. What I undertake is an expose and critique of some of the policy changes. This Chapter demonstrates how Aboriginal peoples have responded to, and become 'partners' in, policy processes and how at other times Aboriginal peoples have needed to take the issues external to Australia. Throughout the Chapter I explore where Aboriginal women have been included, and where they have been excluded.

The Aboriginal women I interviewed spoke of some of the above and of other issues and concepts, which have had little exploration previously. The words of these women are presented in Chapter 6. This Chapter presents what Aboriginal women in Rockhampton articulated in their interviews with me. From the very brief introductions of these women, a sense of who are the women, the diversity and similarities in their backgrounds, their employment status and whether they are mothers or not will be exposed to provide a small snapshot of what their lives might be or are like in Rockhampton. I then analyse common themes raised within the interviews which revealed that the Aboriginal women interviewed have specific needs in relation to accessing health services, along with general access needs similar to other women in Rockhampton. Aboriginal women throughout their interviews focused on, among other things, generational issues, the body, identity, skin colour and Aboriginality.

Chapter 7 presents what can be done by health services to address Aboriginal women's concerns and improve access to their services. In this chapter I have again grouped into themes the issues raised by the Aboriginal women interviewed. These include communication, cross-cultural awareness training, employing Aboriginal peoples in the health domain, sense of place and space, and concepts of empowerment. I bring in other examples and literature to demonstrate what the women have stated and bring my own analysis, experience and understandings within the presentations of the themes. Doing this provided a greater interrogation of the information gained from the Aboriginal women and others with knowledge of the

issues. To do any less leaves the information in a useable form to some health services but does not maximise the richness of what Aboriginal women in Rockhampton have said.

The final Chapter, Chapter 8, offers a summary of the discussions in the preceding chapters. It draws conclusions on the information presented throughout the thesis. I additionally provide what could be called a postscript to this research project. This Chapter is a summary of my Pathway.

Conclusion

Within this Chapter I have outlined the aims, geographic location and significance of the research, language usage and theoretical frameworks that underpin this thesis. I have explained my own positioning within the context of this thesis and how my positioning as an Aboriginal woman is integral to the research project that I have undertaken. This thesis may challenge beliefs about knowledge, research, dissertation and thesis projects, writing and thinking. The next Chapter outlines the *Pathway*, the journey of this thesis project.

Chapter 2

Travelling a Pathway

Introduction

Tewa Educator Gregory Cajete describes the concept of Pathway as it relates to Indigenous learning and education.

The concept of Pathway, revealed in numerous ways in Indigenous education, is associated with mountains, winds, and orientation. Learning involves a transformation that unfolds through time and space. Pathway, a structural metaphor, combines with the process of journeying to form an active context for learning about spirit. Pathway is an appropriate metaphor since, in every learning process, we metaphorically travel an internal, and many times external, landscape. In travelling a Pathway, we make stops, encounter and overcome obstacles, recognise and interpret signs, seek answers, and follow the tracks of those entities that have something to teach us. We create ourselves anew. *Path* denotes a structure; *Way* implies a process (1994:55).

Cajete's work has much relevance in enabling a framework for this thesis. The research methodology can be thought of as laying out the *Path*, as a well thought out structure or the plan for the research. It relates as an external landscape not just in terms of the Path itself, but also the research process within the landscape of the site of the research, Rockhampton. The *Way*, being the process, involved enabling a clear, thought out process for me to follow and also one for me within my Self. I have travelled an internal landscape in the journey of the Self, within my own learning and coming to terms with myself as an Indigenous researcher within the Pathway. I came to learn within the Pathway that I needed to make stops, that I would encounter and need to overcome obstacles, recognise and interpret signs, seek answers and follow the tracks of others that had something to teach me. I also understand that within the Pathway of the research that I have created new ways for others to see Aboriginal women, new ways for Aboriginal women to have voices,

share voices and comprehend more fully themselves and each other. I know that I have come to understand myself more clearly as an Indigenous researcher and I have come to view myself in new ways. I believe that I have created myself anew. This is the nature of Pathways.

In this Chapter I outline the Pathway utilised within the research and present a range of methodological issues. First I give a brief overview of issues pertaining to Aboriginal research, that is, issues that need to be considered when contemplating and undertaking Aboriginal research. This is the broader landscape in which this research is based. Secondly, I explore issues specific to myself as a researcher and more importantly as an Indigenous woman researcher. Describing how I have gained an understanding of my placement as an Indigenous researcher enables me to provide a more complex interpretation to the reader, while at the same time also providing some simple clarity from which the reader needs to view my work. It shows the issues connected with being an Indigenous researcher, that is, as a new traveller within the broader landscape of research. Thirdly, I give a brief overview of myself living within the landscape. These sections provide what could be called a 'window' from which the reader can gain a view of my world as an Aboriginal woman and as an Aboriginal researcher who has undertaken this research with Aboriginal women. The Chapter then moves from establishing the background to outlining the process for this specific research project and provides explanations of specific research methodologies as they relate to this research. I explain within this section how I addressed the issues of developing the research question and the research process, ethics, limitations, data collection, data analysis, the formal university based doctoral research process and the writing. Moreover, I include some critique as to why some research methods are inappropriate for such a research project. This chapter then concludes with some general observations about

this research process. The philosophical reasons for choosing the area of the research were discussed in Chapter One and will not be explained again, although I may make some reference to them to my positioning.

The Broader Landscape of Aboriginal Research

There has been a long history of research conducted on Aboriginal peoples. It is often said that Australia's Indigenous peoples are the most researched people in the world (Aboriginal and Torres Strait Islander Commission (ATSIC), 1994) or referred to as "the most researched group in the world" (Aboriginal Research Institute (ARI), 1993: 2). Maori writer Linda Tuhiwai Smith (1999:3) makes the statement that she has heard that "we [Indigenous peoples] are the most researched people in the world" from several different Indigenous communities. Historically, the vast majority of this research has been carried out by *non*-Indigenous peoples. As Dodson describes, part of the colonial project that was "designed to preserve the dead past and to provide future generations with the opportunity to look back at pre-history, safely bound in books and sealed behind glass doors" (1994:11). In all of this we, as Indigenous peoples living in contemporary Australia, would be cut off and alienated from our own knowledge bases (Dodson, 1994; Brady, 1992a,b). The research experience as the most researched has been and in many cases "continues to be exploitative with little of value being accrued by Aboriginal people or their communities" (ARI, 1993: 2).

Some of this research has been invasive into Aboriginal peoples lives and communities. Stephanie Gilbert, an Aboriginal researcher and social worker, argues (1995:1) that,

In the name of western science Aboriginal and Torres Strait Islander people we have been researched, poked and prodded. Our anatomy,

teeth, skulls have been stolen and studied. The same western science that believed we would die out given the superiority of civilised cultures such as Anglo-Saxons. The study of Indigenous people didn't stop at our anatomy. Our cultures, manners, beliefs and practices have been mocked, denied and forbidden (1995:1).

Over the years some research has been undertaken without permission and without regard to Aboriginal peoples' rights to participate or not to participate. Some communities have not been aware that non-Indigenous people have undertaken research while within their communities. Cruse puts it simply when she states "Many researchers have ridden roughshod over our communities, cultures, practices and beliefs, and we are now in a position to prevent this from continuing" (Cruse, 2001:27). Questions have been raised for many years by Aboriginal peoples, about research, which has been and continues to be undertaken in their communities. Aboriginal peoples have been weighed, have given blood samples, urine samples, faeces samples, hair samples, have given their stories, explained their existence, been interviewed, questioned, observed, followed, interpreted, analysed and written about for years. From the data reports were generated, books generated and theses generated. Roberts cites Aboriginal activist Kevin Gilbert in his summation of research,

... Aboriginals have had the pants studied off them. There are unending, limitless sums of money wasted on bloody research and what the hell has it all led to apart from a recurring harvest of MAs, PhDs etc? Even the odd bit of action that does come out of it has to masquerade under the cloak of respectability of 'research'... (1994:36).

Internationally Indigenous peoples have additionally made statements about research within their own communities and in other Indigenous communities. Smith

(1999:1) states that, “The word itself, ‘research’, is probably one of the dirtiest words in the indigenous world’s vocabulary”. Smith continues that,

It appalls us that the West can desire, extract and claim ownership of our ways of knowing, our imagery, the things we create and produce, and then simultaneously reject the people who created and developed those ideas and seek to deny further opportunities to be creators of their own culture and own nations (1999:1).

Smith draws out the historical impacts of imperialism on Indigenous peoples being denied our claim to our own existence, our right to self-determination and our own cultural knowledges. Henderson (2000), Kenny (2000), Wheaton (2000) and Monture-Angus (1995) provide similar examples of exploitation from Aboriginal peoples from the territories now covered by the countries known as United States of America and Canada.

Australian Aboriginal peoples began in the 1970s to voice more strongly that concern as to what was happening and what still continues to happen in some instances. In more recent times, issues have been articulated regarding some of the inappropriate and offensive methodological instruments that have been used and reports presented in ways that were not useable by the communities they were written about. It is worth remembering, states Rigney that,

... the production, re-production and dissemination of academically generated ideas via traditional research has marginalised and misrepresented Indigenous ways of understanding and knowing by extracting and appropriating Indigenous cultural, spiritual, oral and intellectual testimony (1999:2).

In particular higher education institutions in Australia have become sites where others have assumed ownership of our knowledges, ways of being and doing; other sites where this has occurred are museums, libraries and art galleries.

In the late 1980s and the 1990s several publications and statements included issues regarding research with and within Aboriginal communities. One of the more important statements was contained in *The Royal Commission into Deaths in Custody Report* (RCIADIC, 1991) in the form of recommendation number 330. It recommended that:

Research into patterns, causes and consequences of Aboriginal [problems] should not be conducted for its own sake. Such research is only justified if it is accepted by Aboriginal people as necessary and as being implemented appropriately. Action research of the type that produces solutions to problems is likely to be seen by Aboriginal people as being most appropriate (1991, Recommendation no.330)

It also recommended that,

Where research is commissioned or funded, a condition of the research being undertaken should be the active involvement of Aboriginal people in the area which is the subject of the research, the communication of research findings across a wide cross-section of the Aboriginal community in an easily understandable form, and the formulation of proposals for further action by the Aboriginal community and local Aboriginal organisations (1991, Recommendation no.320).

I have endeavoured throughout this research process to incorporate the above recommendations into my work.

Several publications on ethics in Aboriginal and Torres Strait Islander research followed soon after. *Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Research* was approved in draft form by the 111th Session of the National Health and Medical Research Council (NHMRC) in Brisbane in 1991. This

document still exists in draft form although it is quoted extensively in research projects, and some 10 years later, is only now being reviewed. This document needs to be utilised in conjunction with the *National Statement on Ethical Conduct in Research Involving Humans* (NHMRC, 1999). The Aboriginal and Torres Strait Islander Commission (ATSIC) issued its own guidelines on Aboriginal and Torres Strait Islander Research in 1994. ATSIC's guidelines however, are primarily aimed at non-Indigenous researchers and consultants and not at Aboriginal and/or Torres Strait Islander peoples undertaking research in formal degree programs within higher education institutions, nor Aboriginal and /or Torres Strait Islander peoples who may be undertaking research as part of a consultancy project. Some Aboriginal and Torres Strait Islander tertiary education centres, research collectives and research units additionally produced documents pertaining to preferred research styles and ethics statements, for example:

Aboriginal Research Institute, University of Adelaide: 1993;
Koori Centre, University of Sydney, n.d.;
Jumbunna, Centre for Australian Indigenous Education Studies, Education
and Research (CAISER);
University of Technology Sydney: n.d.;
Institute for Koori Education, Deakin University: 1994;
Centre for Aboriginal and Torres Strait Islander Participation, Research
and Development, James Cook University: 1995; and the
Centre for Koori Studies, Monash University: 1995.

Central Queensland University (CQU) did not have an Aboriginal and Torres Strait Islander Research and/ or Ethics document in 1997 when this research process formally commenced. I was made aware during the course of this research, that one

was being developed through the Nulloo Yumbah, Place of Learning and Research, CQU's Aboriginal and Torres Strait Islander Unit. There were some issues with the development of the Code of Ethics document, which I raised with the Unit at the time. The issues were around lack of involvement by Aboriginal and Torres Strait Islander people in the document development process. For example, I and a number of other postgraduate students living within the region, were not asked to formally contribute to the document. Further to this, Indigenous community members engaged in research activities were not provided with a formalised opportunity to contribute to the document. There additionally seemed to be an oversight of the major works within the area by Indigenous researchers. In the absence of a CQU document or statement at the time and the on-going issues with the development of a CQU document, I chose to utilise the literature and documents on Indigenous ethics and research available through other sources for this research project. These will be addressed in the section below titled Travelling in a Good Way.

Along with the position papers listed in the above paragraph numerous other works around Indigenous research processes and ethics have been written by Indigenous writers.² Many of them in some way place questions before the research academy as to the nature of research and do this from a range of positionings. This demonstrates that Aboriginal peoples and Torres Strait Islander peoples have been actively engaged in determining who, what, where, when and how research will take place and the conditions under which it should take place. Russell Taylor (Chief Executive Officer) and Graeme Ward (Research Fellow) of the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) outlined the

² See Gilbert, 1995; Atkinson, Brabham, Henry and James, 1994; Brady, 1992a,b, 1999; 1992a, 1992b; Cruse, 2001; Acklin, Newman, Trindal, Shipley and Heal, 1995; Collard, 1995; White, 1995; Rigney, 1995, 1997a,b, 1999, 2001; Nakata, 1997, 1998a,b; Moreton-Robinson, 2000; University of Sydney-Koori Unit; Williams and Stewart, 1992. There are others.

Institute's concerns around ethical research and Indigenous Australians (Taylor & Ward, 2001). The Institute has a research grants program and in this way is able to actively encourage and support ethical research practices within Aboriginal communities. More recently, Kim Humphrey (2000) provided an analysis of research specific to Indigenous Australian health and a number of examples of good practice to illustrate what can be done in research with Indigenous communities. Sharon Cruse offered a working example in the health arena with the Aboriginal Health Research Ethics Committee of South Australia (AHREC). She explains that

It may appear that AHREC takes a hard line with researchers, and to some degree we do. But we make no apology for doing so, simply because of the historical effect research has had within Aboriginal communities in South Australia and across Australia ... our focus is to ensure that research projects do have the interests of Aboriginal communities in South Australia at heart (Cruse, 2001:27).

In 2002, an annotated bibliography of the international literature on the ethics of Aboriginal health research was prepared by McAulley, Griew and Anderson and published by the Koori Health Research and Community Development Unit, University of Melbourne (2000). Currently a document titled *Draft Values and Ethics in Aboriginal and Torres Strait Islander Health Research* (NHMRC, 2002) is being circulated for consultation for the revision of the National Health and Medical Research Council's *Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research* (1999). The document that is presently open for consultation was prepared after discussions with a range of stakeholders, the establishment of a working party and a meeting in Ballarat, Victoria which involved researchers, Aboriginal community-controlled health sector representatives, policy makers and Human Research Ethics Committee (HREC) representatives from the National Health and Medical Research Council. Once the consultation phase lapses,

the working party will review the submissions and make recommendations to the AHEC and the NHMRC.

Non-Indigenous peoples researching in the Australian Aboriginal health arena have additionally produced articles around the nature of health research and ethics (see Hunter, 2001; Mosel-Williams, 1998). Other Indigenous and marginalised peoples of the world have also written on the topic of research and ethics, and offer a broad range of perspectives based on their own cultural specificity.³ They too question the nature of the research that has taken place and is in some cases still taking place with regards to Indigenous peoples within their contexts.

Although Australian Aboriginal peoples, Torres Strait Islander peoples and other Indigenous peoples have been writing on research, this does not mean that ethics guidelines are always followed or that inappropriate research does not take place (Humphrey, 2001:197-202). As Rigney asserts with such an “emerging body of knowledge one could be forgiven for thinking that the powerful and powerless dichotomies that plague research praxis has been overcome” (1999:2). This is not so, as research is linked to imperialism and colonialism within Australia just as it is in many other parts of the world. As such it is bound within our history as Indigenous peoples who were colonised, it is also bound up within the imperialistic history of the colonisers. Research processes have been carried out in the past in ways that have often perpetuated further impacts of colonisation and imperialism on us. Williams in a recent article on research (2001:12), re-asserts his position based on a statement he made in 1992 that:

³ See Bishop, 1998; Smith, L., 1999 and Smith, G., 1992 (New Zealand); Monture-Angus, 1995; Kenny, 2000; Wheaton, 2000; Henderson, 2000 and Battiste, 1995 (Canada); Collins, P. 1991, 1997; Asante, 1987, 1988, 1990; Anthias and Yuval Davis, 1993; Ngugai wa Thiong’o, 1972, 1993; Trinh, 1989, 1995, 1997; Stanfield, 1985, 1993a,b, 1994; Archibald, 1993.

Historically Aboriginal and Torres Strait Islander people have been subjected to a range of inappropriate, unacceptable, devious and degrading research methodologies. We have been, and still are, frequently considered objects for research and continue to be put under the microscope of the social scientists. Researchers have tended to conform to this neo-colonial and paternalistic mentality and, in most cases, gained individual rewards through professional advancement.

Research has become very much part of our contemporary lives, we write about it, talk about, tell jokes about it, and as Smith indicates “indigenous people even write poetry about research” (Smith, 1999:1).

Universities, the research academy and research epistemologies, ontologies and axiologies are bound up within the colonial and imperial worldviews in which they were formed. These can impact upon Aboriginal peoples lives and be perceived and experienced as Eurocentric, Anglocentric, Androcentric, racialised, imperialistic and colonial. There are writings which describe the impact of these from a range of viewpoints.⁴ Rigney in his work, writes of “the violence this causes to our Indigenous worldviews and our knowledges” (1999:2) as does Sivaramakrishnan (1989:6).

Aboriginal peoples and Torres Strait Islander peoples have been increasingly engaged in setting parameters and conditions to research about and with Aboriginal and Torres Strait Islander peoples. Aboriginal peoples have become stronger in voicing their concerns about research and what kind of research we want to have

⁴ See Nakata, 1998b; Williams & Stewart, 1992; Moreton-Robinson, 2000; Monture-Angus, 1995; Rigney, 1997a,b, 1999, 2000, 2001; Bishop, 1996, 1997a,b, 1998; Wheaton, 2000, Kenny, 2000, Archibald, 1993, Smith, 1999; and others.

happen within our communities. Gilbert asserts that, “The removal of knowledge from our communities to be used however the ‘researchers’ see fit is not acceptable. Academics must recognise, accept and assist to fulfil these goals or get out of that area of work” (1995:2). She maintains that, “We want to define ourselves. We have had enough of so called ‘experts’ who take our knowledge and then dispossess us of our identity as knowledge holders. If we don’t we risk permanent alienation from what should be our knowledge” (1995:5). Others such as Nakata, Rigney, Brady, Smith, L., Smith, G., Bishop, Monture-Angus, Kenny, Wheaton, Henderson, Battiste, Ngugai wa Thiong’o, and others already cited, have additionally been contesting the ways in which knowledge about us is used, abused, the way we are misrepresented and the ways in which we are held in the position of “Other” by the processes used.

From the ‘global’ discussion to the local experience, this appropriation of knowledge, culture and of us as peoples has profoundly impacted on our lives. At the Fitzroy Indigenous and South Sea Islander Women’s Workshop held in Rockhampton in 1996 a discussion occurred around the issue of research. Discussion included how people in universities and institutions have made their careers from researching Aboriginal health, people and culture. Some of the discussion focused on giving knowledge about research to the women and included questions the community might want to ask the researcher, for example: What is your motivation? What will you share? How will we get the information back?

In 1995, I took part in a paper on Indigenous research ethics with Nereda White, where we outlined some of our recent experiences. In this paper we tried to first provide some ideas about how Aboriginal people might like to be involved in

research, second that we have the right to make our own decisions on whether we wish to be involved in research processes. This important ethical position underpins this doctoral research process.

As stated earlier there is a growing body of scholarship with regards to ethical research within Aboriginal communities and with Aboriginal peoples. This joins the plethora of research that has been undertaken with and on Aboriginal peoples and Aboriginal communities over the years. As a result one can understand how Aboriginal peoples have become sceptical and cautious towards research and researchers. However, as Rigney asserts, “This is not to say Indigenous peoples reject outright research and its various methodological practices. Indeed some research and methodologies has benefited the emancipation of Indigenous communities” (1997a:1). Aboriginal people have been requesting research processes that “contribute to the self-determination and liberation struggles as defined and controlled by their communities” (1997a:1).

Considering all the literature analysed for this thesis, what I know within myself as an Aboriginal woman and what I was told by Aboriginal women in Rockhampton what Aboriginal woman wanted, I have attempted to develop a research process that demanded a range of research methodologies and approaches. These methodologies and approaches will be explored in detail within the section titled ‘Constructing a Path’ and some of the other sections within this Chapter. However, before entering into the construction of the path, I will first outline how I ‘sit’ within the landscape of the research as an Indigenous woman.

New Travellers within the Landscape

“Indigenous researchers are expected, by their communities and by the institutions which employ them, to have some form of historical and critical analysis of the role of research in the indigenous world” (Smith, 1999:5). Here Smith implies that as an Aboriginal woman who wishes to be called an Indigenous researcher, I need to have more than an understanding of the past research undertaken on and or with Indigenous peoples and communities. It also implies that I need to have worked out within *myself* the role of research as it relates to Indigenous peoples and communities today, within a contemporary context. While this expectation is one that I have encountered, it is not one that the university sector and the research academy provided training or preparation for me to be able to meet. There is a further expectation that is also placed upon me, as I am still expected to know the way the western academy undertakes scholarship and the protocols of this.

My survival within the higher education system and the research academy depends on my knowing how the western academy is structured and operates. I need to know how non-Indigenous people do things and who the relevant non-Indigenous people are within the research academy. That is, I need to know who the relevant scholars are, who controls the processes within the research academy, committee procedure and ways of ‘doing business’. Generally and most often such non-Indigenous peoples are ‘white Australians’. This ‘knowing’ is more than ‘knowing’ your discipline. Also, it is knowing your discipline inside and out, how it came to be, how it is used and then turning it upside down so you can see how it relates back to Indigenous peoples. In addition, I accept that I have a role in being an ‘interpreter’ between this form of knowledge and the community and other Indigenous peoples undertaking research. I have at times tried to take other forms of knowledge back the other way to the discipline, with mixed success.

My survival as an Aboriginal woman in higher education also relies on me continuing to develop as an Aboriginal woman. This is not something that holds true in the reverse. “White people” do not have to work in the same way. They do not have to work on being “white”. Everything around them reminds them that they are “white”. All the processes in place, the knowledge in place, structures, systems, other people, all remind them that they are “white”. They do not have to *consciously* think that they are “white”. Further to this, they can have total disregard for my reality and they can be one of the sources of my marginalisation within the higher education system. The result of this, as Monture-Angus argues, is that “the workload level at the intellectual level is at least double” (1995:64). On top of this, there is also the demand for public speaking, papers, articles within the higher education sector, for discipline-based work, for contributions to the Indigenous scholarly network and being part of an Indigenous community and broader community. I have felt the strain of trying to manage all of these aspects of my own reality in undertaking the work I do and in developing this research. I have struggled to balance the issues between this research and the issues associated with living in an Indigenous community and being an Aboriginal woman. In this I am not alone; all of this comes with me as it does with other Indigenous peoples engaged in research. In addition it needs to be recognised as a potential barrier to success.

As I have already stated, my formal western education did not prepare me to undertake the research I am engaging in or the life I live. In my undergraduate and postgraduate years of western formal education (I hold a Bachelor of Education and two Masters degrees in Education), I was often told what I had to do, quote from certain texts and to prepare assignments in a prescribed way. When I used an Aboriginal experience, I was told that I was ‘not objective’ or criticised for my

failure to be objective. What the system of higher education failed and still fails to recognise, is that it itself reflects a specific culture, even if the system does not name the culture it reflects. The criticism I received is really a reflection of the failure of those within the academy to examine their own biases and the bias of the system within which they work. I was never formally prepared within the classrooms in which I sat to be an 'Indigenous researcher'. I was prepared to be an 'Indigenous person' who would know how to teach and research using western frameworks that can further colonise and act out imperial measures on Indigenous knowledges, their ways of being and doing. I have been well trained in the western academy and specific disciplinary methodologies. In this way, I, as an Aboriginal woman, an Indigenous researcher, need to be extremely careful. If as an Indigenous researcher I do not interrogate what I learn, look at how I use what I learn and how I act, I can assist in perpetuating what I and others have been saying the colonisers have done and still continue to do.

Nakata explains that one issue for Indigenous scholars is how to speak back to the knowledges that have been formed around what is perceived as Indigenous positionings within Western worldviews (1998b:4). Nakata essentially asks 'how do we speak to what is known about us, written about us and not owned by us?' We as Aboriginal peoples and as Indigenous researchers within the research academy need to challenge what is written about us and what knowledges are controlled about us, otherwise we will continue to perpetuate the untruths and the ways in which we are marginalised, minimised, misrepresented, represented and devalued. Rigney states that, "sadly, the legacy of racialisation and its ideology continue to reshape knowledge construction of Indigenous Peoples via colonial research ontologies, epistemologies and axiologies which is so fundamentally subtle and 'common sense'" (1997a:6).

If we are to bring about change to the way people think about us, know us as Aboriginal peoples in theoretical, learnt settings, we must be part of these environments. We must challenge the current knowledge bases and ways of acquiring knowledge about us. In this, we must challenge the research academy. In this challenging Rigney asserts that we as “Aboriginal researchers who wish to construct, re-discover and/or re-affirm Indigenous knowledges must function in traditions of classical epistemological methods of physical and/or the social human sciences” (1997a:6). Nakata argues that “In order to understand our position better and to ultimately act to improve it, we must first immerse ourselves in and understand the very systems of thought, ideas and knowledge that have been instrumental in producing our position” (1998b:4). This is not to say that we need to embrace or fit within the classical epistemological methods of these sciences. We do need to know how these sciences are constructed, we need to know how they are used and how they impact upon us as Indigenous peoples. If we do not, we serve to assist in further colonisation. We thus assist in perpetuating the racialised, Eurocentric and Anglocentric knowledge bases against ourselves and other Aboriginal peoples.

At the same time that I ‘know’ that I must challenge and interrogate the system, I also understand the difficulty of interrogating the system, when the system tries very hard at times *not* to be interrogated, *not* to be engaged. There are times when non-Indigenous writers who write about Aboriginal peoples can write without fully interrogating their work to see whether they have perpetuated racism, colonisation, imperialistic and Eurocentric ideals about us and without interrogating their own ‘whiteness’. There are those within the higher education sector who speak about us, of us and never want to or avoid speaking *with us* and *to us*. I have felt what it is

like to be silenced. I have seen Aboriginal peoples left as the shadows of the speakers, as the speechless, the voiceless and the voice of absence. In this process we become re-written. We remain in the periphery and once again in the margin. We are again portrayed as ‘object’, and those who do the talking, the speaking about us, are again given the ‘legitimacy’ and further ‘authority’ to keep doing it, to keep making us ‘voiceless objects’. These people are the ‘cultural overseers’ and the ‘privileged interpreters’ of Aboriginal peoples, issues and objects. In this, the places and spaces within higher education that used to speak about us become further sites of appropriation and objectification and not sites of emancipation, liberation, subjectivity, resistance and sites where we can individually and jointly speak. In making us speechless, voiceless and marginal and maintaining cultural overseer positions, possible sites of radical openness and challenge are lost. It is with a blunt honesty and great sadness that I must also state that some educated Aboriginal people additionally support this happening within some institutions.

The situation in other countries for Indigenous peoples also remains difficult. James [Sa’ke’j] Youngblood Henderson in discussing the Canadian education system explains,

Canadian educators ask daily that Aboriginal peoples acquiesce to or fit within the Canadian version of Eurocentrism. It is a common struggle to all colonised Indigenous peoples around the earth. They ask that we either achieve within the Eurocentric model of education or live a life of poverty and welfare. If we do not fully immerse ourselves in Eurocentric education, we are called “uneducated”. In one way or another, we are being forced to validate the colonialists’ mythology. We are being forced to affirm alien values and to sacrifice Aboriginal worldviews and values for norms outside traditional cultural aims (2000:59).

Henderson further asserts that the “Canadian education systems continue to assert that assimilation within Eurocentric thought is the best path for Aboriginal people.

The penalties are high for refusing to conform to Eurocentric thought”(2000:59). Monture-Angus, a Mohawk woman, lawyer and academic explains in her work that she,

... believed that once I could write enough letters after my name that White people would accept me as equal. I no longer proscribe to the theory of equality because it does not significantly embrace my difference or that I choose to continue to remain different...As I climbed the ladder of success I never understood that I could not climb to a safer place. I now understand that the ladder I was climbing was not my ladder and it cannot ever take me to a safe place. The ladder, the higher I climbed, led to the source of my oppression (1995:69).

In Australia, Aboriginal Australians know what it is like to exist within learning and research environments, which were established on the denial of our existence as Aboriginal peoples. These are places where curriculum and structures seek to continue this denial and where they attempt to assimilate us. There are now new emerging stories about how non-Indigenous academics actively compete with us and the worldviews we represent. In the past, I have experienced being told about Aboriginality, how I should feel, what I feel as an Aboriginal person, and questioned about my Aboriginality by non-Indigenous ‘Aboriginal experts’. This is not unlike what other Indigenous peoples from across the world, such as Monture-Angus (1995), Archibald (1993) and Te Hennepe (1993) describe in their work. Aboriginal Australian people have competed against non-Indigenous peoples for grant monies on Aboriginal issues. Non-Indigenous researchers and education institutions have been responsible for the acquisition, storage and control over much Aboriginal knowledge since the invasion of Australia in the 18th Century. This process continues to happen whereby Aboriginal peoples are forced to quote non-Indigenous researchers about Aboriginal culture, peoples, issues; to seek out non-Indigenous supervisors for higher degrees; to request permission from non-

Indigenous peoples through research ethics committees to undertake research in Aboriginal communities and to contest non-Indigenous researchers on their understanding of Aboriginal knowledges and Aboriginal worldviews. The issues have been around power and control over the research process and with legitimisation, who has the right to speak, representation, intellectual property, ownership and accountability from a range of angles. To say the least, it has been difficult in the past with the power imbalances within universities to challenge the on-going colonial research practices.

In the past the majority of Aboriginal peoples employed within the higher education sector were engaged as support workers for Aboriginal and Torres Strait Islander undergraduate students within Aboriginal and Torres Strait Islander support units. Some of these workers were provided with opportunities to develop teaching materials and to teach units. The push for people working within the higher education sector to output more research and to generate funding from external sources has not been isolated to just the non-Indigenous workforce. Some Aboriginal staff working within such support units are now being required to look at their own research along with teaching and student support. I have been part of a group of Aboriginal and Torres Strait Islander peoples who have been participants in forming the National Indigenous Postgraduates Association Corporation (NIPACC). I was additionally a participant at the 2nd National Indigenous Researchers Forum held in September 2000 and the forums held since then. At the 2000 Forum there was a call for and support provided to establish a National Indigenous Researchers Association. This association which is in the process of being established will encompass Aboriginal and Torres Strait Islander peoples engaged in research in universities, government departments, research centres, community organisations and as individuals (consultants). In reflecting on the

establishment of the national association it will also provide a space for dialogue on Indigenous research issues and for Indigenous researchers to dialogue with one another for support, critique and provide opportunities to work collaboratively. It will provide the space to further explore what we mean when we talk about Indigenous research, processes of Indigenous research and what it means to be an Indigenous researcher. It will additionally provide sites where Indigenous people can work on the contestation of knowledges, ways of being and doing in regards to Indigenous peoples, cultures, issues, being as Indigenous peoples. The challenge to the landscape is something which has been happening at a range of levels. The following section provides examples and demonstrates the challenge to this landscape.

Challenging the Landscape

This section will provide some demonstration of Indigenous peoples and their challenge to the research landscape in Australia and in other geographic landscapes. I will begin with what has become known as the Bell-Huggins debate. This debate is an example of the emerging and on-going challenges to the dominant Anglo-Celtic paradigm of research and a debate about the place of women and of Aboriginal women in the landscape. The Bell-Huggins debate involves Aboriginal spokeswomen and anthropologists and the other a non-Indigenous anthropologist with an Aboriginal woman. The debate is an example of how Aboriginal women have challenged what was spoken out, as well as the process of the speaking and the writing (Moreton-Robinson, 2000: 111-125). What began the debate was an article titled *Speaking about Rape Is Everyone's Business* published in the *Women's Studies International Forum* written by non-Indigenous anthropologist Diane Bell and Aboriginal Elder Topsy Napurrula Nelson (1989) regarding intra-racial rape in

Aboriginal communities. The article placing Aboriginal rape and intra-racial rape in the public arena stated that

No matter how unpleasant, feminist social scientists do have a responsibility to identify and analyse those factors which render women vulnerable to violence. The fact that this is happening to women of another ethnic or racial group cannot be a reason for ignoring the abuse (Bell and Nelson, 1989: 404)

The article presents an overview of colonisation, gender relations in Aboriginal society and Aboriginal perspectives on rape. Then discusses why Aboriginal women have not been engaged in debates about rape or feminism as it relates to rape. The authors express that there are commonalities between Aboriginal and non-Indigenous women who have experienced rape. Last, strategies are put forward for action and reform. Within the article Bell is seen as the authoritative voice on what is Aboriginal intra-racial rape and what we as Aboriginal women need to do to address the issue.

Jackie Huggins is a leading Australian Aboriginal historian, writer and educator. She was a member of the Reconciliation Council in Australia, on numerous other boards and committees, and is presently the Deputy Director of the Aboriginal and Torres Strait Islander Unit at the University of Queensland. The other Aboriginal women who were alongside Huggins at the debate's commencement, are highly regarded and respected (there names are listed in Moreton-Robinson, 2000:75). Huggins and the other women wrote a letter (Huggins, et al.,1991) to the editors of the *Women's Studies International Forum* on the grounds that Bell did not have the right to speak for all Indigenous women on the issue of rape (Moreton-Robinson, 2000: 75). That is, Aboriginal intra-racial rape is not for everyone and anyone to know and read about and that the article should not have been published. It is the

business of Aboriginal communities. Within the article, Bell positioned Nelson as the authentic voice of the women raped and subject to violence. No other voices were heard. There are issues of representation in terms of Nelson and Bell and it is the opinion of Huggins et al. that Nelson was not a co-author but an informant (1991). It was viewed that Bell had set female solidarity ahead of racial solidarity and had used the legitimacy of anthropology and her positioning within a large Australian higher education institution (Moreton-Robinson, 2000). It is Bell's right to speak on intra-racial rape that is questioned. The debate is discussed in Larbalestier (1990), Yeatman (1993) and at length in Moreton-Robinson (2000:111-125; 2003:66-80). Since the original article the dialogue has continued. What remains clear throughout the debate is that Bell relies on the authority to speak from the power she gains from within anthropology and the higher education system. She does not have the authority to speak on behalf of Aboriginal women.

Another current debate is the theoretical debate between Williams (1997a,b) and Nakata (1998b, 1997) regarding the speaking to perceived Indigenous positions that are set within the contexts of western thought and order. Nakata is Australia's first Torres Strait Islander person with a PhD, has studied in the disciplines of education and anthropology, and holds the position of Professor at the Jumbunna Centre, University of Technology Sydney. Williams is a non-Indigenous male researcher who has undertaken research in the field of education. The debate centres as I have outlined around the speaking to perceived Indigenous positions and in particular around Torres Strait Islands positions. Nakata argues that Western scientific research methods of inquiry legitimate racist descriptions and positioning of Torres Strait Islands peoples. Nakata puts forward questions around how to speak back to the knowledges formed around what is perceived to be an Indigenous position/s in the western order of thinking (1998b). In his writing about the need to do this, he

argues for the “necessity for Indigenous students and scholars to develop particular standpoint theories from which to read knowledges that have been produced about Indigenous positions by outsiders”(1998b:1).

This debate has not been as vigorously written about, talked about or silenced as the Bell-Huggins debate. There are other debates in which Indigenous researchers and non-Indigenous researchers and knowledges relating to Australian Indigenous peoples including Hindmarsh Island. I will not go into this debate within this thesis. I anticipate that we will see many more debates in the future.

I am not in any way foreshadowing a strategic attack on non-Indigenous researchers. I do recognise that some of the historical research that has taken place is now assisting Aboriginal peoples in Native Title claims and other such issues and understandings. Nakata has provided an Indigenous positioning in how we as Indigenous peoples can negotiate western research and how we are positioned within that research (1998b). I was a participant in the Indigenous PhD Workshop hosted by the University of Melbourne in February 2002 where Martin Nakata spoke about the importance of this in terms of viewing historical documents from the field of anthropology and other disciplines. Moreton-Robinson additionally provided a public dialogue with Indigenous scholars at the *2001 National Indigenous Researchers Forum* on the role of anthropologists in constructing images and representations of Aboriginal women. She provided a rigorous interrogation based on her work of the way in which “Indigenous women are represented as objects within texts etc, representations that have become truth in public and academic discourses” (2000:75). She clearly demonstrated at the National Forum the way we need to be talking back to those objectifications, representations and positionings. Moreton-Robinson, in her powerful theoretical

contribution, discusses how anthropologists and other academic women undertaking research have developed representations of Indigenous women. Using the work of Asad, Moreton-Robinson states that

When white women anthropologists write about Indigenous women, they do so in the conventions of representation bounded by their discipline, university and politics and white Australian culture. Such representations are based on interpretation and translation and, as such, offer partial truths about Indigenous women (2000:93)

She illustrates this by showing how Aboriginal women have been represented through the publications and teachings of white Australian women and how at times these are in contrast to writings by Aboriginal women. For example, Moreton-Robinson uses Marcia Langton's summary of goals of Indigenous self-determination⁵ to make the point that they "are clearly not based on the same experiences, priorities and practices or theory of the subject position middle-class white woman as are embedded in Australian feminism" (2000:162).

I gained an understanding from the work of Moreton-Robinson that anthropological, feminist and academic interpretations of "Indigenous woman" are in many instances reinterpretations of our lived experiences. She maintains throughout her book, with numerous examples, that the reinterpretations erase our subjectivity, because of the conventions of representation bounded by their discipline as well as with university and political and white Australian culture (2000:93). It is about how we are written about and from the positioning from which it is written. Moreton-Robinson explains how Australian white feminists

⁵ Marcia Langton worked on the United Nations draft universal declaration on the rights of Indigenous peoples.

...accept, without criticism, anthropological representations of Indigenous women. These representations emerge as constructs of the methodology deployed by white women anthropologists who objectify and essentialise Indigenous women in their texts. They juxtapose Indigenous women to the position middle-class white woman within a traditional versus contemporary binary. The subjectivity of Indigenous women is denied by methodological erasure (2000:181).

Thus we become re-written objects, ‘Other’. In brief readings of works by non-Indigenous researchers, I can only but concur with Moreton-Robinson.⁶ Further to this, I gained an understanding of ‘whiteness’ as it exists and as it exists within feminism and how ‘whiteness’ impacts upon representation, understandings and the positioning of Indigenous women and maintains the positioning of “white middle-class women”.

The other disciplines are based and enshrined with the same “exclusions, silences and absences” in regards to Indigenous women and Indigenous peoples. It is in reading works by Indigenous researchers⁷ that I can begin to view my own situation, the situation of Aboriginal peoples, and come to an understanding of what it means to be an Indigenous researcher. I know that calling myself an ‘Indigenous

⁶ Including Cowlshaw (1986, 1987, 1988), Bell (1983), Bell and Ditton (1980), Bottomley, (1994, 1991), Bottomley and de Lepervanche (1984); Caine and Pringle (1995) Pettman (1992), Bullbeck (1998), Berndt, C.H. (1983, 1984-85, 1986, 1989), Hamilton (1981a,b), Burbank (1985, 1994) and Barwick (1974, 1978, 1979). These works represent a diversity of positionings over a 24 year time frame, including Barwick’s early works in 1974 (which was long before anthropologists and feminists had given thought to feminist theory and Indigenous standpoints) to Bullbeck in 1998. These writings are valid as they document how knowledge has been produced through anthropological methods and how it has been used to shape understandings of us as Indigenous women by white women.

⁷ Indigenous researchers such as Moreton-Robinson (1999, 2000), Nakata (1997, 1998), Smith, L. (1999), Smith, G. (1998), Rigney (1997a,b, 1999), Bishop (1996, 1997a,b, 1998), Huggins (1987, 1994), Battiste (1995), Kawagley (2000) and Cajete (1994). These are varied and diverse in terms of their disciplines and approaches but all encompass the positioning of ‘talking back’ to the disciplines from which they are within.

researcher' brings about a range of labels from other University researchers where I am based, and from within the greater academy. It is assumed that I work with Indigenous people as the objects of my research. It is assumed I am Indigenous. Both of these assumptions are correct. However, there are other aspects that also need to be considered. It could be considered that I am both subject and object. I attempt to work in ways that are responsive to Aboriginal peoples, that encompass empowering strategies, education approaches, skills development, broadening ownership and in returning the outcomes of this research in ways that Aboriginal peoples can use and incorporate for Aboriginal peoples. I additionally attempt to work in ways that highlight racialised and biased knowledges and exclusionary practices within the research domain.

Some Indigenous researchers such as Rigney (1997a,b, 1999) and Warrior (1995, 1999) give varied suggestions as to how best research Indigenous peoples and determining what is Indigenous research and who are Indigenous Researchers. They both discuss ways of decolonising, re-positioning and supporting Indigenous knowledges and research methods within higher education institutions. Rigney (1997a:2) suggests the concept of an Indigenist methodology, as a, "step toward assisting Indigenous theorists and practitioners to determine what might be an appropriate response to de-legitimise racist oppression in research and shift to a more empowering and self-determining outcome" (1997a:2).

Rigney's work builds on the scholarship from the work of a number of African-American researchers (for example Molefi Kete Asante, 1990, 1988 & 1987) who discuss Afrocentric emancipatory methodology while critiquing dominant epistemologies. Asante's (1987, 1988, 1990) work in particular provides inspiration for viewing and challenging knowledge usage and positionings of marginalised

peoples. Rigney (2001) additionally builds on the work of Native American Robert Warrior (1995, 1999). Warrior's research efforts have stressed the need for Indigenous intellectual sovereignty (1995, 1999). He maintains that Native American intellectual traditions need the freedom to break away from the constraints of the Western academy (1999:11). In his argument Warrior outlines that sovereignty is the path to freedom via a process of emergence for Indigenous peoples, as a group or collective (1995:91). He provides direction that intellectual sovereignty is a process; it is not about outcome (1995:91). It is about the speaking, reflecting and articulation through a range of means about the Indigenous struggle and what strategies to freedom are needed. Rigney in his interpretation of Warrior's writings outlines that,

If Indigenous intellectual sovereignty is to be emancipatory it must be 'process driven' rather than outcome oriented...it is now for Indigenous scholars committed to sovereignty to realise that we too must struggle for intellectual sovereignty and allow for the definition and articulation of what that means to emerge as we critically reflect on our struggle (2001:10).

Some Australian Indigenous intellectuals, I believe, have been making progress towards this concept of an Indigenous intellectual sovereignty through the establishment of Indigenous standpoints, seeking solutions, participating in open dialogue with other Indigenous scholars and peoples, dialoguing with non-Indigenous people and disciplines, and addressing some of the issues in contemporary Australia and the world in which we as Indigenous people live today. Indigenous scholars have been sitting, talking, critically reflecting, analysing documents, policies and literature and undertaking formal processes of research. This also is a process, whereby reading through materials and dialoguing with others via an Indigenous standpoint, is different from reading and dialoguing via the use of western forms taught in higher education. There is an emotional, social and

spiritual engagement that is not often seen in the realms of non-Indigenous scholarly activities. There additionally may be tension present as a result of the double positioning of Indigenous researchers as brokers as discussed above.

In order to bring about the required changes within the knowledges bases, there must be a link between research and the political struggle of our communities. This link needs to be in and through those Indigenous Australians who are simultaneously engaged in research and the Indigenous struggle. Rigney asserts that “Only in this way can research responsibly serve and inform the political liberation struggle” (1997a:2). I know that it is up to us as Indigenous peoples to make the decisions between what is liberatory and what is colonising in orientation for us.

When I view how other Indigenous peoples see their research, the ways of Indigenous researchers and the nature of Aboriginal research, there are two particular other sources of inspiration, two Aboriginal women from Canada. Kenny (2000) and Wheaton (2000) have negotiated the western academy, obtained their PhDs and gone on to do further research. Carolyn Kenny, a Choctaw educator, outlines that,

Aboriginal research is research which reflects the values and beliefs of our peoples. Hopefully, when Aboriginal researchers do research, they will keep their thinking broad in terms of methods and approaches, and will, at the same time, be able to construct their research in a way which is in accordance with their worldviews (2000:144).

Kenny adds that,

Aboriginal research is an opportunity for us to create innovation and change for our people. If we develop an approach to research which is unique and reflects our values and beliefs, we will be

reflecting the spirit of our ancestors, the spirit of our people who are alive today, and the spirit of our Aboriginal children who are yet to be born (2000:148).

I see Kenny advocating for us to enact our rights as sovereign peoples within the realms of research.

It is the work of Cathy Wheaton (2000) that touched my heart and spirit. I chose a quote from Wheaton to begin Chapter One, as her words are powerful reminders of what Indigenous researchers are trying to do. Wheaton argues for the need for Indigenous peoples to challenge the systems, ontologies, axiologies and epistemologies within the research academy; and for the need for Indigenous peoples to develop research processes that are about us as Indigenous peoples in order to represent us best. There is without doubt a need for Aboriginal research processes that reflect who we are, what we do, how we think, our protocols and processes, in order to represent us best. I believe we need to be resourceful and to think deeply about what we mean when we talk about Aboriginal research and Aboriginal research processes. We have a difficult task ahead of us in how we develop and articulate Indigenous research methodologies and an even more difficult task ahead when we begin to push collectively for the implementation of various Indigenous research ways within a higher education system that is highly racial, colonial and imperialistic. I have seen the higher education system act like a predator⁸ within the broader landscape where we struggle for existence as Indigenous peoples. I am sure others have also witnessed and experienced its snarling, and the sharpness of its teeth.

Living in the Landscape

⁸ I use the term 'predator' to refer to the sensations and process of being hunted, controlled, dominated over and captured.

This section will give a brief picture of my location within the landscape of this research. I will describe and demonstrate how I have lived within the landscape of this research while being simultaneously engaged in research and within the political struggle of Indigenous peoples (Rigney, 1997a,b; 1999; 2001).

It is important for me to acknowledge my own identity and history as it is a significant factor in this research process. I am a woman of Indigenous, invader and immigrant histories who identifies as an Aboriginal woman from Aboriginal peoples of what is known as the South-east Queensland region. My Aboriginality is from my maternal kin. My grandfather on my mother's side was adopted as a child and reared by a non-Indigenous family in Brisbane. My grandmother on my mother's side is of English Australian heritage. My mother is one of my grandfather's eight children. From my grandfather's line there are numerous grandchildren and great-grandchildren. Some of my family through my family identify as being Aboriginal people, some identify their Aboriginal heritage but do not identify as Aboriginal people and some do not identify as anything other than as Australian. We are a mixed family, with mixed and at times highly complex identities.

Aside from my family's mix of heritages which has gifted me questions, thoughts, and ways of being and knowing, I have also been given deeper understandings about inclusions and exclusions, about the multiple forms of discrimination as well as the many differing levels one could be marginal yet still be connected to the centre. This came about through my involvement in the broader Indigenous communities of Brisbane, Ipswich, Melbourne and now Rockhampton. I also became involved through employment, friendships and relationships for some twenty years with members of the Brisbane Chinese community.

I have both witnessed and experienced the ways which immigrant peoples and racial minorities can internalise colonialism. Thus, despite being relegated to varying structural marginal positions it can happen that there is a *replication* of patterns of colonial relationships. I state varying structural marginal positions because from the dominant culture, the positioning is connected with, but not absolutely, 'whiteness', the ability to speak English and the ability to transgress to the centre, which in Australia is 'white' and English speaking. I have experienced a range of privileges that have been given to me because people perceived that I was all 'white'. I have also experienced the withdrawal of these when people have realised I am not. Then there are all the in-between notions of part-this and part-that, and the dynamics that come from this. For some there is respect for the 'whiteness', but not the 'other'; or respect for the 'other' but not the 'whiteness'. I have been excluded based on aspects of my whiteness and on aspects of my Aboriginality.

Prior to joining the academy I was employed as a Project Officer with the Commonwealth Department of Health and Human Services in the Disability Services Program and the Family and Children's Services Program. My work within the Family and Children's Services Program saw me oversee the funding to some childcare programs and facilities. My work with the Disability Services Program saw me oversee funding to programs, services, hospitals, take part in assessment of services, working with people with a disability in service direction setting and policy development. I additionally had carriage for a number of portfolio responsibilities across Queensland, including disability issues for Aboriginal and Torres Strait Islander peoples, Australian South Sea Islander

peoples and peoples from non-English speaking backgrounds. These state-based portfolios were carried for some three years (between 1993-1995).

My work with the Disability Services Program gave me further insights into inclusion, exclusion, discrimination and marginality. I witnessed within the world of disability particular access given to some people and not others, for example, people with high support needs were discriminated against and there was a lack of understanding by the general community of issues of disability. I gained an in-depth knowledge of how disability issues, concepts of disability and beliefs of disability are embedded within cultural bases. I understand they are embedded within Western realities, Eurocentric, white realities within this country, how sometimes the Westocentric ideas of disability complement cultural interpretations of disability and how sometimes they collide. I additionally saw how government interventions sometimes steam roller over the top of some of the most vulnerable people in our society.

I have worked as an educator within Queensland Education, TAFE and Central Queensland University, as a locum Coordinator with the Management of Public Intoxication Program (Rockhampton), as a consultant to write submissions, proposals and briefing papers and to facilitate planning and management workshops for community-based organisations. In this, I saw discrimination happening against groups, particularly those groups who had a difficult time negotiating the bureaucratic system, when the issue was more to do with the type of writing governments required and knowledge of the greater scheme of the Australian political system.

Over the years I have been active in Aboriginal women's issues and at many different levels. I have offered papers and workshop sessions on Aboriginal women's issues, for example at the International Indigenous Women's Conference in Christchurch, New Zealand in 1993 and at The Third National Women's Conference, Canberra in 1995 (Fredericks, 1995b&c). In 1996 and 1997, I assisted in the preparation of the reports for the Aboriginal, Torres Strait Islands and Australian South Sea Islands women's conferences held in Rockhampton (Fredericks, 1996). I have additionally written responses to papers and articles regarding Indigenous women (see Fredericks, 1999a for an example). Most recently, I presented at a Rockhampton Business Women's Breakfast Meeting (Fredericks, 2000a), the Reclaim the Night Rally in Rockhampton (Fredericks, 2001b) and spoke at the 10th Anniversary Dinner of the Rockhampton Women's Health Centre (Fredericks, 2001a).

As an Aboriginal woman, I have undertaken work within Aboriginal communities, been involved in community development, establishing services, served on committees, assisted in organisations, held positions that were representative, that were specifically to support Aboriginal peoples, and have been an advocate for change. I additionally have undertaken work in the broader communities in which I have lived. I became involved in community organisations at 16 years of age. As noted in Chapter 1, at 18, I was the President of an organisation in the broader community of Ipswich. I have been involved and committed to 'community' since early adulthood. I do see that there is a need to facilitate change for and within Aboriginal communities and between Aboriginal communities and broader communities. I see that some of the work that I, and many others, have been involved in over the years has moved us all towards change.

I have been asked to present papers (Fredericks, 1995a, 2000a, 2001a,f, Fredericks and Hornagold, 1996) on a range of issues. I have been required to prepare statements, presentations and overviews in some of the roles I have within the community. In my role as Chairperson of the Bidjerdii Aboriginal and Torres Strait Islanders Corporation Community Health Service Central Queensland Region for the past 7 years, I have undertaken a range of public presentations (Fredericks, 1999c, 2000b, 2001 c, d, e, g are examples).

I have endeavoured over the years to support women and men to know better who they are, just as I endeavour to move closer to the person I am. As I was once told by my grandfather, “we become no better or worse, just closer to who we really are”. I additionally try to foster a sense of optimism for the future. It is hard sometimes with a seeming increase in the number of deaths in the Rockhampton Aboriginal community, deaths of strong women and men along with deaths of people not so strong. It was difficult at times, when I’d hear of yet another death and of deaths of Aboriginal people I knew in Brisbane, Sydney or elsewhere. Non-Indigenous women and men in the community may think, another person, another statistic. At times, I think how lucky I will be to reach my fortieth birthday. I was saddened when Intellectual Warrior Palawa Japanangka Errol West passed away on 11th April 2001. He was an Indigenous researcher of Australian and world renown. I had last seen him in September, 2000 at the National Indigenous Researchers Forum in Adelaide. I remember his words after the NIPAAC Inaugural Annual General Meeting. He said that as he watched everyone in the room, the speakers and the presenters that he ‘can die now’. I struggled with this as he went on to tell me how he had shared his visions and his dreams and done what he needed to do. It was now up to us and he was leaving the struggle in good hands and in good minds. He had spoken in the Forum earlier about the next phase of our struggle within

education that being 'the war of the minds'. I have come to understand clearly what he was referring to, through this thesis.

As an Aboriginal woman with family, friends, people, across numerous communities and who holds a number of positions, I am faced with the difficulties of Aboriginal peoples every minute of every day and every day of my life. The deaths of Aboriginal people of renal disease, suicide, alcoholism, drug abuse, the increasing numbers of people with HIV/AIDS, diabetes, knowing that we can be admitted into nursing homes at 45 years of age. The minimum age for the general population is 60 years of age, with deaths resulting from heart attacks and heart disease, circulatory diseases, childhood preventable illnesses, asthma and other issues. I know of the levels of violence and abuses in our communities, the numbers of Aboriginal men and Aboriginal women in correctional centres and all the rest of the statistics. They all take their toll on me, as they do on other Indigenous people. For me the statistics are walking, breathing, surviving, sometimes barely existing before my eyes; they are in my dreams when I sleep. Thus this research process is also of me, part of me, given from me. It is not something undertaken from interest or from a desire to know more for knowing's sake, as the outsider looking in, as a cultural voyeur. It is in essence about me.

At times I have been referred to as an Aboriginal activist, community activist and community advocate. The invitation flyer for the Rockhampton Women's Health Centre celebrations (31 May 2001), advertised the guest speakers as Wendy Edmond MLA, Queensland Minister for Health, Marilyn Leeks, founding member and Coordinator of the Centre and myself, community activist and advocate. While it may be perceived as though I was marginalised, as I had no title in comparison to the other speakers, I did not speak that evening under the title of a position or an

organisation. To do so would mean I would need to speak from the perspective of my employer or from the organisation I was representing. I did not wish to do this. I know that my roles within the community (past and present), along with my role as a general Aboriginal and broader community member, lobbyist and advocate, sister, sistergirl, Auntie, daughter, have all and still inform what I do. All engage me within the Indigenous struggle. All engage me directly at the coalface of living every minute, every day and every year as an Aboriginal woman in the struggle for Aboriginal peoples. It is above what I think about, what I breathe and what I dream about.

I believe I am in a position to call myself honestly and with integrity, an Aboriginal researcher. I rest within the landscape as me. All of the experiences that I have been given, give me and continue to give me, a rich and diverse mixture of knowledges, skills and abilities. Who I am, with my own blend of Indigenous, invader and immigrant histories and cultures, gives me and continues to give me knowledges, skills and abilities. Who I am as an Aboriginal woman gives me and continues to give me connection with other Aboriginal women and communities, and knowledges, skills and abilities that can be and are shared. It is this that I brought to the research, this that motivates me to undertake the important work I do and this, that feeds my commitment to the community of Aboriginal women in Rockhampton and the Aboriginal community in the future. It informs and provides me with a basis from which I work as an Indigenous researcher, and how I worked with Aboriginal women in Constructing a Pathway for this research.

Constructing a Pathway

Thinking out the Pathway: Methodologies

There have been numerous research studies on Aboriginal people over the years from all sectors, including the health arena (whether it be the sector, discipline or health departments). Some of these studies have looked at cross-cultural awareness training, making services more appropriate, health promotion programs encouraging access and interactions with general practitioners and nurses. There is quite an abundance of recent literature written by nurse researchers and nurse practitioners on servicing Aboriginal women and Aboriginal people. There have been few studies that have explored the way in which Aboriginal women experience their encounters with health care providers and other aspects of the health care system. This research project has explored in-depth with a group of Aboriginal women from Rockhampton their encounters with health care providers and other aspects of the health care system. One of the outcomes has been to generate ideas for improving health care delivery and policy for Aboriginal women in ways that are empowering for Aboriginal women.

In being mindful of the commitment to understand Aboriginal women's accounts of their health care experiences from their own perspective, I chose to undertake a qualitative research process. Burns outlined using the education arena as an example that "the qualitative researcher attempts to gather evidence that will reveal qualities of life, reflecting the 'multiple realities' of specific educational settings from participants' perceptions" and they use a range of approaches in an "attempt to capture and understand individual definitions, descriptions and meanings of events" (2000:388). Sarantakos, states that this type of research refers to,

... a number of methodological approaches, based on diverse theoretical principles (eg. phenomenology, hermeneutics and social interactionism), employing methods of data collection and analysis that are non-quantitative, and aiming towards exploration of social

relations, and describes reality as experienced by the respondents
(1998:6)

Earlier in the study I considered the possibility of undertaking an ethnographic or phenomenological study, however I came to believe that I could not. Ethnography is in essence derived from anthropology and that discipline has a long history of documenting Aboriginal women and Aboriginal peoples lives from a colonial perspective. Glesne writes that ethnography is concerned with “illuminating patterns of culture through long-term immersion in the field, collecting data primarily by participant-observation and interviewing” (1999:9). Thus the process of interactive dialogue with the participants or building an empowering element within the process, of skills development or learning for participants is not crucial to this approach. As I discussed earlier these were the very aspects identified by Aboriginal women as elements required for research to be undertaken.

Within the realm of broader ethnography however, stands the process of autoethnography. Glesne drawing on the work of Reed-Danahay (Glesne, 1997) outlines that the term is used in a variety of ways, to

... describe narratives of a culture or ethnic group produced by members of that culture or ethnic group; to describe ethnographies of “other”, but one where the writer interjects personal experience into the text as in the confessional tale; and more akin to autobiography, to investigate self within a social context, whether it be your own or that of another culture (Glesne, 1999: 181).

Glesne asserts that “Autoethnography begins with the self, the personal biography” and then moves to the scholarly discourse and the cultural group that is the site of the research (ibid.). Richardson states that the researcher may write in such a way that the reader may “‘relive’ the events emotionally with the writer”(1994:521). This thesis includes the process of autoethnography. I have used narratives of the

self, and drawn on experiences and events I have participated in or witnessed over time while living within the community. Remember that my narratives of self, also relate to the narratives of the community. In one sense it is individual and in another it is community, they intertwine. It is the narratives that offer further information, assist me to understand the dynamics of this research process and that add greater depth to this research. It compliments what Rigney describes as Indigenist Methodology (1997a) and allows me to centre myself within the field of this research.

Other forms of qualitative research approaches such as symbolic interactionism, case studies and phenomenology were also considered and rejected. A recent Canadian study demonstrated “phenomenological strategies of inquiry and women-centred ethnographic research approaches” worked extremely well in providing an understanding of women’s lived experiences (Browne, Fiske and Thomas 2000:6). Phenomenology, although preferred for the study with Aboriginal women in Canada, did not look at how the women could be part of the changes required. From what can be ascertained, it did not begin to identify models or develop participant’s knowledge of the research process or empower women through the process. These were spin-offs from the research rather than built into the process of the research itself. In addition it was unclear from the research whether the researchers were engaged in political processes at the same time within the landscape of the research as it was being conducted. Two other Canadian publications provide belated direction and questions. The first titled “Black Women’s Health: A Synthesis of Health Research Relevant to Black Nova Scotians”, included a secondary literature review and synthesis, consultations with researchers in the Black community, and a workshop (Enang, 2001). The second was a publication by the Canadian Women’s Health Network focusing on Aboriginal Women’s Health (Canadian Women’s

Health Network, 2002). This publication includes several articles concerning research, and outlines the outcomes of certain pieces of research. One article by Timmins explains that in the past if “the researcher failed to “pay” for the knowledge being offered, he risked putting himself and the giver of that knowledge in jeopardy” (Timmins, 2002:3). She explains this further, utilising the words spiritual contract, balance and how we treat each other. Connie Deiter, quoted by Timmins, makes the point that “if you take something from someone, you have to give something back: this keeps life in balance. In this way, all knowledge is spiritual knowledge” (Timmins, 2002:3). My interpretation of these explanations is that they are embedded around the issue of what Indigenous people in Australia call reciprocity. The concept of reciprocity was built into my formal research process.

In viewing specific research approaches undertaken in Australia with Aboriginal women, several studies were accessed and drawn upon for direction. These included Atkinson, (1990a & b) and Mow (1992), who both explored domestic violence across Aboriginal communities; Daylight and Johnstone (1986) who brought together a range of women’s issues nationally in a large consultation process for the very first time; Harrison (1991) who wrote the report titled *Tjitiji Tjuta Atunymanama Kamiku Tjujrpawanangku Looking After Children Grandmother’s Way*; Manderson, Kelaher, Williams and Shannon (1998) who discussed negotiation and consultation on women’s health issues in communities; and Kirk, Hoban, Dunne and Manderson (1998) who explored the barriers to and appropriate delivery systems for cervical cancer in Indigenous communities in Queensland. The later works of Kirk et al. (2000a,b) were accessed and utilised in this thesis as my project evolved and additionally validated and confirmed some of my findings. The collective research of The University of Queensland and the Woorabinda Community (1998) and The University of Queensland and the

Cherbourg Community (1997) both presented health concerns and issues of women in those communities. These research projects are part of the Indigenous Project of the *Australian Longitudinal Study on Women's Health*. These Community reports contain both qualitative and quantitative data. The Indigenous Project is being undertaken as a separate component of the Study while still being part of the Study. The research process incorporates training Indigenous women in the community, research sites, collecting and workshopping data, local community reference committees and a larger Queensland Indigenous Women's Steering Committee. I participated in a number of the Queensland Indigenous Women's Steering Committee meetings. The Indigenous Women's Project will no longer operate after June 2003 despite the continuation of the *Australian Longitudinal Study on Women's Health*. There has been expressed anger at this by Indigenous women from throughout Queensland, without any changes to the cessation date as yet. Thus where it appeared to me as an Indigenous researcher, that an attempt was being made to specifically address the issues associated with ensuring appropriate research methods with Aboriginal women according to Aboriginal women, this is now no longer the case. This is disappointing and demonstrates that Aboriginal women still have to fight for the necessary research methods to be not only developed, but also utilised and owned by Aboriginal women. What can be established aside the example just provided, is that in Queensland and nationally health research processes are increasingly being owned by Indigenous peoples in a developmental, action-based way. In the research they utilise the NHMRC Guidelines for research with Aboriginal and Torres Strait Islander peoples in full or in part in the process.

During the time of this research I turned to the recommendations 320 and 330 of the Royal Commission into Aboriginal Deaths in Custody (quoted earlier in this

Chapter), which outlined action research as a preferred research approach. Action research could best be described as an “interpretivist paradigm with the researcher working with others as agents of change” (Glesne, 1999:13). It is described at length by a number of researchers.⁹ In my readings of Australian literature where action research approaches have been utilised I have drawn upon the works of Kemmis and McTaggart (1988), McTaggart (1997), Stringer (1996) and Burns (1990). This is due to the practical way they have addressed action research, examples given, the disciplines from which they are drawn and the applicability, to the Australian context.

Action research developed from the work of Kurt Lewin (Glesne, 1999:13; Burns, 1990:253), grounded within the positivist paradigm with a clear separation between research and researcher (Bryant, 1996; Burns, 1990). Lewin’s work included cycles of discovery, reflecting and acting within the model. Over the years, Lewin’s model was further expanded and became highly popular in the discipline of education. It is used consistently within the areas of pedagogy and education management and the cycles of discovery, intervention and evaluation have been added to with observation, reflection and action (Burns, 1990; Kemmis and McTaggart, 1988; Stringer, 1996). My own experiences and training within the education discipline as a student at undergraduate and postgraduate levels, along with teaching within secondary schools, TAFE and higher education enabled me to practice action research techniques.

⁹ See Anderson, Herr and Nijlen, 1994; Bartunek and Louis, 1996; Bissex and Bullock, 1987; Bryant, 1996; Burns, 1990; Cochran-Smith and Lytle, 1993; Ebbutt, 1985; Goswami and Stillman, 1985; Kemmis and McTaggart, 1988; McTaggart, 1997; Miller, 1990; Mohr and Maclean, 1987; Noffke and Stevenson, 1995; Reason, 1988; Stringer, 1996; Whyte, 1991; and Zuber-Skerritt, 1996.

Data is first gathered through qualitative means and sometimes quantitative means and then a range of phases take place. These phases involve reflection, interpretation of data, interaction with stakeholders and then action, to bring about change (Burns, 1990; Glesne, 1999; Kemmis, 1991; Kemmis and McTaggart, 1988; Stringer 1996). What Stringer (1996:7) proposed was that “those who have previously been designated as ‘subjects’ should participate directly in research processes and that those processes should be applied in ways that benefit all participants directly”. Stringer’s work has direct application to community-based action research and not just to work within teaching and learning sites for students. In a community-based action research process, the research begins with working with a group, community or organisation in defining the problems, situations, issues and then involves the group, community or organisation in the process of working towards change, finding solutions or answers (Glesne, 1990; Stringer, 1996). Wadsworth, in writing of action research, describes it as ‘participatory’, that is, people need to participate to make it happen (1997:61). Participatory research according to Indigenous researcher, James Lukabyo, is usually developed with “the purpose of empowering community people to find solutions to community problems” (1995:4). Participatory action research therefore has the capacity to provide a notion of community development, social justice and empowerment. It can additionally encapsulate elements of political awareness and political action if designed this way.

In reflection of what I wished to do with the Aboriginal women and what they wished me to do, I made the decision to explore feminist research approaches in the broadest possible sense. I came to understand through my reading that broad definition of feminist and action researchers raise questions about how we carry out the processes of research, and about the nature of the research and the relationships

between the respondents and the researcher (Glesne, 1999:9). There are correlations between community-based action research and feminist participatory research approaches. Writers other than Glesne on feminist research, give the perception, that women experience oppression and exploitation.¹⁰ Further to this, they all address in some way the varied experiences of women including the multiple identities of race, class, culture, ethnicity, sexual preference, age, disabilities and geographic location. Naples in particular places research within community activism and crosses the boundaries of race, class and gender. Feminist research according to Sarantakos has the following characteristics,

... it puts gender in the centre of inquiry; making women visible and representing women's perspectives ... it places emphasis on women's experiences, which are considered a significant indicator of reality and offer more validity than does method ... it discloses distortions related to such experiences. It sees gender as the nucleus of women's lives, shaping of consciousness, skills, institutions and distribution of power and privilege. It is preoccupied with social construction of 'knowing and being known'. It is politically value laden and critical, and as such it is not methodic, but clearly dialectical. This implies that it is an imaginative and creative process which engages oppressive social structures. It is not solely about women but primarily for women, taking up an emancipationist stance, it entails an anti-positivist orientation. It is supposed to use multiple methodologies and paradigms (1998:63).

These characteristics of feminist research sit comfortably within the framework of this research project, but raised the concept of gender being the nucleus of women's lives and experiences. Aboriginal women have experiences as Aboriginal women yes, however, the research work I undertook was not primarily on gender because

¹⁰ Such as Behar and Gordon, 1995; Collins, 1997; Farganis, 1994; Fonow and Cook, 1991; Fook, 1996; Harding, 1986, 1987; hooks, 1984; Lather, 1991a,b; Luke and Gore, 1992; Mies, 1983; Neilsen, 1990; Olesen, 1994; Rienharz, 1992 and Usher, 1996

for Aboriginal women, gender is not experienced in isolation from other oppressions such as race, culture, class, sexual preference and disability. Some of the issues associated with the identity of Aboriginal woman are addressed in the next Chapter.

After careful consideration of a range of methods, I came to accept that Feminist Participatory Action Research needed to be one of the research methods. It enabled me to adapt it to fit within an Indigenous context. It allowed me to break away from some of the pre-existing conceptualisations. Although having an issue with the concept of feminism per se, which will be addressed in Chapter 3, I was able to borrow from the area known as feminist research for the purposes of this research (Lather, 1991a,b; Rienhardz, 1992; Mies, 1983). The Feminist Methodology literature provided numerous strategies for me to utilise, with women speaking being the core strategy. Reinhardz presents the practice of women 'telling' and the ways in which the 'telling' occurs and can occur (1992). This form of 'telling' is not just a 'feminist' owned practice. It is regarded as an Indigenous practice. A practice, not only about what is said but how we speak and how we listen. Implicitly often explicitly, it is a more egalitarian concept of power. It can be linked to the writings of Miriam-Rose Ungumerr (1988) and her descriptive work titled *Dadirri*,

It is inner, deep listening and quiet, still awareness... the deep spring inside us. We call on it and it calls to us. It is something like what you call 'contemplation'... A big part of *dadirri* is listening. Through the years, we have listened to our stories. They are sung, over and over, as the seasons go by... As we grow older, we ourselves become the storytellers. We pass on to the young ones all they must know. The stories and songs sink quietly into our minds and we hold them deep inside...In our Aboriginal way, we learn to

listen from our earliest days. We could not live good and useful lives unless we listened. This was a normal way for us to learn... Quiet listening and stillness-*dadirri*-renews us and makes us whole... (1988:9-11).

The following authors have all utilised the process of *dadirri* in the journey to the papers that they have written, Atkinson (1998); Atkinson, Kaur and Doyle; and Atkinson and Ober (1995). The processes connected to *dadirri* in some instances revealed the information contained in the papers and the information generally came from individuals and was shared with others. Through this process, stories were witnessed. For some, this led to feelings of greater empowerment. All of those authors listed have been based in Rockhampton for part or all of this research. Since my arrival in Rockhampton in 1994, I have heard numerous Aboriginal people read aloud a shortened version of *dadirri* to begin workshops, healing sessions and some formal community gatherings. I believe that in some instances the reading and sitting within the place of *dadirri* has offered a vehicle for renewing and remembering traditional Indigenous knowledges and practices and made connections between this and the contemporary lives we live today. While it was not my intent to utilise the written words of *dadirri* during my interviews or during the reading of literature, I did utilise the skills I have gained and enhanced from the practice of quiet, still awareness and reflection at deep levels.

Other research has taken place that involved Aboriginal women as researchers and subject. They include the works by Kirk, et.al, Daylight and Johnson, Acklin et.al, Atkinson, Harrison, Huggins and Huggins and others provide legitimation to Aboriginal women's voices in texts and reports authored by them as Aboriginal women. Brady notes disappointing that generally "outside autobiography the stories of Indigenous Australia only receive legitimation when written in texts edited or authored by non-Indigenous academics (Brady, 1998). Some Aboriginal women

have utilised story-telling techniques that are also described by Reinhardz (1992). Acklin, Newman, Trindal, Shipley, and Heal explain that,

The approach to research that was agreed upon was storytelling. We believe that as Aboriginal women we have a unique opportunity to develop a genuine Aboriginal story-telling which will be successful means of disseminating the information we possess, and to utilise storytelling as culturally appropriate health education approach to educate Aboriginal women, in all aspects of health care for women ... This approach (story-telling) enabled us as researchers to take information and put it into a format and language that is appropriate (1995:6).

We own our stories, from the time we are born until the time we die. Our stories are powerful learning and teaching tools. It is in the listening to someone else's story as a human being that we can give honour to the journey someone else has travelled. Our stories are not as Atkinson suggests to be pathologised, they are sacred (1998:49). She argues that it is "our stories that link us to each other, that builds the bridge between our creative diversity to our human commonality" (1998:49). As one South Australian document states,

This project recognised the importance of Aboriginal people taking the primary role in telling of their stories, and the exploration of these stories so that special knowledge and skills relevant to healing processes might be honoured and reempowered. ... to take further steps to break free of the destructive stories that have been imposed upon them by the dominant non-Aboriginal culture, including many of the ideas of health and well-being that are so often imposed by mainstream services. (Dulwich Centre, 1995:20)

The telling of the stories is one way for Aboriginal women to explore the way that Aboriginal women think about their history and to identify the effects of events on their lives. Brady states that, "storytelling is an ageless tradition, considered by most cultures to be vital to the health of each individual, the community and their

environment” (1998). She adds that “the knowledge our stories contain can be shared but its sources and ownership belongs forever to those who have given the gift of the story. The listener's responsibility is to learn from it” (1998). Stories open the door to critical reflection, and can assist in moving us to another level of understanding the self, family and community.

Aboriginal researcher Maureen Kirk and colleagues in their recent work with Aboriginal women on cancer undertook a process of semi-structured interviews, case history interviews and group discussions (Kirk, et al. 2000b:4). Their research explored women's personal experiences, their understanding of breast cancer and their views of care and health services. In essence they undertook a process of Aboriginal women 'telling' their stories, as did the other works cited earlier by Daylight and Johnson, Atkinson, Harrison, and The University of Queensland et al. reports. These researchers were all able to undertake shifts and changes within the process of the research. Further to this, they have all been linked to other developments either in policy and/or programs for Aboriginal women. The findings from these works have been useful in examining the findings from this research.

There are other strategies that were utilised from the fields of Qualitative Methodology and Feminist Methodology. Denzin and Lincoln (1994) suggest that the qualitative researcher utilises a variety of strategies and methods to collect and analyse a range of empirical materials and evidence. The data gained by the qualitative researcher may be from field notes, interview transcripts, documents, reports, pictures, recordings, graphic representations, newspaper articles and other literature. Tesch (1990) identified 26 analytic strategies that could be applied to qualitative data.

I believed that it would be possible to engage several approaches from methodologies known as community-based action research, feminist participatory research and Indigenist methodology as outlined by Rigney (1997a,b; 1999) and elements of reflexivity and/or introspection. These can all be worked together to bring an approach that could be regarded as Indigenous participatory community-based action research. I discussed a range of these strategies and approaches with my supervisors, my guides in the journeying. I drew on their experience and advice to additionally assist me in my decision-making along the path of this research journey. The next section will address the issue of supervision.

Guides in the Journeying: Supervision

Normally guides, supervisors are not mentioned in a thesis aside from the acknowledgments page. In regards to supervising Indigenous postgraduate research, they play an important role and can have major impacts on Indigenous students and communities. This will become evident in the following paragraphs. For me, a number of people have assisted in the journeying, in the travelling along the Pathway of this research. There were however, several people who were specifically appointed by CQU to be the official guides in the journeying (these are named later in this section). I agreed to the specific people being appointed after much thinking and working through some dilemmas. There were numerous issues that needed to be explored, behaviours that needed to be watched and language that needed to be deeply listened to within the course of supervision selection. My observation capacities were drawn upon as was my spirit for confirmation of my thoughts.

As an Aboriginal woman who has varying levels of responsibilities, who works in ways where I am perceived to be a community activist and who believes that I have

certain rights as a sovereign woman, I very much needed to think through issues. I was not prepared to be supervised by people who were not familiar with working with an Aboriginal woman who was working on her own empowerment and sovereign rights. I was not prepared to be subject to Objectification through the relationship of student/supervisor. I was not prepared to have a 'non-Indigenous Indigenous expert' supervise my work as an Aboriginal woman, with Aboriginal women within the greater Aboriginal community, if that meant substantiating their 'privileged positioning, cultural overseer, cultural interpreter status and giving them further authority to speak'. I was not prepared to be used to give anyone a stamp of legitimacy to talk on Aboriginal business. I was not prepared to be sucked dry, like marrow from a bone and then discarded as not even being good enough to contribute to a broth. I have been used by non-Indigenous peoples within higher education many times for purposes of legitimising, accessing information or to get their work done, and then discarded because I was of no further use.

I knew what I did want. I knew that I would accept supervisors who would be respectful of me, my positioning; supervisors who were respectful of difference, who accepted my difference and who didn't make me hide my difference, who would not make me 'fit' but who would encourage me and show where I could find a place for myself. I knew that I wanted open and heartfelt communication in my relationships with all my supervisors. I knew that I was prepared to gift the University-based supervisors with knowledge and wisdom that I can give, in reciprocity for their wisdom and knowledge of the research academy. In this way, we would be learning from one another in the true sense of teaching and learning. I knew that I was prepared to gift them the status of being the supervisors of an Aboriginal woman who gains a PhD from CQU just as they were gifting me their skills, time and status of their supervision.

There were issues of power to consider and issues of deep importance to my well-being as Aboriginal woman, my living in Rockhampton and other communities. Non-Indigenous researchers know they can pack up and go somewhere else, begin a fresh with little consequences. I cannot, without my story coming with me and without it impacting upon and within the deepest sense of who I am. I am one of the people with some knowledge of education, health and systems. I knew that I was trusted to make the decisions regarding who should be and would be my supervisors, my guides to undertake the research. If I was not wise in my decisions, if I did not stop any one of the supervisors in a process that could cause harm to me, Aboriginal women in the community or the Aboriginal community at large, I would have also contributed to the harm. This is something that I was not prepared to carry.

Some of these issues are written about in Fredericks, Croft and Jensen (1997). However, at that time I was undertaking Masters degree programs. In starting the PhD, I had thought about what I didn't want and what I wanted in supervisors, guides. I had come to another level of my wisdom about postgraduate education as I have again at the closing of this research. In the selection process of supervisors, it was difficult to come to know people from behind their images as to whether they would be the right people to be part of the landscape. There were some people I knew that would not be suitable. It took some time and the following people became my supervisors, guides within the landscape:

Danielle Stehlik	Dani is based at CQU and provided day to day guidance, overall supervision of progress, along with undertaking
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discussion on progress. Dani has a background in sociology, regional studies and human services.

Alice Michaels began as the CQU supervisor and then moved to Canada. Her interests included young people, mental health and empowerment.

Ronald Labonte Ron is based at the Saskatchewan Population, Health and Evaluation Research Unit, Saskatchewan University, Saskatoon, Canada and has extensive experience in the issues of empowerment, health promotion, facilitated processes in the community to explore health issues. Ron has experience in working with vulnerable peoples. He has visited Australia several times and has visited and facilitated workshops in Rockhampton.

Priscilla Iles Priscilla has long-term experience in working within the Aboriginal community and with Aboriginal women's issues. She is a long term resident of Central Queensland and Rockhampton. Priscilla is an Alcohol and Substance Abuse Counsellor, Health Worker and been a long-term advocate for Aboriginal women and peoples.

All three supervisors were important in this PhD process. The supervisors provided different roles and different functions. The CQU paperwork did not allow for a team approach although this is what I was seeking at the on-set. The paperwork required a principal supervisor. The principal supervisor role, I believed initially,

was no more important than anyone else, as I believed in the team approach and that all roles were equal. Much later, I came to view the principal supervisor as a vital person in assisting in the co-ordination of the Pathway in its entirety.

Talkin' Up the Pathway: Developing the Research Process

When Aboriginal peoples refer to the term 'Talkin' Up' it means to speak up, outwardly, back. Aileen Moreton-Robinson (2000:187) in her book *Talkin' Up to the White Women* explained the term as speaking back and the term Talkin' the Talk as "tell people about what you are going to do". For me I was given the Talkin' Up words to describe our process by a number of Aboriginal women. When I first started thinking about doing a PhD and research around Aboriginal women's issues, I'd be asked to Talk Up: Throw my ideas out, let the women hear what I was thinking and let them question me about what I was doing. This context is why the words Talkin' Up the Research are used. We needed to collectively bring forth the areas of discussion and the topic, and in essence Aboriginal women needed to reply on the topic for this research. It was not going to be decided upon by myself, by my supervisors or by the University community alone.

The important ethical principle as defined in numerous pieces of literature (Brady, 1992; Koori Unit, 199? (undated), White, 1995; Gilbert, 1995; ARI, 1993; Collard, 1995; Atkinson, Brabham, Henry and James, 1994) was to involve Aboriginal women from the Rockhampton area in the *development* of the topic. Numerous topics were discussed over several years prior to the commencement of the research. I encouraged Aboriginal women to ask questions, to put forward ideas and suggestions, and to ask about the long-term benefits of the study: 'What action would result?' 'Who would be involved?' Questions were asked such as 'What was a PhD anyway?' 'Why did I wish to do a PhD?' 'What did I see the purpose of a

PhD?’ ‘What were my motivations?’ ‘What was my purpose?’ ‘Who will own it?’ ‘Whose interests did it serve?’ ‘Where would this get us [as Aboriginal women/people]?’ ‘Where did I see it fitting within what I was doing within Rockhampton?’ ‘How would it fit with other work being done by other Aboriginal people?’ There were concerns later articulated about me possibly moving away when the thesis was near to completion, as others, both Indigenous and non-Indigenous, had moved away when their Masters or PhD theses on Aboriginal peoples or Aboriginal issues were being finalised. These questions and many more, along with consequent discussions took some time to work through and posed some internal questions and dilemmas for me.

The questions are not just about ‘political correctness’ nor are they just about ensuring ‘everything’ would be worked out before we began the research. A few of the questions would be asked by Aboriginal people to both non-Indigenous and Indigenous researchers. There are, as Smith describes, “many researchers who handle such questions with integrity and there are many who cannot” (1999:10). She asserts that some of the questions are part of larger criteria that a researcher cannot prepare for such as “Is her spirit clear?”, “Does he have a good heart?”, “What other baggage are they carrying?”, “Are they useful to us?”, “Can they fix up the generator?” and “Can they actually do anything?” (1999:10).

As an Aboriginal woman wishing to undertake research, other factors come into play. As a woman regarded as an ‘insider’, there are other aspects that needed to be considered by women and community members: my background, my placement, linkages, age, gender, status, political connections, political base, organisational connections, my work (both paid and unpaid) background, whether I could actually do the work, whether I respected and followed the protocol and process, my place

within the Rockhampton Aboriginal community, and many more issues. These issues pertaining to me as an Aboriginal woman researcher are not the same as those which pertain to the non-Indigenous researcher's.

As the research program developed, there continued to be an on-going dialogue and questioning about the research. It became in some ways very much part of community process, similar to other projects and programs in which I have been involved. There was multiple levels of education occurring as to "What was research?", "What questions have I got the right to ask?" and about the process of research. I was conscious of the heightened sensitivity required by me and became very aware of what it is to be an 'insider' researcher and the dynamics associated with what is termed 'insider' research. Smith proposes that, "[I]ndigenous researchers work within a set of 'insider' dynamics and it takes considerable sensitivity, skills, maturity, experience and knowledge to work these issues through"(1999:10). Furthermore that, "Non-i[I]ndigenous researchers and supervisors are often ill prepared to assist [I]ndigenous researchers in these areas and there are so few [I]ndigenous teachers that many [I]ndigenous researchers simply 'learn by doing'" (1999:10).

My experience supports Smith's argument. I sought out many avenues for support, knowledge and others to talk to about my concerns as an Indigenous researcher within CQU, the Rockhampton Indigenous community and the national Indigenous community of scholars, researchers and academics. I additionally sought engagement through attendance at Indigenous forums, symposiums, conferences within Queensland, Australia and overseas. The majority of these were funded by sources external to the university.

I needed to deal myself with issues relating to being an Aboriginal woman undertaking research: why even do a PhD? Why did/do I put such importance on education anyway? Through this process of talkin' around, talkin' up, down and then waiting a few more weeks, months and talking more, an area of investigation was born. It was put to me that 'why study a particular issue of Aboriginal women's health when if we couldn't be Aboriginal women when we went to get the health problem seen about, then what did it matter? This meant that if Aboriginal women didn't feel free to be Aboriginal women in all that meant in terms of identity, it didn't really matter if I looked at mammography, kidney disease or diabetes.

Aboriginal women involved in my research felt that they sometimes needed to compromise their Aboriginality to access health services. Things happened they didn't like and they didn't say anything, because they needed to go to the same service again. They just put up with what happens or don't go back. Thus it came about that the area I was drawn to was the complex relationship between Aboriginal women and health services. My initial discussions within the community revealed that if we could address this, then we could address many health issues. Understanding us as Aboriginal women involves many issues that impact on health: for example, history, dispossession, disempowerment, years of colonial processes and government interventions. It therefore means health services need to better reflect Aboriginal women's needs and the situation of Aboriginal peoples. Health services need to make Aboriginal women feel good about being Aboriginal women and want us to seek out assistance from them as health services and health providers. My words are about empowering interactions. The process of talkin' up gave Aboriginal women the opportunity to start sharing their thoughts and talking about some of their life experiences. It allowed issues to begin to surface, and allowed a dialogue about those issues. In this talkin' up process, a couple of

Aboriginal women came to the realisation about a number of problems for them when accessing health services. Reflection around the positioning of Aboriginal women in regards to those health services and broader society was articulated. The question for the research then became, “How can the health services be more empowering in their interactions and in health service provision?”

During the ‘Talkin’ Up’, I thought about and discussed the possibility of establishing a formal reference group to work with me on the research project. This was the way I had operated in the past and what had always been suggested for projects and identified positions. Through my discussions with a number of Aboriginal women and connecting with other Indigenous postgraduates, it was suggested as an alternative and I decided to follow the suggestion, that I approach an Aboriginal woman who was very involved in Aboriginal ‘women’s business’, to be a formal supervisor. Along with this arrangement, there could also be a loose circle of Aboriginal women who would always be asking me how the studies were going, and taking an active interest and wanting to know where I was up to. It was put to me ‘Did I have to have and make them meet as a formal reference group?, ‘Wasn’t this really making us women fit into the university structure?’, I came to understand more fully what a number of women had suggested, and to see that the structures within the community were and are already there. It wasn’t that I didn’t recognise that they were there. I did and I didn’t. It was about me more closely recognising them and really working with women in the community and in the process of community. That is this research process would fit within the flow of the community rather than me trying to make community fit the structure of the research.

It was identified in my discussions with other Indigenous researchers that it could be difficult to maintain a reference committee, group or circle for the purpose of the research, when some women had so many priorities. I was asked 'Do we want community people being there for what may be perceived as just for us, our work in the university?' I came to understand in the discussion that some women may feel obliged to come to meetings for 'my research', yet know that they have other commitments. Some women may feel they needed to forfeit being involved in this project in order to attend to their business. I did not want to set up a system where Aboriginal women felt it was a university thing, something they couldn't come to all the time so dropped out or something that was just for me. Instead this project was to be primarily about Aboriginal women and a structure was developed that respected the constraints that Aboriginal women lived with every day.

Aboriginal women I talked to suggested that I could be a facilitator of a process to improve access and service provision for the community of Aboriginal women in Rockhampton, of which I am additionally a member. However others would argue that I am the one who submits the thesis and that I will gain the PhD. The writing is part of the process that I undertake as an individual. It can also be established through my past work, paid and unpaid and community work, that if I had not been enrolled in a PhD, I'd be doing the same thing in a different way. I'd still be working in community. I'd still be working with Aboriginal women and Aboriginal peoples. I'd still be talking with health services about service provision. The PhD is therefore a community process, with the thesis the individual work that documents that community process. In the long term, the community benefits from the research process in the gains made, skills developed, sharing of a process, with a sense of achievement by an Aboriginal person and also in the PhD itself.

As a result, it was agreed that one Aboriginal woman could become a formal supervisor and the drawing together of women if and when needed along with providing me with cultural balance, guidelines and a person to disclose. In addition there would be a loose circle of Aboriginal women who I could meet with, not often, but who I might sit with at times individually, at times with a couple. These women come together when there is the opportunity, for 15 minutes of quiet time at a function, at a community social, in the same way we discuss other issues, issues of importance in our lives, such as family, kids, men, or to catch up on the 'Murri Grapevine'. A couple would call me over at a function and say 'how ya goin'; or 'how's your studies'. A couple of women would ask that I specifically tell them how it's going (meaning the PhD) and what I'm up to, what I know and ask about my work (meaning community work and my study work).

The Aboriginal woman identified by others as the woman I should approach was Priscilla Iles. Priscilla has done a lot of work in the community for many years. I sent a letter to her asking her to be my supervisor. The agency that was mentioned over and over again to seek support from in terms of linking with the project was the Aboriginal and Islander Community Resource Agency (Inc) (AICRA). This organisation had repeatedly undertaken the task of organising women's conferences over the years with Aboriginal women, Torres Strait Islands women and Australian South Sea Islander women. Priscilla was the Chairperson of this organisation and at the time additionally a member of the Central Queensland Aboriginal and Torres Strait Islander Commission (ATSIC) Regional Council. I received a letter supporting my research from AICRA.

During this 'Talkin Up' the research, information, reports and literature were gathered and read. Analysis of this material occurred and dialogue surrounding the

reports and readings took place with some key community people in regards to the contents of the documents. I spoke with a number of people during this process of analysis with whom I would normally discuss such matters during the course of my community work. We are constantly engaged in a form of analysis of documents, programs, effects they have on us as Aboriginal peoples, and of the possible long term gains and impacts.

Talkin' Straight: Interviews

I have used the term Talkin' Straight as a means to discuss the interview phase of this research. In this context, Talkin' straight means to talk to the point, to the heart of the matter and to be highly focused on the issues at hand (Moreton-Robinson, 2000:187). At the commencement of this phase a plain language information statement about the research project was sent out to Aboriginal community groups who service women within the Rockhampton area. This promoted greater awareness and potential for involvement of Aboriginal women whose members access services provided by organisations. A number of Aboriginal women indicated early in the process their willingness to be interviewed when I talked about the topic. They indicated they would like to participate in the project. Words I heard were 'can't wait to tell you', and 'I've got a story you need'. Some women self-identified that they would like to participate in this research and contacted me by telephone. I was referred to other women who wished to be involved after a discussion had happened elsewhere. This was how I came to have contact with the young Aboriginal women that I interviewed; it was through one of their mothers who was familiar with what I was doing in this research. I may not have had these young women in my sample had I tried to canvass younger women myself. Generally Aboriginal women shared with one another some of the information they had told me and encouraged others to seek an interview. I sought out other

Aboriginal women asking if they wished to participate: some said yes and others declined. I had one woman ask me if she could she participate in an interview some 18 months after she had originally declined; this was due to the fact that we had seen each other around in the community more and she came to know me better. I believe a number of the respondents would not have agreed to undertaking an interview if they had not known me or of me. This emphasises the point of how vital relationships are and the development of rapport and trust is in undertaking research within Aboriginal communities.

I did not have to seek out many Aboriginal women. Most women either self-identified or agreed to be interviewed when I spoke with them within the community about the project. We then made suitable times for an interview to take place. All were resident of Rockhampton. I did not seek to interview any Aboriginal women from outside of the Rockhampton region. I thus cannot comment on how these Aboriginal women individually experience the health services provided in Rockhampton.

The open-ended interviews were undertaken with 20 Aboriginal women aged between 18 years of age and 55 years of age who lived in the greater Rockhampton Region. I could have undertaken this open-ended interview process with more Aboriginal women as more indicated they wished to be interviewed, but I believed that I had gained sufficient data. I had a good spread of Aboriginal women across age ranges, backgrounds, education levels and employment status and different family situations. I believed I had a rich base of data gained from the interviews and that I had reached saturation with the data (Minichiello, et al., 1995: 162). I still had more women wanting me to interview. If I had interviewed more women I would have been meeting their needs to tell their story and the data analysis would have

been delayed. I needed to make the decision to cease interviewing at some point and I knew that I would still have women wishing to be interviewed at a later time. This might be an area to follow up on after the thesis to negotiate the production of a book around women's health stories.

The open-ended interviews were developed based on the practices of Denzin and Lincoln, 1994; Minichiello et al. 1995; Coffey & Atkinson, 1996; and Reinharz, 1992. The purpose of open-ended interviews in relation to my project based on the literature of those authors cited, was to allow women respondents to articulate their knowledge of health and well-being and their experiences of health services in their own words. I wanted the women to feel that they as much as possible could take the interview where they wished in terms of what they wanted to tell me. The question sheet I developed, as suggested from the literature (as Attachment A), was to act as a guide and to ensure that the questions were addressed at some point within the interview. Most of the women spent time looking at the question sheet prior to the interview and also during the interview, to ensure all questions were addressed in some form.

Where possible, interviews were taped. Four of the 20 Aboriginal women did not wish to be taped, these were all women under 30 years of age. With the interviews with Aboriginal women who did not wish to be taped, notes were written directly after the interview. Those women who did not wish to be taped agreed to notes being made during the interview. At all times I tried to be within our Indigenous process of listening. This was easier when a tape recorder was being utilised, listening to what is said, how it is said and the way in which it is said. Sometimes it can be what is not said that is of importance. It involves listening, contemplation, stillness and reflection. I have learnt, as many other Indigenous peoples have, to

listen to stories over and over again and remember the stories. Indigenous people in this kind of Indigenous process learn to 'remember to remember'. It also provides the teller of the story with the respect of being the teller, the teacher and the knowledge holder of the story, including their own story. When notes were being taken the listening process became somewhat harder. I had to try and take notes without being intrusive or feeling disrespectful to the teller of her story. The notes were to remind me after the interview of what we had spoken about. A more full set of notes was developed directly after these interviews based on many years of experience on the part of the listener (myself). The process of interviewing offered a shared recognition of the forces of oppression and an openness to the re-energised language of witness. It contested some of the academic androcentrism and allowed for the reinstating of marginalised and dispossessed peoples as makers of their own lives (Miles and Crush, 1993). It was with all of this in mind - the listening, contemplation, stillness, and reflexivity that I worked with the Aboriginal women participants, within the interviews, within the discussions and within the thesis. It is also how they worked with me in the process of the interviews, discussions and the thesis. All recordings were transcribed, or copies of the tapes made and provided to the participants to read or hear before any materials were utilised in the analysis. Copies of my notes were returned to participants where I didn't utilise tapes during interviews. It was important for the participants to have copies of what they had said and to be able to contact me if anything needed to be corrected. This enabled the women to have ownership of their words. None of the women contacted me to change their words or to take back the interview.

Feminist methodological literature identifies the way in which women talk, listen and learn. I gained an understanding from Reinharz (1992) that the whole concept of telling is regarded as a new practice and that it is regarded as a deeply feminist

practice. Further to this that it is not necessary only what we say or how it is said but additionally how we listen. Listening can thus be tied to the implicit and explicit, which can bring a more egalitarian concept of power. Perhaps for Reinharz and others it is a 'new concept' however recent works written by Indigenous peoples demonstrate that this implicit, explicit form of listening, reflection, contemplation is part of Indigenous cultures (for example Rose, 1996; Ungunmerr, 1995; Atkinson, Kaur, Doyle, 1996; Atkinson and Ober, 1995, Wangeneen, 1994; there are others). While these works post-date the writers of feminist methodology what needs remembering is the context in which the Indigenous writers have written, the political, social and historical context. Aboriginal writing only began to strongly emerge in recent times.

Five interviews were not used in this thesis. One woman passed away, and the other four were women under 30 years of age. If I had included these women, I believe that I would have had a greater focus on younger women's issues rather than a cross-section of Aboriginal women. Furthermore, what they had articulated was covered comprehensively by the other respondents. I believed that I would be best to present a sampling of ages and backgrounds and of the discussions that took place. I understood that I was gaining a sample that would allow for categories to be developed and examined (Minichiello, et al., 1995: 162). The categories included varied according to what was discussed, knowledge and experiences. I did identify some possible categories. There was one category that I did not expect to emerge so dramatically, the category of 'generational issues' and one that I did not expect at all, 'the category of body'.

In 1998 there were 3,413 Aboriginal people living in the Rockhampton region (Australia, 1998b:7). Of this number 1,764 were female, and 1,007 were under 18

years of age (ibid.7). There were 757 Aboriginal women over the age of 18 years compared to 31,916 non-Indigenous women (ibid.:7). I did not attempt to gain a representative sample of the population of Aboriginal women in Rockhampton from a statistical viewpoint. I wished to include the individual variations of women whilst allowing the emerging categories to develop. I wanted to be able to show the preliminary assumptions and the provisional findings (Minichiello, et al., 1995: 168). The Aboriginal women are in the colloquial sense to be representative, in terms of age spread, education, employment status, if they had children or not and whether they were originally from Rockhampton or another locality. I believe I achieved this spread using the 15 interviews I have presented.

A workshop will be held after the submission of this thesis work with three specific health services in Rockhampton, one woman specific service, one Aboriginal specific and one broader community specific along with Aboriginal women who wish to be involved to share what women have said and to explore how health services can enhance their services. I did not envisage any difficulties in seeking involvement, as all health services indicated a verbal desire to be involved in improving their service provision. The workshop will begin a collaborative process that will result in the enhancement of health services for Aboriginal women in the Rockhampton Region. This will begin the broader dissemination process of the research findings.

Crossing a Gully: Confirmation Seminar

On the 29th March 2001, I presented my PhD Confirmation Seminar at Central Queensland University (CQU). Prior to presenting the Seminar a number of issues needed to be considered. I carefully thought about the requirements for the Seminar from CQU's perspective and I carefully considered my own and the community's

requirements. I considered the process I had undertaken up until that point with the PhD process, my commitment to empowerment of Aboriginal peoples and my commitment to the on-going opportunities for the provision of voice to and by Aboriginal women and peoples. I carefully considered the Indigenous ethics and preferred styles of research papers I had read. None of the papers or documents addressed the issues pertaining to 'the Confirmation Seminar'. They did however, discuss issues pertaining to 'involvement, participation and dissemination'.

As a result of statements pertaining to 'involvement, participation and dissemination' and references to all stages of the research process, I made the interpretation that my PhD Confirmation Seminar fitted within all stages of the research. I also felt that it could be about 'involvement, participation and dissemination'. I had talked about trying to be inclusive of community at all levels of the research. I had talked and advocated previously about community members being involved in what happens within University processes in regards to Indigenous matters, being part of the University, I had verbally used the words many times of 'bring in community', 'advising community' and 'honouring community in what we are doing and not just talking about community as if it is out there'. I additionally considered that the Seminar could be another means to demystify the University to the community. If I invited community members it was certainly one way to show what is involved in undertaking a PhD and what a Confirmation Seminar was. It would also be a means of showing University staff and students what we can do, that community is here as well as out there, that the University resides within community and we needed to remember this always. I thought that it could be a way to demonstrate what I do, what we as Indigenous peoples can do and an Indigenous way of honouring in a formal way the contemporary composition of research and community. It was also a form of

contemporary celebration of where we are as Indigenous peoples, that we are in fact entering a new era and a new space at CQU.

With all of this in mind, I prepared an invitation and found a map that would show invitees where they could park and the room within the building where the Seminar would take place. Within the invitation there was also mention that an afternoon tea would be provided. I carefully drew up the list of whom I would invite. It contained names of Indigenous individuals and organisations and non-Indigenous individuals and organisations. The day of the Seminar over one hundred people attended and some people provided me with apologies. A number of people asked if they could have a copy of the overheads and the notes. These were Indigenous individuals who were unable to attend the Seminar. It was noted by individuals from the University that most PhD Confirmation Seminars attract some ten to twenty people. A number of University personnel expressed that they were shocked and surprised. These are their words not mine. I was not shocked or surprised. I knew that people would attend. I knew that the community owned my research just as they owned me and I owned them. I know that what I do is valued and that who I am is valued, just as I value other Aboriginal peoples.

Overall, the Seminar was very well received by both Indigenous and non-Indigenous peoples. People were invited to stay for an afternoon tea and at least half of the people in attendance at the Seminar choose to stay on. It needs noting here that it is customary that if you invite people to something you have organised, you need to provide a refreshment of some kind. This is in essence about being host to people, about being respectful of people's needs and offering a form of reciprocity. It is not a token gesture but an organised and planned form of respect. The Research Office in the Faculty of Arts, Health and Sciences agreed to provide

the afternoon tea. It was the first time such an event had taken place after a PhD Confirmation Seminar.

There was an air of excitement and there was lots of emotion expressed by people. One woman became very teary and described the event as “a moment in history for us Murries and the University”. This woman and I had often spoken about Indigenous knowledges and placing Indigenous knowledges well within the University walls. Despite all the talk of Indigenisation at CQU (a plan of inclusion by the University) and the best intentions of a few University personnel, nothing much has changed. Several Indigenous scholars, mostly those external to CQU who live in Rockhampton, knew the challenging had to be done by us, for us (Indigenous peoples). I knew I had to be, as Nakata (1998b) has outlined, well versed with the Western order of things to be able to speak back from an Indigenous standpoint. I did this on the day of the Confirmation Seminar. I also knew I needed the support and strength of other Indigenous peoples to do this when the time came, and that support and that strength was there. The dynamics of the extension of self, the community was at play. Through the Talkin’ Up process and through other community processes there is always connection that occurs, of who we are as Aboriginal people. A placement, roles, and responsibilities are formed, and reciprocity, obligation and cooperation are carried out. This adds to the shared experiences and other contexts in which people find themselves. In this case, it was this research project. There was a claiming of space that happened that day by the Aboriginal community, space within the health sciences building and space within the University. In physically occupying the space and what occurred in the Confirmation Seminar, I believe that the community were also speaking back. Community members chose to be there on the day and to be part of the collective of community who were present and part of the total number of people who were

present. In their presence and in their silent manner they exerted power individually and as a collective and I believe more importantly they exerted power to the words that day. Self and community were connected. I understand that at times we can perceive power to be held within institutions and with people who are given titles, but I know power is also found within dialogue and within community connection and relationships. On the day of my Confirmation Seminar, I publicly contested the dominant discourse around research methodologies as they apply to Aboriginal peoples and argued a framework of Indigenous research. I presented my reflections on the realities for me as an Indigenous researcher, which connected in and out of community member's realities of educational and institutional experiences and the beginnings of an Indigenist framework, and presented in a way which I believed challenged some long held assumptions, beliefs and values about Indigenous peoples. The Confirmation Seminar provided an opportunity to collectively voice and to re-weave some of the thinking held about Aboriginal peoples by both Indigenous peoples and non-Indigenous peoples. For non-Indigenous peoples it demonstrated our Indigenous collectivity and support of dialogue, a challenge in assumptions, beliefs and values along with asking questions to the dominant society about research. For Aboriginal peoples, it provided connection, belonging, pride and positive affirmation of our coexistence, the dialogue and for us as Aboriginal peoples. I felt so strong in the room with the support and this is from where I have additionally drawn strength to undertake my research work.

Recognising and Interpreting the Tracks: Data Analysis

A number of approaches were undertaken in regards to data analysis. Throughout this research project all materials that were relevant to the topic underwent a content analysis. This included newspaper, magazine and journal articles, books, radio interview transcripts, reports, policy documents and websites. As Sarantakos

identified, content analysis is a “scientific means of data collection and analysis, content analysis employs a systemic approach as well as standards and principles found in all methods of social research” (1998:279). Feminists have utilised children’s books, fashion, post-cards, letters, handbooks, and works of art along with textbooks, journal articles and research publications (Lather, 1991a & b; Reinharz, 1992:147). What content analysis can provide is thematic content of communication and can draw out what individuals or groups articulate as their ideologies, values, intentions or sentiments (Sarantakos, 1998:280). Sarantakos identifies two types of content, which he terms *manifest content* and *latent content* (1998:280). *Manifest content* is content which is visible, the surface text and parts of the text that are manifested in the material, for example the words, paragraphs, pictures, graphs and diagrams. *Latent content* is the “underlying meaning conveyed through the document” (1998:280), for example, what is ‘between the lines’, meanings inferred or hidden and messages that may be additionally conveyed and be significant to the document or the study by the researcher (Sarantakos, 1998:280). I have undertaken content analysis into both manifest and latent content with this research project.

All of the data was grouped into thematic categories. My understanding of what should be categories was based on repetition within the interview data, my own experiences and knowledge, and that of others that I knew about from experience and the literature. This provided a useful starting point. While at times categories could be clearly defined, at other times they were not so clear. For example, what a document might be saying might not seem significant to a theme and yet what it isn’t saying might make it significant. There was the possibility of overlooking information when documents were not addressing the same topic as this research. I needed to look out for interconnections between the materials relevant to the study.

Once I viewed all the materials, I kept constantly comparing documents, articles and reports with what women had said and not said. I made notes on paper and notes on the computer. I drew maps and diagrams of how the information related and interconnected at times. I drew on a large sheet of paper a matrix of what the women had said and added notes from the readings as I revised. On the left hand side going down the page, I placed categories such as age, background, education, employment, children, general comments and I placed the assigned pseudonyms for individuals across the top. On another, I did the same across the top and then down the left hand side of the page I wrote down issues - cultural comfort, space and place, feel good accessing a health service, cross-cultural awareness, areas for improvement. I did others as the need arose and the data from the women and/or other sources revealed issues, which I had not included in my first draft of analysis, such as skin colour and utilising the privilege of whiteness. These became apparent after re-reading of the information. I placed these sheets of paper around the walls of my office at home. I had to continually work through and between my reflections, experiences and knowledge, the literature and the interview data, while at the same time trying to develop the merging total picture for Aboriginal women. In this, I kept checking and re-checking with some of the women I had interviewed and discussed some of my interim conclusions too. At times I felt overwhelmed by the large amounts of data I amassed and with the task of undertaking such a project with Aboriginal women. I came to conclusions and the writing after much reading, reflection and revision of my work. I wanted to ensure through this project what Patti Lather described as being able “to tell a story that makes a difference not only at the site of thought but also at the site of socio-political practice” (Lather, 1991b:151).

There were several benefits of utilising content analysis. First it could be used for all the materials, including the reports, policy documents texts and articles as well as with the transcripts of the interviews with the participants. Second, all the materials were relatively easily accessible, except for a few reports which I had to source from individuals and organisational resource collections as they were not held in the CQU Library or other university libraries. These were documents produced locally and regionally in Central Queensland. This taught me that such reports, when produced, need to be sent to the Rockhampton City Council Library and CQU Library to allow others to access them for developmental or research purposes. Third, content analysis is relatively low-cost compared to other methods, such as mailing out surveys to collect quantifiable data able to be analysed with a computer. This type of research approach would not have worked in this research project. It would have altered the story structure, community process and removed a sense of the personal. Lastly, bias is minimised as the documents such as texts, journal articles and reports are already prepared. Some for example come from the Australian Bureau of Statistics (ABS) reports; Indigenous Australian HealthInfonet gains its data from them as do the government departments which additionally publish reports.

There are weaknesses with content analysis. Memos and documents relating to reports or events are not always readily available or accessible, and may or may not been relevant to this research project. Sarankatos states that one of the disadvantages is that the documents utilised “often contain information related to a small proportion of people, and therefore not representative” (1998:286). It could be argued that Aboriginal women are a small proportion in relation to the general Rockhampton population. Using the reports produced locally is the only way to gain a more accurate picture of the situation as experienced by them. Sarankatos

additionally states that documents may be incomplete and therefore may be biased or unreliable (1998:286). As I have used a wide variety of documents from a range of sources, I believe the problem of unreliability of the information is minimised. By using existing documents and reinterpreting I believe I have minimised the problem of Aboriginal women feeling over-researched.

Overall content analysis proved a very effective method of data collection and data analysis. I became aware through this research project that while it is a useful method in itself, it is also useful in the context of other methods of research. All research deals with some form of texts and thus some form of content analysis must be employed.

Travelling in a Good Way: Ethics

The success of this research enterprise depended on me knowing what the issues were relating to Indigenous people and research, being an Aboriginal researcher, and the ethical issues around Aboriginal women's research.

Ethical consent was sought from the Human Ethics Research Review Panel, Central Queensland University. I received notification of a favourable outcome. I was very much aware of my ethical obligations towards the research participants and the Indigenous community.

I was a participant at the National Indigenous Ethics Conference at James Cook University in 1995 and from this time have taken a very active interest in the ongoing development of my knowledge and skills concerning ethical issues in relation to undertaking research with and within Indigenous communities, and being an Aboriginal researcher and working with Indigenous communities. I saw that there

were ethical issues that pertain first to the Aboriginal women who would be participants for the purpose of this research and second for me as an Aboriginal person undertaking this research. Some of the issues relating to ethics are linked to methodological questions and so are discussed here.

I used the Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research (NHMRC, 1991), the Koori Unit's (n.d.) and the Centre for Aboriginal and Torres Strait Islander Participation, Research and Development at James Cook University (1995), which I considered extremely comprehensive documents. I make mention of these as I believed that CQU's ethical guidelines are inadequate for research with Aboriginal communities; these other documents offered a more structured process.

I prepared a letter to the Aboriginal and Islander Community Resource Agency Inc. (AICRA) seeking support, as AICRA was an organisation known to work with Aboriginal and Torres Strait Islander women. A number of women felt that it would be most appropriate to link this research project to an Aboriginal agency over the period of the project. I also prepared a letter to community organisations regarding my research process. That was sent out in 1998. This promoted awareness of the research I was undertaking and provided information dissemination. In 1999 I was listed as a speaker at the Rockhampton Aboriginal and Torres Strait Islander Community Interagency Meeting, held regularly on the first Friday of the month, at the Queensland Education Support Unit, North Street, Rockhampton.

I discussed the project with numerous people. One was the head of the Aboriginal and Torres Strait Islander Unit at CQU; others included Aboriginal health workers, government workers and organisation workers.

One woman passed away during the research. After talking with her family, I made the decision that her data would not be used in the research. While I do not know what she would have wanted, I can anticipate that she would not have liked me to use her data. I additionally needed to care for myself. Her death came as another stark reminder of not only my own death but the impending death of so many other Aboriginal women.

Information sheets were provided to each of the 20 women and to other Aboriginal women who were interested. A consent form was signed by each person who wished to be taped (Attachment B). A consent form was not signed by the women who did not wish to be taped and who stated that their verbal consent, their 'word' was sufficient. I accepted this form of consent. The four younger women who did not wish to sign the consent form or be taped, all stated that they had not participated in such a research process before. I used the opportunity to explain why research processes based in education and other environments require such forms. I acknowledged and validated the women who did not wish to sign a consent form. Their verbal agreement was consent enough. I offered the question sheet, information sheet and consent form ahead of time if any of the women wanted to receive them earlier.

A number of women did not want me to talk while they told me their stories. The younger women in particular wished for me to write as they spoke. The interviews were carried out in a range of locations from offices, homes, to near the Fitzroy River, which runs through the main part of town, and some were conducted on the University campus. I offered the choice of location to women. A number of women stated that they wanted to share the experience of the interview and wished for

another woman to be with them or wanted to observe me interview another woman before they gave an interview. One participant was very nervous and wanted to sit in on an interview with another woman. They both agreed. When this had happened, she felt more settled and was ready to give her interview. It wasn't that she didn't want to give an interview, she indicated she didn't want to make a mistake on her own behalf or get it wrong. After the interview she said she felt good that she was able to tell part of her story and that she felt stronger. Informal discussions with participants were documented through field notes.

Sixteen women were given copies of their transcripts via a taped version and /or a copy of the cassette. The four women who were not taped were given a copy of the notes that were taken during or directly after the interview. All the materials provided to the women were sent via Australia Post, in envelopes marked private and confidential, to the addresses they had indicated was best for them to receive this mail. Two women did not want it sent to their home addresses. All women thus had the opportunity to correct, edit or otherwise amend the transcripts of their interviews if they wished. This provided a validation of their stories, as well as allowed for mistakes to be rectified. One woman sent me an in-depth email after I interviewed her with further information. Another woman asked me to come back as she had much more to tell me and had thought further about what she had said. She had 'remembered some more things' and had also thought about some 'more ways to improve things' in relation to health services.

I did not ask for any personal client information in terms of medical files or records because I did not need this for the research. I was not undertaking an analysis of what the medical records showed. I was exploring their perceptions and experiences in accessing health services as Aboriginal women. Sometimes women discussed

highly personal information that I didn't need for the research, which they also knew, but it was given in the process of sharing and with respect from both of us engaged in the interview.

I did not gain any negative feedback during the research process other than the length of time it was taking and then they would add words of encouragement, 'I don't know how you are managing to get it done'.

My dilly bag's full: Data Storage

There is a large variation in the nature of the data gathered during the research. There are tapes of the interviews and copies of the transcripts. The tapes and transcripts were and still are stored in a dedicated place at my home. This place is locked and can only be accessed by myself. Access to the dedicated place will be arranged in the advent of my death, illness or if I need to leave my home. All women additionally have copies of their transcripts either in paper form or a cassette. At the completion of the required amount of time, as set down by the University for destruction of research materials, women will be asked what they wish done with their transcripts and tapes. Some women have indicated that they wish them to go to a Cultural Keeping Place but this needs to be re-established after the eight years (i.e. in 2009).¹¹

Each participant involved in this project was a volunteer and was made aware of her rights. Each participant could withdraw from the research project at any time without prejudice or recourse from myself. All recordings, transcripts and notes

¹¹ Computer stored materials have all been copied to floppy disks for storage and the hard drive of my computer at Central Queensland University and at my home cleared. A hardcopy of materials used during analysis are stored in the dedicated place. All other paperwork connected with the research, field notes, butcher's paper and diaries are stored in the dedicated place.

were kept locked in my office in Building 18, Rockhampton campus, CQU or at my home. All materials transferred from Building 18 to my home are kept in a locked case. All materials relating to specific individuals will be destroyed at the end of the research (after specified time period) unless participants have identified they wish to keep the materials or we collectively wish to use the materials in other work. Any original materials such as tapes, transcripts and notes that may contain sensitive materials needed to be negotiated with the participants and Aboriginal representatives during and after the completion of the research.

I have now a detailed collection of literature as a result of the research and my community work in the health arena during the past decade. I did have a large private library prior to commencing the research which has since had many items added. Some of the materials are of historical value as they are limited copies of reports, draft reports or due to their highly specific nature. Many such copies are not held at the CQU library nor would the CQU library perceive them of value. They are however, of value to Aboriginal and Torres Strait Islander peoples or to people undertaking very specific research into issues particular to Aboriginal and Torres Strait Islander peoples. Some of this literature I will maintain within my personal library. Some of the other literature, copies of reports and documents will be reviewed and discussions will take place with Aboriginal people within Rockhampton as to where they should best be housed. There are three possible options, the Cultural Keeping Place or the Indigenous Resource Collection, both managed by Nulloo Yumbah, CQU; and/or the Central Queensland Social and Emotional Well-Being Centre, managed and administered by the Bidjerdii Aboriginal and Torres Strait Islanders Corporation Community Health Service Central Queensland Region. The Social and Emotional Well-Being Centre has established a collection of resources specifically addressing Aboriginal and Torres

Strait Islander health issues in light of the proposed training the Centre will deliver and the research focus it will have in the future. I, and other people, will be able to access anything that is gifted to the Centre or the Indigenous Resource Collection. The Cultural Keeping Place has restrictions on access, which will be useful for some materials.

Keeping the Secrets: Confidentiality

I understood the importance of maintaining privacy and confidentiality of participant's responses, concerns, identity and specific cultural information. I understood that there may have been dilemmas in keeping such assurances such as loss of theoretical strength. While I understood this, standards were maintained for this research, as set down in several ethical documents and decreed by CQU.

Whilst the right to cultural knowledge and identity are basic human rights, 'knowing' is not an assumed right in many cultures including Indigenous Australian cultures. Access to knowledge is according to the role and positioning that each Indigenous person has within a particular Indigenous culture or community (Brady, 1992). Thus there are some knowledges that I have access to and some knowledges that I do not have access to, and this does not begin or stop with the commencement or conclusion of this research. There were some knowledges that I have had access to as an Aboriginal woman that a non-Indigenous woman undertaking a similar project would not have access. Guidance was sought where appropriate from my supervisor Priscilla Iles and other older Aboriginal women on any information that should not be provided for the readers of this thesis due to cultural access issues.

Imprinting the Journey: Writing the Thesis

For me, one of the issues from the place of story, of the words and the feelings, was how I was going to convert the information into a written thesis and what style, format and type of writing would the thesis would contain? I asked the question as I have many times in public domains about writing, ‘writing and good writing is determined by what and by whom’? Its characteristics from some texts could be said to be scientific, logical, reasoned, removed, non-sensitive, non-intuitive, scholarly and regarded as intelligible. Its characteristics could be said from some viewpoints, to be biased, ‘white’, Eurocentric, Anglophilic and exclusionary. I know the arguments from both sides after years of being within the education system.

I have been told, as other Aboriginal people have been told, that in writing ‘we need to assert our identities’, ‘be true to ourselves and our peoples’ and that ‘more of us are needed to undertake research work’ and to ‘work with Aboriginal communities’. However, to write well from the perspective of what is ‘considered’ to be written well, I have in the past often felt pressured to either espouse the dominant way of writing, become like the ‘us’, or transcend borderlines. In this in the past I have often become confused, it comes from, I have to ‘forget me not but forget me’ sensation that so many Aboriginal people get when entering into education facilities. For me in this situation, it could be cast as “forget me not as the Aboriginal woman researcher undertaking research with Aboriginal women” and forget me in the writing of what is deemed as ‘scholarly’. There was an issue that arose in writing this thesis of how to please myself, the Aboriginal women in the community, the broader Aboriginal community, markers, academia, ‘everyone’ and may be ‘no one’. There was the risk of being accused of ‘ignoring Aboriginal culture’, ‘being whiter than white’ or of being not ‘scholarly’ enough, not ‘academic’ enough. I know there have

been criticisms of the autobiographical and biographical nature of authorship (as explored by Grossman, 2001). I additionally know that Aboriginal writing still provides further evidence and support to the statements made about Aboriginal peoples in a range of disciplines and genres that are said to be ‘factual’ and ‘academically rigorous’. Further to this Aboriginal writings serve to give us all another articulated sense of the politics of identity and struggle, and are often constructed through race, gender, class and culture.

I know and have learnt that the process of education and research has the capacity to affirm culture, heritage and identity, then strip it off me in the writing and then paste it back on me when I graduate. ‘Hail the victory of another black graduate’. CQU will take pride when I graduate with the PhD as an Aboriginal person. Few that make up the University will be aware of the issues that surfaced for me in the journey. Few will be aware of the danger I outlined earlier in this Chapter, the danger of learning western methodologies and how neo-colonialism, racism and bias can be perpetuated back on our communities if we as Indigenous researchers do not interrogate what we have learnt to get to the point of graduation (when I am cynical, I wonder if in fact they really do understand the danger for us). I did not wish to lay claim to presenting women’s voices while remaining sovereign over the writing, using language to cull and colonise. This was important to me and I have attempted not to do this in the writing. I know that gowning up and accepting my graduation piece of paper on the day will make me ‘equal’ only in terms of the piece of paper and in the title of PhD, in the environment of academia. This has been shared with me by a number of Aboriginal Australian PhD graduates. I know that the whole process of undertaking a PhD and writing a thesis has alienated me in the process. This

is the fear I have for future Indigenous thesis writers as they make their journeys.

There are many issues that present themselves to the Indigenous researcher. One of them is the writing of the thesis itself. In the writing, I could see that I could be jeopardised as writer, as woman and as an Aboriginal woman. I needed to work out for myself issues of thesis writing, as I have undertaken this research. I needed to negotiate the writing with my supervisors and come to some acceptance of things I couldn't change. I would not state that the writing has been an obstacle, but how the writing was expected to look, to be shaped and the words that created obstacles. Further obstacles are addressed in the following section.

Recognised Obstacles in the Journey: Limitations

I did not wish to generalise from the research findings and thus one of the difficulties I encountered was in encouraging a level of engagement by Aboriginal women to address the issues I had raised. I found this personally difficult. It was not that Aboriginal women did not wish to discuss the matters, did not wish to be engaged; it was more about my personal comfort levels and asking specific questions, clarifying questions and paraphrasing. In a sense, I knew I was undertaking an interview and I know how much I dislike being interviewed for 'research'. These feelings I came to understand were based on my own historical experiences of research.

I recognised that as Aboriginal women we have so many competing priorities in our lives. I know that to work for three, may be six years in my case, reading, writing and thinking is a luxury that few people are given, even fewer Aboriginal people. The life of a full-time PhD student, academic and researcher is largely one of

privilege in the context of the situation for millions of peoples and millions of women in the world. It is a privilege that few Aboriginal women have in Australia. Thus I knew that there would be times when I saw what I was doing as important and other women would not. There were times when I would see what I was doing as not important in terms of the day-to-day struggles of Indigenous women. I knew that with the commitments and obligations I had in the community, that at times I might also see the research as a hindrance to doing 'grass roots on the ground work where I see improvements in the health of Aboriginal peoples'. My role as Chairperson with the Bidjerdii Community Health Service has allowed me to often see direct improvements in the health care of Aboriginal peoples. I was offered several jobs during the years 2000 to 2002 and was told that I had 'served my community apprenticeship' and that I 'didn't need the PhD to get some of the jobs some people wanted me to get' (whether elected or paid positions). It was a difficult time.

I continued reflecting on my goals and I knew that I wished to present the collective story of Aboriginal women's experiences and of the research process itself. I needed to know how other researchers, in particular Aboriginal researchers dealt with issues of 'rigour' in their qualitative research while continuing to avoid the trap of objectivity and subjectivity. Whilst doing this, I wished to be mindful of not removing voice and of disconnection for myself. I needed to know how other Aboriginal women and peoples have undertaken qualitative research within a western educational framework whilst maintaining a sense of cultural connection, belonging and balance. Carolyn Kenny's work gave me some inspiration, as did the work of Patricia Monture-Angus (1995). Aileen Moreton-Robinson's works gave me impetus to go on.

In much of the work undertaken I was so personally enmeshed in the topic that at times it triggered issues within my mind, body and spirit. In some of the readings I was brought to tears and experienced deep frustration as an Aboriginal woman at what still persists for us as Aboriginal peoples. At times it overwhelmed me. I was able to discuss some of these issues with other older Aboriginal women. I know that Dani Stehlik saw some of this within me, and Ron Labonte saw glimpses of it. I additionally sought out one other woman to debrief with at times. I believed she could provide confidentiality and meet my needs on a personal, emotional and mental level. I sought out other Aboriginal women who were undertaking postgraduate studies and some who had completed postgraduate studies. I did not receive from non-Indigenous postgraduates the same level of personal engagement, or the same level of emotional, spiritual and physical engagement in their work.

At times I became extremely frustrated with the structures within the University. I saw the rules as constraints, Eurocentric, Anglocentric and imperialist measures to keep in place a process which was about me as an Aboriginal woman undertaking research with Aboriginal women in an Aboriginal community, but also within a broader community. Their thinking - our way is best, meaning the 'white way' is best - seemed at times to permeate through the University structures. At the time of writing this thesis there are around 25 Aboriginal people with a PhD in Australia. I considered the issue of who had undertaken what could be considered Indigenous research in the social sciences or health discipline, and who had undertaken straight quantitative research. I narrowed down the field of Aboriginal people to talk to about my own difficulties and research challenges. I found out that there were expectations that I didn't know about within the University connected with processes and paperwork of my Candidature. I only found out when I didn't meet some of the expectations that I should have known about 'this' or 'that'. This

happened on numerous occasions. Some of this was additionally around the informal processes such as joint papers for conferences, attending meetings and involvement in some research activities. It became even more difficult when I knew I could have asked, but at times I didn't even know what questions I was supposed to ask.

I found it extremely difficult managing my community responsibilities, friendship and family commitments and obligations, and the on-going research demands. As an Aboriginal woman I needed and need to constantly maintain my placement as an Aboriginal woman and my on-going responsibilities within the women's domain. I needed and need to nourish my identity, my placement and my spirit. I could not and cannot do this from within a higher education environment which is essentially 'white', Eurocentric and in which I am isolated as 'Other'. I was faced with having to constantly choose over the time I was giving to family and community versus this research project. In this, I had to choose between nourishing myself as an Aboriginal woman and assisting family and community and the work of the thesis within the University. At times there was great tension and conflict between me the researcher and my sense of self, and the self in connection to others.

I did find the whole research environment within the University stifling at times. At times I just needed to be away from the office, the building and the University. I needed to be with my sisters, the Aboriginal women I hold dear. I needed to be with other Aboriginal women, along with Aboriginal men and Aboriginal children and to be within community and with family. It was here, with family and within community that my spirit would be replenished, uplifted, nourished, where I could feel who I really was again.

Conclusion

Within this chapter I have outlined the *Pathway* of this research project. I have established the *Path*, the external landscape in which the project is based and in which I must operate while undertaking this research. I have provided an overview of the broader landscape of Aboriginal research in Australia, which in the past has tended to be undertaken by non-Indigenous peoples. As Aboriginal peoples, we have been generally the objects of the research as has our art, dance, stories, artefacts, music and bodies. This is not unique to Australia, as the experience has been similar for other Indigenous peoples of the world. As a group of peoples, we are generally regarded as the “most researched group in the world” (ARI, 1993:2). Smith additionally argues this point (1999:3) and states that “The word itself, ‘research’ “is probably one of the dirtiest words in the i[I]ndigenous world’s vocabulary” (1999:1). Despite all of this, we now witness Aboriginal Australian peoples entering this landscape of research.

Aboriginal Australians are relatively new travellers within this landscape. I explored some of the issues that I have had as one of these new travellers and have raised issues around the struggles to maintain my sense of Aboriginality, the western anglophilic nature of Australian universities and the objectification of Aboriginal peoples that at times leaves us voiceless. I have found little evidence of sites within this landscape where we can all talk and enact strategies for emancipation, liberation, subjectivity and resistance, and where we can individually and jointly speak. I know that if the present situation within the landscape continues, we will be maintained as the voiceless and as marginal and there will be little opportunity for openness and challenge. Yet at the same time, I know within the hardness of the landscape at times there are little gaps, like crevices within what

appears to be barren ground that can be worked on and utilised to challenge and to attempt to make changes that can have an impact.

Over the past fifteen years but more specifically over the past six years, I have observed several Indigenous researchers make challenges. These have included Nakata (1997, 1998b) Moreton-Robinson (2000) and Rigney (1997a,b, 1999, 2001). There has been a call that we as Indigenous peoples need to be Indigenous researchers within this landscape (Rigney, 2001). Rigney (1999), Smith (1999) and Warrior (1995, 1999) all assert the need for decolonising, re-positioning and supporting Indigenous knowledges and research methods within higher education institutions. In order for us to be Indigenous researchers and to work towards decolonisation, re-positioning and supporting our knowledges and research methods, we need to understand the western disciplines and systems in which we operate as researchers. Nakata argues that “we must first immerse ourselves in and understand the very systems of thought, ideas and knowledge that have been instrumental in producing our position” (1998b:4). This has been part of my *Pathway*, the *Pathway* of this research project and the *Pathway* of my entire higher education learning experience. It is why the Chapters detail Aboriginal sense of being, the history of health and Aboriginal health in Australia and then health policy before I present the voices of Aboriginal women. I have outlined what I needed to make this journey within the university in which I was based, the methodologies, the frameworks, the supervisors, the research process, interviews, confirmation seminar, data analysis and storage, ethics, confidentiality and writing this thesis. This format is the *Path*, the structure I have put in place for you to follow my journey, my *Way*. In my *Way*, I was reminded that Aboriginal and indeed Indigenous societies are based around process; it is about the journeying and

coming to know oneself. As Cajete has stated, “we create ourselves anew” (1994:55).

Rigney (2001) and Warrior (1995, 1999), in discussing Indigenous intellectual sovereignty, outline that it is a process and not about an outcome. This process concerns the individual *and* the group. In this research project, a process has taken place, allowed for speaking, reflection and articulation through a range of means about Aboriginal women’s struggles within Australia and what strategies are needed. This process provided the opportunity to move away from some of the constraints of the western academy and provided a sound foundation to speak back to that academy, along with governments and agencies on Aboriginal women’s health. I have demonstrated this within this chapter. The next chapter will explore Aboriginality and Aboriginal women in Australia.

Chapter 3

NOT “just a little black bastard”

Introduction

“I’m just a little black bastard”, my grandfather would say. He said this sometimes when he referred to himself. As a young girl I never really quite understood what he meant and why he referred to himself as he did. In sharing what he knew, we, his grandchildren, would sit with him in his lounge room as my grandmother, mother and sometimes my aunties sat in the kitchen drinking tea. They were doing what they needed to do. My grandfather told us stories about himself, growing up and the world. He shared some of his ways of seeing and always, the words just seemed to roll off his tongue.

As we, his grandchildren, sat in the lounge room with him to talk and listen, so did many other people who came to have a yarn (share, talk, discuss). Some called him “Teddy”, “Ted”, “Camel”, others called him “Smithy” and others fondly would say “how are ya, ya old bastard” or “ya old black bastard”. Me, I called him grandpa and as I grew and matured, I came to know my grandpa was a man who possessed great insight, generosity and knowledge. I also came to recognise his adoption as a child and the immense loss and confusion he felt. This came from the loss of knowing about who he was and the loss of knowing about his placement. The confusion came from the multiple truths and the multiple explanations of who he was and was supposed to be. I have come to understand and know some of what my grandpa felt and some of what he experienced. His life instilled within me a need to explore my own belonging, Aboriginality and placement in the world. This is an on-going journey. I have moved along my own life’s journey, developed an awareness of my grandpa that I never knew when he was alive. It is from this place that I write this chapter and why I dedicate it to my grandpa.

This chapter explores Aboriginality from a range of perspectives including my own, other Aboriginal perspectives and other perspectives including that of governments. The chapter will go from broader societal perspectives to more specific perspectives of Aboriginal women, and addresses and extends beyond known definitions and labels to deeper human understandings and experiences of Aboriginality. It examines how the historical processes of invasion and colonisation have affected these understandings and experiences. This chapter argues that it is only when Aboriginality is looked at in its entirety can one fully comprehend the connections between Aboriginality, ill health, well health and well-being. Finally, it offers conclusions that Aboriginality and the right to define oneself is a human right and that this right has been attacked but never ceded by Aboriginal peoples. Furthermore, it suggests that this right is being re-vitalised and re-energised in the processes of Native Title, through numerous other aspects of the Aboriginal movement and the re-empowering of Aboriginal peoples and communities.

A Label

Since colonisation commenced in 1788 Aboriginal peoples have been labelled, called and described by a deluge of names - Natives, Blacks, Aboriginals, Aboriginal Australians, Indigenous and Indigenous Australians. Along with such names and descriptions, the status of Australia's Aboriginal peoples has been continually contested and marginalised. The right of Aboriginal peoples to be Indigenous peoples has been the subject of a continuous flow of commentary and classification regarding Aboriginality: what it means to be Aboriginal, who is an Aboriginal person and who is not an Aboriginal person. There has been, as Beckett describes, "a medley of voices black and white, official and unofficial, national and local, scientific and journalistic, religious and secular, interested and disinterested, all offering or contesting particular constructions of Aboriginality" (1994:7).

This process continues in the present day. For example, those peoples claiming Native Title are challenged in the systems introduced as part of Native Title claims; whereby individuals, clans, tribes must produce detailed genealogies, stories and evidence of their claims. Anthropologists and historians are engaged to construct Aboriginality and the right to claim land on paper as defined by Australian law. With the processes of Native Title Claims and Agreements, there will be Aboriginal people under Native Title Agreements and Aboriginal peoples who are not under Native Title Agreements. This has the capacity to operate in much the same way as 'Treaty and non-Treaty Indian' peoples in Canada and the United States of America. In some cases it has worked for those Nations and in other cases it has created further disparity amongst Aboriginal peoples. As Aboriginal peoples, we need to ask the question "do we wish to go down the same path as Treaty and non-Treaty and Status and non-Status with relation to our selves?" (See Sawchuck for an overview of Canadian and United States of America identities, 1992:1).

In most circumstances Aboriginal peoples when accessing government programs and support mechanisms, must now produce a Certificate of Aboriginality, a piece of paper that states we are 'Aboriginal' and gives us the right to say they are 'Aboriginal'. This certification must be produced to access Aboriginal and Torres Strait Islander Commission (ATSIC) Home Loans, education programs specifically for Aboriginal peoples, including Abstudy (student allowances), housing commission (state government) homes specifically for Aboriginal peoples, sponsorships, training programs and employment programs. This is similar to Canada, USA and New Zealand. It can be a humiliating experience and process to be told to get a piece of paper that states one is or is not Aboriginal. The question must be asked: Why non-Aboriginal people do not have to get a piece of paper or a 'Certificate of Non-Aboriginality' to access programs? Non-English Speaking Background peoples (immigrants) additionally do not need the same type of certification. The number of non-Aboriginal people who may choose to try and 'work the system' for their own gains (imagined or not) by

stating or ticking a box that they are an Aboriginal person are few and are generally quickly identified. There are many issues that additionally come with identifying as an Aboriginal person, the social, political, cultural, economic issues, stigmas and responsibilities of being an Aboriginal person. This is not unique to Australian Aboriginal peoples, it is a commonality between Indigenous peoples across the world. As Pita Sharples explained at an international conference of Indigenous peoples, to “be Indigenous means to have responsibilities. To be Aboriginal means to have responsibilities ... What are your responsibilities? What will you do when you go home? Nothing? Something?” (1998:25). He concluded with “I don’t want to come back in two years and ask you and you have been to more conferences, smiled, eaten good and done nothing!” Edwin Jebb, at the same conference, stated,

Take ownership of yourself, your being, your spirit. Take ownership of your lives. Take ownership. Don’t be Indian sometimes and not other times. Don’t tell people they’re not being Indian when you’re not. Look in the mirror if you’re saying someone is not being Indian (1998:15).

I have attended many Indigenous conferences where such discussion, talking and directives are given. I have never been to a conference for the broader population where the people present have been reminded of their responsibilities to others and to humanity itself. I have come to see that in many ways it is part of the Indigenous way of reminding us to remember, making us ‘remember to remember’ all that we are, the total sum of who we are as individuals and as a member of a collective. The collective is our family, our communities and the peoples to whom we connect nationally and internationally.

Some Aboriginal peoples have rejected the Certificate of Aboriginality and refuse to go through a ‘white man’s process’ to prove they are ‘Aboriginal’. Greater offence and insult is experienced by Aboriginal peoples when it is realised that the label ‘Aboriginal’ is in itself not Aboriginal. In this refusal of an imposed identity, they jeopardise their and their children’s access to any programs

designated for Aboriginal peoples. In reality the legislated and policy definitions and concepts of Aboriginality are imposed identities due to the processes of colonialism, imperialism and racism. Indigenous peoples throughout the world share the experience of a legislated identity. Sharples stated that, “The Indian Act is rubbish, Metis rules rubbish, Maori must register to be a beneficiary, Aboriginal Australians rules same. What if you and your family don’t know your tribe, clan? Rubbish rules, Rubbish Acts” (1998:24).

Aboriginal peoples everywhere are still fighting for the right to be Aboriginal, the right to be Indigenous peoples, while at the same time justifying Aboriginality and justifying our existence as Indigenous peoples. Indigenous people in many parts of the world have concerns about the imposition of identity, the discussions of identity and the legal status attached to identity (Sawchuck, 1992:1). Sawchuck argues, “Imposed identity was part of a world-wide classification that diminished all peoples with the false dichotomy of primitive or civilised; Native or non-Native” (1992:1).

In Australia there existed well over 300 nations prior to colonisation ¹², which have been reduced to the concepts of ‘Aboriginal’ and ‘Indigenous’ through government processes and interventions. Colonisation has also resulted in the creation of the ethnicity of non-Indigenous and non-Aboriginal and therefore grouped all others who aren’t Aboriginal Australians together even though they are no more homogenous than the group labelled as ‘Aboriginal’ or ‘Indigenous’. In Australia it was not only the British Empire and the State that imposed identity on Aboriginal peoples, it was also the churches, institutions, academics and the media. The division between Aboriginal and non-Aboriginal has been part of us for so long now that it seems to have entered the sub-conscious of all of us. There seems to be a clear distinction made between Aboriginal and non-Aboriginal thoughts, concepts and worldviews. While there are distinctions, we cannot and

¹² See Horton’s (1999) *Aboriginal Australia* for a pictorial map of the nations of Aboriginal peoples.

should not also forget that a vicious cultural imperialism has been at work for many years within Australia that has trivialised the cultural differences amongst Aboriginal peoples. This is not unique to Australia, it has happened across the world. What the process of cultural imperialism additionally did was create differences and status amongst Aboriginal peoples and between Aboriginal peoples and non-Aboriginal people. One need only look at the terms and what is sometimes implied by the words 'Tribal', 'Traditional' and 'Urban' Aboriginal peoples. Discussions around 'Traditional' verses 'non-Traditional' arise from time within the community and political circles, as does the issue of blood quantum in relation to Aboriginality (Taylor, 2001). Blood quantum dates back to European understandings of blood and race. The work of Jones discusses blood, as investigated by science theory philosophy and religious circles (1996). While Starr addresses how blood of people from different races was kept segregated in the United States of America (2000:114-5, 126-7, 201-2). There is even broader talk in Australia that one day blood DNA tests will be used to prove that a person is Aboriginal or not, that is if a person "has more white genes than black genes" (Droste, 2000:12).

What is really being said with statements like "the real Aborigines", "real Aborigines live in the Northern Territory", "dilution" or "which part of you is Aboriginal?" Along with statements that deny Aboriginal aspects of colonisation that help to shape issues around Aboriginality today, these type of statements reflect a lack of understanding of the nature of Aboriginality and additionally reflect questioning what constitutes Aboriginality. Aboriginality in the past has been questioned by numerous people including missionaries and anthropologists (Stockton, 1995:29). Anthropologist Ronald Berndt (1971) suggested an identity politics in which Aborigines might deliberately cultivate their Aboriginality as part of a greater plan to express uniqueness in contrast to other Australians. This, he argued, could be an attempt to rectify a situation in which Aboriginal peoples were held in a position of inferiority, nonentity and general deprivation (1971:xviii-xix). The type of statements made in the past by some anthropologists

such as Berndt and others and the ideas that the statements are premised on still find their way into many other areas of Australian society.

There are not only questions around Aboriginal identity that surface, questions also abound about Aboriginal accounts of history. For example 'The Stolen Generation'. In 2000 and 2001 much discussion occurred on this issue in newspaper, magazine and journal articles and also television and radio programs as to whether the Stolen Generation even happened. In 2001 the first essay in *The Australian Quarterly Essay* series appeared, entitled "In Denial: The Stolen Generation and the Right" written by Robert Manne (2001). Craven in the Introduction of the Essay states that it is,

... an attempt to come to terms with the fact that a group of right-wing commentators (centred in the first instance around Manne's old magazine *Quadrant* under the editorship of Paddy McGuinness) has effectively railroaded the national awareness of how large numbers of Aboriginal children were separated from their families (2001:iii).

Ian Syson, the editor of *Overland*, a quarterly literary magazine outlined in an editorial that Manne's essay "sharpened the focus on an ongoing ideological battle in Australian cultural life" (2001:2). In this instance, Syson was referring to the Left and the Right side of issues particularly since he mentions that the Left had known of and talked about widespread massacres of Aboriginal people and the forced removal of Aboriginal children. Syson on discussing the essay specifically states that it has "demonstrated again just how much is at stake when arguments take place about the treatment of Australia's Indigenous People" (2001:2). Why I present this as an example, is that it highlights that even at the national level of political, cultural and intellectual discussion we are still a topic of debate. *Quadrant* has long being noted as the Prime Minister's favourite Australian magazine (Manne, 2001:105). Our identity and our history is still being discussed, denied and agreed upon. It commenced at the time of colonisation and it continues here and elsewhere.

There has been a range of portrayals of Aboriginality within Australia and in other parts of the world. Along with some of the portrayals discussed already there is also at times the tendency to speak of some Aboriginal nations as more significant or important or given preference over others. I clearly remember discussions with a non-Aboriginal man who was working with Aboriginal peoples in Rockhampton who had taught in the Northern Territory with “real Aboriginal people”. He referred to one particular Aboriginal nation of the Northern Territory as “still having their culture”. Needless to say he was continually challenged about his ideas here in Central Queensland and returned to the Northern Territory.

Aboriginal Australians in the past and the present do distinguish themselves from other Aboriginal societies and also from Europeans. Aboriginal societies had and continue to have, distinct cultures, languages and worldviews. Aboriginal and non-Aboriginal peoples all have ethnocentric and at times condescending attitudes towards outsiders of their society. Sawchuck states that this “is one of the most universal, although least estimable of human emotions” (1991:2). Some Aboriginal nations have been able to maintain their distinct cultures, languages and worldviews throughout the processes of colonisation and others have had much greater difficulty. In this, there still may exist ethnocentric attitudes between Aboriginal nations along with outsiders. With other Aboriginal peoples, the ethnocentric attitudes exist between Aboriginal society as a whole and the non-Aboriginal world.

The process of colonisation witnessed the imposition of British and European concepts of identity on Aboriginal peoples throughout the world. It also imposed concepts of self on Aboriginal peoples through domination, oppression, concepts of what I deemed to be ‘civilised’, ‘uncivilised’, ‘superior’ and ‘inferior’. Writers such as Fanon (1963, 1967) and Memmi (1967) detailed this process in their works. Fanon (1963) explained how peoples who were oppressed could become

profiteers from their own people by gaining power and inspiration from previous imperialistic practices and peoples. Fanon used the terms 'Negro-ism' and 'Negritude', despite the universalism of these terms, he supported the use of the terms for the purpose of bringing African peoples together in the collective resistance to colonisation. Negritude is not based in African-ness in the same way that Aboriginality is not based within Aboriginal cultures. It is the historical processes of colonisation that binds and connects Aboriginal peoples together in the same way as it does for African peoples. Fanon suggests the need for the renaissance of cultures in the form of cultural empowerment (1963:28). Further to this that cultural empowerment must accompany the process of decolonisation (1963:28). Ian McLean in his work discusses the concepts put forward by Fanon and the emerging concept of 'Aboriginality' (1998:98-119). McLean explores the emergence of Aboriginality through the visual arts and connects this with cultural empowerment and the political arena at the time. Ngugi wa Thiong'o (1993), bell hooks (1994), Linda Tuhiwai Smith (1999) and James [Sakej] Youngblood Henderson (2000) all discuss the concepts expressed by Fanon from the positioning of Kenyan, Afro-American, Maori and Native American perspectives.

Memmi (1967) demonstrated that the coloniser would not only characterise the colonised peoples as inadequate by European standards, but could further manipulate the situation so that the colonised world would eventually accept the concepts of 'inferiority', 'uncivilised', 'immoral' and all the other labels given to colonised peoples as true of themselves. Through language usage and colonial processes, the British and the Europeans were also imbued with a spurious sense of superiority over the rest of the world (see the Canadian work of Sawchuck, 1992, Henderson, 2000). This resulted in discourse in which Aboriginal Australians and other colonised peoples became the 'Other'. Everything and everyone else was subordinate to Britain and Europe culturally, economically and politically. This is repeated through exclusionary language and privileging difference. Some of these attitudes still prevail and are deeply entrenched in the peoples at sites of colonisation. When the British arrived in Australia in 1788,

they established us as the Indigenous peoples and the environment as ‘Other’. In doing so, they created as they did elsewhere (USA, Canada, New Zealand, Africa) the ‘Other’ in grotesque terms in the process of transforming the continent into a place of conquest. These stereotypes and constructions of ‘Other’ are still promoted and sustained within Australian culture today. Aboriginal peoples still live with this day in day out.

Australian Aboriginal Identity

Aboriginal anthropologist, Professor Marcia Langton explained in 1993 that there were “at least sixty-seven definitions of “Aboriginal people” (1993a:28-29). Aboriginal lawyer, Michael Dodson (1994) and Russell Taylor (2001) have provided valuable additions to the work of Langton. Since Langton wrote about the numerous definitions, the number has grown. Langton states that the number of definitions reflect,

... not only Anglo-Australian legal and administrative obsession, even fixation, with Aboriginal people, but also the uncertainty, confusion and constant search for the appropriate characterisation: ‘full-blood’, ‘half-casts’, ‘quadroon’, ‘octoroon’, ‘such and such an admixture of blood’, ‘a native of an admixture of blood not less than half Aboriginal’, and so on. In one legal case, whether or not an Aboriginal person lived in a ‘native’s camp’ became an important issue of definition (1993a: 28-29).

Langton continues that,

This fixation on classification reflects the extraordinary intensification of colonial administration of Aboriginal affairs since 1788 to the present. Elaborate systems of control aimed, until recently, at exterminating one kind of ‘Aboriginality’ and replacing it with a sanitised version acceptable to the Anglo invaders and immigrants (1993a:28-29).

From all the work ‘done on’ Aboriginality since the time of invasion, the most influential has been State Governance in the construction and shaping of Aboriginality and the control of land. It has had numerous purposes, the most significant being the control over our identities and our land and thus, our lives.

As Russell Taylor explains “Most of the (re)inventions and (re)invocations of Aboriginality have overwhelmingly lain in the domain of non-Aboriginal individual and institutional constructionists” (2001:136). They have attempted to shift and shape us as Aboriginal peoples. There is enough information and documentation around to argue that non-Indigenous peoples and the State have assumed it to be their right and taken it for granted that they could just dissect our identities. The words of Langton, Dodson and Taylor clearly articulate this aspect of our identity.

In assuming the right to dissect our identities and re-shape our identities over and over again there is a violation of our rights. Australia is tied to a range of conventions including International Human Rights Covenants, which are supposed to protect our right to control our own identities. Human rights activist Alston speaks to the International Covenant on Economic, Social and Cultural Rights when he outlines how States should report to the United Nations (Alston, 1998). Pritchard provides a comprehensive analysis of the Covenant on the International Covenant on Civil and Political Rights in relation to Indigenous peoples in Australia and overseas (1998:184-202). Indigenous people according to Pritchard have “begun exploring the limits of the right of their members” (1998:199). Other documents additionally contain wording that support we have the right to name who we are as Indigenous peoples. The Coolangatta Statement of Indigenous Rights in Education was commissioned by the 1993 World Indigenous Peoples’ Conference on Education to discuss Indigenous Peoples’ Education rights. The central focus of the Coolangatta Statement is the principle that ‘Indigenous Peoples have the inalienable right to be Indigenous, which includes the right to self-determination’. This means to be Aboriginal, people have the right to be Aboriginal peoples in the past, present and in the future. This right is also connected to the health and well-being of Aboriginal peoples as Indigenous peoples. It will be discussed in the following two chapters. As Taylor argues, the right to define our own identities is supported by some specific provisions of the United Nations Draft Declaration on the Rights of Indigenous

Peoples (Taylor, 2001:137). Indigenous peoples have the right to distinct identities. Dodson states that tied to identity is also “the broader right to self-determination, that is, the right of a people to determine its political status and to pursue its own economic, social and cultural development” (1994:5).

Despite overwhelming evidence and documents that the Australian Government has signed and is therefore party to these covenants, there continues to be control and denial of such rights by the State. An example (and there are several) is the amendments to the Native Title legislation which have been, “internationally condemned as being racially discriminatory, a matter which appears to be of little concern to the current Government which has, subsequent to the amendments, faced an election and been returned to office“ (Taylor, 2001:138).

The Coalition Government, at this point in time (2003), has now been returned to Government not once but twice. The Australian public that voted for the Coalition therefore appears prepared to accept the way the Coalition discriminates against its Aboriginal peoples and continues to breach international covenants that Australia has signed. Aboriginal Australians such as Dodson continue to work at the international level demonstrating the lack of control over identities and that this lack of control lies “at the core of the violation of our rights” (1994:5). Internationally, the Coalition Government is not as popular, as Aboriginal Australians help show the world the deep void it is sustained within. An example could be said to be the action generated by Australian Aboriginal peoples on the International Covenant on Civil and Political Rights. The Covenant was adopted at the United Nations (UN) Assembly in 1966 and entered into force by the Assembly in 1976. It was entered into force for Australia in 1980 (Pritchard, 1998:199). Australia must report periodically to the associated UN Committee on the measures it has adopted for enacting this Covenant and the progress made towards this for all Australians. This provides Aboriginal Australians with the opportunity to table issues with the contents of the report and the reporting process of Australia. As the Covenants of the UN rest within the

framework of international law, it enables Aboriginal Australians to utilise international law for challenging Australia (Dodson, 1998).

Other Australian writers such as Beckett (1994) and Morris (1988) discuss the role the State plays in controlling Aboriginal identity and the shaping of identity. They highlight the resistance and the fighting back of Aboriginal peoples towards the State and the shaping of our identities. Morris's arguments are worthy of reading for the range of contexts in which he explores the power relationships between the State and oppressed Aboriginal peoples and communities. He provides a lengthy discussion as to how the historical and political processes of colonisation and the State dealing with our identities has resulted in our identities being owned by the State which has resulted in an encompassment of Aboriginal peoples and aspects of Aboriginality. Morris (1988), Wood (1997) and Taylor (2001) all present this encompassment as resulting in Aboriginality as a site of resistance. The work of Brewster explores Aboriginality, within the family structure and the Aboriginal family as a site of resistance (1996). Families are often woman-centred arenas and sites of women's knowledge and practices. In this way, Aboriginal families and Aboriginal women's placement within them operate differently to the ways that First World feminism thinks about families and women. This will be explored in more depth in a later section of this Chapter.

What this literature asserts is that attempts to assimilate Aboriginal peoples through shifts and changes in identity via the State have failed as Aboriginal peoples have resisted. Their definitions, reconfigurations and discussions that have attempted to tell Aboriginal peoples and non-Aboriginal peoples, who Aboriginal peoples are, how we should behave, live and think, have not worked. These notions of us have now been added to the constructions of who we are by a range of peoples including Government, politicians, historians, Anglo-Australians, immigrants and at times ourselves. Morris argues that this resistance produces new forms of social individuality and social practices which develop in opposition to the specific structures of the dominating society (1988:4). In the

development of new social practices it can be argued that there is cultural dynamism and the will of survival in a society that has tried to exterminate, control and subjugate us during colonial processes; in the same society that questions how we can and should look Aboriginal, be Aboriginal, behave as Aboriginal and which still enables Aboriginal peoples to be defined by others. Australians need to understand that we carry all of this within us, within our contemporary constructions of ourselves and choose what we take from it and what we leave. This could be said to be for our survival as Aboriginal individuals and as a collective in 2002 and for the future. Dr Wendy Brady discussed some of the complexities with Aboriginality and how this manifests within us when she wrote that,

... what dominant culture often refuses to consider are the elements of Aboriginality. Aboriginal Australians reflect the history of invasion and colonisation. We carry it in and on our bodies. We range in colour, form, attitude across a complexity and multiplicity of layers. These layers have come from our generational knowledge and from the imposed notions of who we are as a people. These contradict and are more complex than the often simplistic descriptions used to represent us as Aboriginal people. In contemporary culture we carry those elements which have been imposed but which we have also appropriated from others and retained for our own cultural maintenance (1999:28).

Brady's powerful statements highlight for me, how I see some of the complexities of Aboriginality. As Aboriginal women our identity has additionally been the subject of men's and women's commentaries, biases and notions just as Aboriginal peoples collectively have over the years. I discuss this further below. Aboriginal identity, as Brady describes it, is a growing, living and changing concept that is highly complex, political and historical. It is also something, which resonates with the varied words of other Aboriginal peoples over many years.

From my own life's journey and this research, I take Aboriginality as not something which is stagnant or something that is constantly changing. I believe it

does develop and grow and new aspects of Aboriginality appear to an individual from time to time. For example, Aboriginal radio and television broadcaster, Wayne Coolwell stated that, “because of the Aboriginal program ‘Speaking Out’, and my book ‘My Kind of People’, and other things that have happened in my life recently, there’s no doubt I’ve had a re-awakening of my conscience, and of my Aboriginality” (1995:2).

It can be suggested that Aboriginal peoples have varying levels of depth to their Aboriginality along with varying understandings and knowledges of their Aboriginality. This does not mean that there are people who are any less Aboriginal than anyone else or any more Aboriginal than someone else. Darlene Oxenham wrote, “reflecting on my life to date, I would summarise it as a journey towards becoming actualised as an Aboriginal” (Dudgeon, Grogan and Oxenham, 1995:19-20). Oxenham discusses the importance of recognising that there is a diversity that exists among Aboriginal people. She suggests that there can be and are a range of Aboriginalities. Ian Anderson (1997a, 1995, 1994c) a Tasmanian Aboriginal man wrote several papers discussing the complexities and diversities of Aboriginality, colonisation and decolonisation.

We know that in some cases, individuals do deny their own Aboriginality. There can be denial by other people that someone is an Aboriginal person and self-denial that someone is an Aboriginal person. The reasons can be diverse and complex, at times difficult to understand. Cowlshaw and Morris (1997) present a range of perspectives on Aboriginality, including its denial, to escape prejudice and racial discrimination, control by the State, socio-economic and political issues or for other reasons. This has been a source of much debate amongst Aboriginal families and communities. In some families, there are multiple statements about identity, denial by some people, acceptance by others and attempts by some people to reclaim Aboriginality previously self-denied (Taylor, 2001). This may happen one or two generations earlier and even as Taylor suggests they may be “denied by their siblings” (2001:137). Some people choose

not to identify due to thinking that they may be ridiculed in the broader community (Droste, 2000:12). Some, states Droste, an Aboriginal mental health worker based in Brisbane, are “expected to deny a heritage going back through eons of time on the basis that they don’t fit the stereotype of what an Aboriginal person should “look” like” (2000:12). She adds that, “all these identity issues can have devastating impacts on the mental health of Indigenous Australians” (2000:12). The issues of identity and health are intertwined and have been well documented in the past 10 years. I will be speaking to this more directly in the next chapter. From my own experience, I can additionally speak to this; within my own extended family this phenomena of acceptance and denial of Aboriginality exists. Other Australian writers such as Brewster (1996:15), Beckett (1988), Cowlshaw (1988, 1987) all explore the multiple facets of identity and Aboriginality. However in my review of this literature I found that few writers focus specifically on the issues of Aboriginal women. It is to these women that I now turn.

Aboriginal Women

In analysing the array of historical literature specific to Australia, it becomes obvious that the colonisers, missionaries, explorers and others had little regard for any patterns of communal relationships amongst Aboriginal peoples. The British Euro-centric view of male and female relationships denied an important reality. In Australia, Aboriginal women's position and participation in productive activities was parallel to that of men, rather than subservient, subordinate or oppressive.

Australian Aboriginal women and men were diverse within their own gendered realities. Aboriginal women and men lived and live within their own domains and within a common domain that was and is now called 'community'. As far back as I can remember I have heard the term 'community' to mean "everyone's business". Similarly, I have come to know women's business is about knowledge, activities or 'business' for women only. Both Aboriginal men and women have processes of mediating and negotiating their responsibility with each other. Communication across the gendered realities was and is at times specific and set within Aboriginal cultural contexts. Remembering that Aboriginal cultures are diverse and relationships including gender relationships were and are dynamic. Even in today's contemporary lifestyles, Aboriginal people still refer to Aboriginal women's business and men's business. Both Aboriginal men and Aboriginal women were and are distinct and both were and are of vital importance in the balance of community. The gendered concepts and roles of Aboriginal men and Aboriginal women are now acknowledged in national government documents and reports and have come to be broadly accepted by the State (see NAHS, 1989).

There are mixed concepts of female/woman gendered realities and balance within communities. Some writers have described Aboriginal societies as patriarchal in

nature (McGrath, 1980; Hamilton 1981a,b). Hamilton for example, suggests that men's power over women is achieved by the threat of physical force and perhaps violence, that is, by applying the sense that physical force could be needed and could be applied (1981b:74). However an alternative view is that of Burbank in writing of 'Fighting Women' (1994). Burbank sees Aboriginal women as aggressors in asserting their rights. She does not see Aboriginal women as victims of men's authority or threatened by violence, physical force or dominance.

In reading the above literature and other works, I am reminded that the writers generally write from a process of ethnography, that is, as observer. More often than not, such writers historically have been male anthropologists of British, European or Anglo-Australian backgrounds that also provided another set of eyes from which to observe, the eyes of Western patriarchy. It is generally accepted historically, there was a lack of acknowledgment by male anthropologists, that Aboriginal women had their own practices within the spiritual and ritual domains. Male anthropologists were not allowed access to the knowledge or practices of Aboriginal women, due to their gender. The Aboriginal women in the communities being studied were working within their own gendered realities and within the restrictions of their particular Aboriginal culture. When one recognises this, one begins to further develop the understanding that it is from this place that the interpretation has been gained. Interpretations are thus based on the disciplines in which they are formulated and additionally based on the cultural views of gender and sexuality of the person undertaking the interpretation.

When female anthropologists such as Diane Bell (1983), Annette Hamilton (1981a,b), Jane Jacobs (1989) and Peggy Brock (1989) began to enter the field of anthropology, they and others that followed began a more detailed ethnography of Aboriginal women's domains within the communities in which they studied. Jacobs gives acknowledgment to Bell for providing "the first detailed study of an empowered and autonomous women's spiritual and ritual life" within the

Aboriginal society she conducted her research (1994:177). Bell's ethnographic research based in Warrabi (375 klms north of Alice Springs) detailed in supported Aboriginal women's knowledge and claims to land within that locality, noting these were just as important as those of Aboriginal men (1983: 36-37). This work argues Jacobs, "shook the foundations of masculinist readings of Aboriginal society" (1994:177). Bell's work was said to re-position Aboriginal women differently, according to other white female anthropologists, within the thinking of non-Indigenous Australians. The work of Moreton-Robinson (2000) identifies the problematic nature of the work of white middle-class female anthropologists in their interpretations and representations of Aboriginal women. She asserts that

White middle-class women anthropologists' representations create a binary opposition of "traditional" versus "contemporary" Indigenous women which privileges certain groups of Indigenous women as culturally and racially authentic and positions the rest as racially and culturally contaminated. The "contemporary" and "traditional" Indigenous woman binary has salience because women anthropologists utilise a distorted methodology, which relies on a particular ideological construction of culture and race (2000:75)

She provides concrete examples of how this is played out by anthropologists within their work. What becomes clear from the work of Moreton-Robinson (2000) and then on the reading of works such as Bell (1983, 1998), Lilley (1989), Burbank (1985) and others is the establishment and presence of the "contemporary" versus "traditional" binary. The problem with the created binary is that it does not allow space for the multiplicity of Aboriginal women's experiences and cultures. It does not allow for the dramatic changes of colonisation and dispossession and basically implies you are one or the other. Moreton-Robinson states that, "Indigenous women have forged and continue to forge cultural practices under conditions and in contexts not of our choosing; and we do so creatively. The cultures that we create do not mirror those represented by anthropologists" (2000:89). The problem is that the interpretations and representations are used to inform other anthropologists and some of the key writers on feminism in Australia.

Based on anthropological gender research findings, we know that assumptions were and are made as to what were and are the ways of being, men's ways and women's ways and that these became somehow universal. That is, a Euro-centric approach to gender becomes normalising. As Linda Tuhiwai Smith explains when discussing observations of Indigenous women, such views often "resonated with views about the role of women in European societies based on Western notions of culture, religion, race and class" (1999:8). Sometimes these have been universalised to other Aboriginal women and men's ways of being rather than examined in the context of the particular Aboriginal society or nation observed. That is, rather than maintaining the particular Aboriginal cultural context in which the research took place, the research has been carried across to be interpreted to be the same for all Aboriginal women. Just because one cultural practice takes place or one set of gender relations is present in one area, does not mean it takes place or is appropriate for another area. With regards to women, just because a woman may be highly knowledgeable about land in her Country does not mean that she is knowledgeable in land within the Country of other women.

Still, other writers describe a balance between male and female domains and write of 'egalitarian hegemony'. For example, enjoy women's sovereignty and authority in certain social, economic and spiritual domains. Bell, writes of Aboriginal women as autonomous in their own right in all domains, economic, social, political, spiritual, ceremonial (1983). Lawlor, a male anthropologist explains that,

[U]nderneath their apparent submission to male pomp and ceremony, women maintain their balance of power *physically* by providing 80 percent of the food consumed by the tribe and *spiritually* through their own tradition of magic and sorcery, which men rarely dare to challenge (1991:201).

On giving further examples Lawlor states,

Although men apparently control most of the formal relationships in society, such as the bestowal of wives, women's informal control ensures that the entire society adheres to characteristics conducive to women's concerns for procreation, growth, and nourishment of life (1991:201).

Lawlor places the emphasis on what he perceives to be 'formal' and 'informal', or 'pomp'. He makes interpretation as an observer from his own cultural and gender identity along with his disciplinary bias. While he states that women had "informal control" and discusses "procreation, growth and nourishment of life", he has not set his words within the context of Aboriginal society, beliefs or brought in the issues about cultural continuation. What Lawlor misses is that without women and the important role women play there are no people, there is no continuation of culture.

What can be ascertained from the literature is that Aboriginal societies were very gendered. Women had their roles and men had their roles. Children also had their roles although this is less well documented. However it is important to note that within these gendered realities, women assertively affirmed their place and their role within the societies. According to Berndt this provided independence for Aboriginal women and Aboriginal men, yet also provided an essential interdependence between the gender groups, between men and women (1989:6).

As a result of colonisation Aboriginal men and Aboriginal women's gendered realities were greatly affected. They still exist and there are still living gendered realities, but colonisation had a profound impact upon the cultural development of those gendered realities and how they manifest themselves within broader Australian society. For Aboriginal women it was particularly difficult to maintain their identity, as it existed prior to colonisation in the face of powerful socialisation. This does not mean that they lost their identity. Aboriginal women have survived as Aboriginal women. The marginalisation, violation and

exploitation of Aboriginal women that began with the British invasion, has resulted in the on-going disempowerment of Aboriginal women.

Etienne and Leacock explored the impact of colonisation on women in numerous parts of the world (1980). These women researchers argue that as the ultimate goal of the colonial system was the economic exploitation of place and of both men and women, it thus had a profound impact on personal relations between them (1980:17). In some processes of colonisation, the imposition of the European patriarchal social structures destroyed the more egalitarian Indigenous societies (Leacock, 1980; Nash, 1980). The imposition of British patriarchal relationships in Australia that presupposed the universal subordination of women deprived Aboriginal women of land and personal autonomy and restricted the productive functions played prior to colonisation. That is, within the domains such as the economic, political, social, spiritual, and ceremonial written about by Bell (1983), as well as within those that were not named within the research that were known by Aboriginal women. Aboriginal men additionally suffered from deprivation of lands and personal autonomy and restrictive productive functions.¹³ It can be argued however, that the system imposed and the long term effects that have involved the overriding patriarchal systems and structures, sexism and sexual violence have been and continue to be more oppressive to Aboriginal women than to Aboriginal men. These policies continued through the 19th and into the 20th centuries have been well integrated into the capitalist system of production that is entrenched within Australia. What has persisted and resulted is internalised colonialism where Aboriginal women are relegated to a structurally marginal position by non- Indigenous people, both women and men.

Raymond Evans, an Australian male anthropologist, provides a good overview of the changing position of Aboriginal women,

¹³ Hammill (2001a) relates how masculinity has changed within one former Aboriginal reserve.

With the onset of white colonisation, women's functions were either severely truncated and rendered marginal in a reconstituted social environment or utterly destroyed as their populations were decimated and their society and culture dismembered and fragmented. During this process the position of black women plummeted from being co-workers of equal importance to men in the balanced use of the environment to that of thoroughly exploited beasts of burden. It fell from being valuable human resources and partners within traditional sexual relationships to that of degraded and diseased sex objects and from being people of recognised spiritual worth to that of beings of virtual animal status in the eyes and the belief systems of their exploiters (1982:9).

The work of Evans and others (see Bell) supports the concept of balanced gender realities and of Aboriginal women being valued, respected and considered of worth. Aboriginal women, men and children all had specific and important roles within the broader construct of community. I have come to learn over the years that Aboriginal women were valued for the role that Aboriginal women played. We were not of lesser value to men or men a lesser value to women. Aboriginal women had and have their own ceremonies, songs, dances, law and sacred sites. Through ceremonies Aboriginal women's connections, associations, affiliations to country, people and culture were strengthened and they were also for specific purposes or times in a woman's life (Vaarzon-Morel, 1995). Aboriginal women were taught by other Aboriginal women. Lucy Nampijinpa explains one facet of Aboriginal women's law in the following,

I'm talking about the old women, my mothers and aunties, and how they are telling stories about the olden days, about Aboriginal Law. The Nampijinpas [daughters] are going to follow the old women. The old women are responsible for choosing which of us Nampijinpas will also talk, because they carried us around as children. They gave birth to us. Our mothers, the three Nungarrayis, nourished us with seed from the country. I'll be telling stories like those women (Vaarzon-Morel, 1995:5).

An Arrente woman cited in the Northern Territory's *Sun* newspaper provided a statement to the Welatye Therre Defence Committee (which was established to fight against the Northern Territory's plans to build a dam across an area

containing an Arrente women's sacred site) regarding the sacred objects stored at the site, "They are a vital part of being a woman ... for hundreds of years we've had ceremonies which control our conduct, how we behave and act and how we control our sexual lives ... They give spiritual and emotional health to Aboriginal women" (1983:13).

What the above two quotes emphasise is that women's cultural ways and spiritual practices still continue in some communities in contemporary Australian society. They further demonstrate Aboriginal women's relationships to land, children, men and each other, law, ceremony, secret and sacred and Aboriginal women's responsibilities to all of this within Country. All of this involves the social, psychological, mental, emotional, sexual, physical, sacred, spiritual, cultural facets of Aboriginal women. Ultimately, this is all about health. The quote above cited in the *Sun*, provides a statement about the sacred objects, that "They give spiritual and emotional health to Aboriginal women" (1983:13). The objects that are sacred and secret and that are linked to relationship, land, law, ceremony and women are interconnected to the health of the Aboriginal women to whom the article was in reference. This provides an example of how the removal and dispossession of Aboriginal women from their traditional lands where relationships would be maintained and responsibilities carried out, has had a disastrous effect on Aboriginal women's health over the years. Through invasion and colonisation Aboriginal women have experienced different forms of genocide and ethnocide that have attempted to exterminate and assimilate Aboriginal women. We know through these processes that Aboriginal women's lives were disrupted to different degrees, depending on the level of penetration of the colonising dominant society.

The important work of Aboriginal scholar Jan Hammill (2001a) gives another view of life for Aboriginal women within an Aboriginal community, where family dysfunction within this impoverished Indigenous community is a result of being stripped of their cultural practices. She explains how alcohol and illicit and

prescription drugs have become coping elixirs for profound feelings of despair and hopelessness. She presents the links from this coping strategy to the high rates of neglect, child abuse, interpersonal violence, suicide and early death. Hammill (2001b) puts forward that the decades of suppression and oppression have resulted in a contemporary social environment where violence in many forms is endemic and normalised. This is additionally supported by the work of Phillips (2003). Hammill argues that in these environments it is the grandmothers and great grandmothers, whose values were shaped in another era, who are therefore carrying the care roles for children and others (2001a). In this she argues for grandmothers and great grandmothers to be provided with health knowledge.

Greg Phillips' (2003) work based within an Aboriginal community in Queensland provides an understanding grounded in the principles of Indigenous research science of the life in that community (xiii), including the life for women. He offers that the process of colonisation and dispossession has produced disenfranchisement and traumatisation, much of which is unresolved (2003:xviii). In his research Phillips identified that personal and community histories of unresolved traumatic episodes were common; alcohol and marijuana usage and gambling were pervasive in the community in which he studied; and that the usage and gambling contributed to the existing traumatic stressors (2003:xv). Hammill (2001b) identified within her work within one contemporary community environment that violence was endemic and normalised. Phillips found within the community in which he studied, that "some people believe alcohol, marijuana and gambling use is so prevalent that it becomes normalised" (2003:81). Both Hammill (2001a,b) and Phillips (2003) provide an understanding of the cycle of hopelessness, the continued process of colonisation and substance abuse and how this is linked to further trauma, violence and abuse. Meaningful contexts can be gained from their work and parallels can be drawn to numerous other communities who may experience similar phenomena. What can be understood is

that communities in a contemporary context can become sites of negativity and of survival.

What can be ascertained it that the roles of Australian Aboriginal women, men, children, family life and community life, was forever changed in most communities. It is not non-Indigenous anthropologists who can tell the story from the lived experience, from the personal or from within the knowledge base of Aboriginality. It is Aboriginal women who understand what has happened from the position of being, of having lived the experiences, having heard the stories and having seen and felt the pain as Aboriginal women. It is Aboriginal women who can in some areas of this Continent, recount aspects of daily life before the arrival of the British and the subsequent invasion of this Continent, along with the changes since that time. It is Aboriginal women who have been required to gain an understanding about white women and white society in order to survive as Aboriginal women. It is Aboriginal women who have been required to gain meaning from and reinterpret the dominant culture, to be able to live within it as an Aboriginal woman. Aboriginal women have been writing about the changing position of Aboriginal women and the continuing issues of colonisation, racism, sexism, classism as they impact on Aboriginal women today.¹⁴ These works and others are the articulation by Aboriginal women about the positioning of Aboriginal women. Some of the articulations draw from the large geographic region that is occupied by and come to be known as the State of Queensland. Atkinson (1998), Atkinson and Ober (1995), Atkinson, Kaur and Doyle (1996), Croft (2003, 1997), writings are all based within Central Queensland. Judy Atkinson's work over the past 10 years has specifically focussed on revealing the violence in colonisation and in particular the sexual violence against Aboriginal

¹⁴ See Atkinson, 1990a,b, 1996a, 1998; Atkinson and Ober, 1995; Atkinson, Kaur and Doyle, 1996; Croft, 1997, 1999; Daylight and Johnstone, 1986; Flick, 1990; Goodall and Huggins, 1992; Huggins, 1987, 1994; Langton, 1981a,b, 1985, 1993a; Moreton-Robinson, 1999; O'Shane, 1995; Reed-Gilbert, 1996; Robinson, 1997; Smallwood, 1991, 1995; and Watson, 1987.

women. She argues that the increasing levels of violence and sexual violence in Aboriginal communities, is a result of the violence of colonisation (1990a, b, 1993, 1996). While Atkinson and Ober (1995) and Atkinson, Kaur and Doyle (1996) focused on workshop processes aimed at healing individual hurts and trauma responses as a result of violence and dysfunction.

Aboriginal women have additionally been engaged in one of the predominate genres of Aboriginal writing in the form of writing life story or autobiographical narrative (although the works don't often fit the chronological narrative generally used in autobiographies). During the 1950s and 1960s this style of writing primarily focused on Aboriginal men (Brewster, 1996:7). Aboriginal men still write in this genre however, it has been Aboriginal women who now dominate it. The 1970s saw **the** start of books being published by Aboriginal women, which detailed the experiences and daily lives of Aboriginal women. They offered different accounts to life in Australia in comparison to the lives of white women. Moreton-Robinson states that in the "life writings Indigenous women speak of the practical, political and personal effects of being "other"" (2000:3).

Sally Morgan's (1987) book *My Place*, is regarded as a significant contribution in that it gave all Australians an understanding of contemporary urban Aboriginal life as opposed to regional life. Her work detailed some of the complexities of families who lived in large urban centres away from their Country, along with the multiple issues that surface when exploring identity. *Auntie Rita*, the work of Rita Huggins and Jackie Huggins (1996) which was short-listed in 1995 for a women writer's award (Nita B Kibble literary Award) was additionally a significant contribution outlining the removal of family, experiences and the violence in domestic service and relationships. Huggins and Huggins (1996) provide a greater understanding that the relationships between white women and Aboriginal women were generally based on the relationship of servant and master, the master being the white woman of the house.

Rockhampton based writer Mabel Edmonds '(1992, 1996) writings, are based on her work and life on the geographic areas of Rockhampton and the Capricorn Coast. Edmonds is of both Aboriginal and Australian South Sea Islander ancestry and writes within the context of this lived experience. She provides a context of not only white and Aboriginal relationships but those with Australian South Sea Islanders too. In this, she gives a historical reflection and context to the lives of numerous women in Rockhampton today who are also of both ancestries.

Rockhampton based Aboriginal artist Pamela Croft, undertook autobiographical research combined with art practice in exploring the issues of land, home, place and belonging (1997, 2003). Croft explains

Communicating the multiple layers of stories within my journey has helped me to discover my own identity and heritage. In this way 'living history' is being recovered and shared with the wider community... The conceptual contexts developed as a form of cultural criticism that does not privilege a white dominant source (2003:68).

Croft reveals through her self-presentation in her writings and artwork, the ways in which she has survived as an Aboriginal woman. She encapsulates strategies of resistance and sites of empowerment.

In the later books written by Aboriginal women, some focus on the lives of Aboriginal women, others are broader and encompass biographies and histories of families. Aboriginal women now write from positions of what Brewster (1996:7) identifies as the autobiographical and biographical, although there may not be a distinct chronological process to the writing. It is from this positioning that we can all gain greater understandings of our lives as Aboriginal women. What these writers detail is lives and the changing face of those lives through generations, at times they document a woman's story, her mother's, grandmother's and so on (e.g. Huggins & Huggins, 1996; Morgan, 1987). They additionally detail issues relevant in those peoples and in those women's lives

including a sense of Aboriginality as it relates to Aboriginal women. Brewster explains that “many Aboriginal writers whose exploration of the past is an arena in which they can define their own Aboriginality” (1996:9). Collellmir discusses this point (2002:53-76). I think they additionally teach about history, sociology, psychology, health and place in the context of colonisation. They are representations of Aboriginal women and Aboriginal women’s experiences of colonisation, dispossession, racism, classism, sexism and white privilege as told by Aboriginal women. Their writings reveal how they as Aboriginal women learnt to survive. Their stories provide an historical context for Aboriginal women in the contemporary context. In this way, the stories show how our individual stories are connected through historical and human commonalities. They are all that we truly own from the time we are born until the time we die. It is in the reading of someone else’s story or in the hearing of someone’s story that we give honour to their journey as a human being. In respect to this research they document Aboriginal women’s lives along with Aboriginal women’s identity, health issues, well-being and connections to empowerment.

Some would argue that the writings are ‘just stories’, just accounts given on memory and so questions are asked about the way they are written and the facts presented. It could be said that there is sometimes a blurring between one’s own life story, the family’s life story, broader Aboriginal stories and Australian society. Often these stories are intricately bound up within one another, interlocking. However, this is part of the genre and set within a cultural basis. There are generally multiple aspects of identity revealed within the story. This type of writing can be seen as the mapping between an oral to a literate society. Much Aboriginal writing is taken from the spoken to the written in a way that it is thought and spoken. In the past my own writing has been criticised for this switching between the personal and the impersonal, the first person and the third person but from the context of these writings of Aboriginal women and Aboriginal men, I place myself within one of the genres of Aboriginal writing. I will add at this point that the criticisms have come from mostly non-Indigenous

peoples. Public criticisms of widely published Aboriginal authors is based on what I think is a form of literary elitism and racism. Jane Cornwell in *The Australian* quoted Ian Jack, the editor of the influential literary journal *Granta*, who made the following statement, which gives an example of the elitism and racism to which I am referring, “Aborigines are excellent painters ... Why expect them to be good novelists, too? How many things do people want them to be good at? It just seems as if there are impossible requirements” (2000:10).

Grossman in her analysis discusses the Eurocentric notions of writing that Aboriginal writers are measured against and refers to Aboriginal writing as, “one version of the final frontier of Indigenous participation in the colonising culture” (2001:152). She additionally states, “Aboriginal writing is conceived as a frontier territory along which lies, on one border, ‘writing’, ‘theory’, textuality’, ‘history’ and ‘mediation’; and on the other border, ‘talk’, ‘experience’, ‘story’, ‘performance’ and ‘witness’”(Grossman, 2001:152). Grossman provides me with a further understanding of the way in which I can view my writing including the writing of this thesis, and those writings of many other Australian Indigenous people.

Others view Aboriginal women through a range of lenses, including those of race, gender, class and culture. Through all of these we know ourselves to be women who are still suffering the consequences of colonialism, economic exploitation, cultural domination, marginalisation and social discrimination. Aboriginal women have watched the rape and exploitation of other Aboriginal women and of the land. These are two common threads in Australia’s colonising history, being used as a vehicle to suppress, control, and even extinguish the unique cultures and identities of Aboriginal peoples. Aboriginal women are involved in conservation, development and human rights organisations, along with active participants in the struggles for improved education, health and housing for Indigenous peoples. All the while, Aboriginal women are life bearers, transmitters of language and cultural identity and engaged in the emerging

empowerment processes within communities. The writings of Aboriginal women are a demonstration of the resurgence and self-valorisation of Aboriginal women from the impacts of colonisation and of a society that has historically subordinated us, a society that has legally, politically and socially subordinated Aboriginal women.

Historically, Aboriginal women generally found little comfort or support from non-Indigenous women in Australia who were additionally involved in this subordination. Non-Indigenous women were active participants in the marginalisation and the denial of human, civil, political, legal, sexual and Indigenous rights of Aboriginal women. Their attitudes, like male attitudes, are forged within a different race, class, sex, colonialist and neo-colonialist practice. Non-Indigenous women have benefited and profited from past and continued marginalisation and oppression of Aboriginal women. They are therefore not separate in how they view Aboriginal women and Aboriginality. Despite the struggle for women's rights and the growth in momentum of the women's movement in Australia, the positioning of Aboriginal women remained stagnant for many years. In a well-known and often repeated analysis, Aboriginal writer, Jackie Huggins in her discussion of the place of Aboriginal women and the White Women's Movement suggests that,

Aboriginal women are viewed as the 'other' based on a menial or sexual image: as more sexual but less cerebral, more interesting perhaps but less intellectual, more passive but less critical, more emotional but less analytical, more exotic but less articulate, more withdrawn but less direct, more cultural but less stimulating, more oppressed but less political than they are (1994:77).

Huggins made an important contribution to Australian feminism and has challenged the Australian feminist movement in its attitude and perception of Aboriginal women. The work of Huggins and other women writers such as Moreton-Robinson will be explored in the following section in an attempt to look specifically at the women's movement's response to Aboriginal women.

Aboriginal Women and Feminism

Within a research project focusing on health services to Aboriginal women a brief discussion on Australian feminism is necessary, specifically the relationship between Australian feminism and Aboriginal women. Some of the earlier feminist literature can be described as simplistic as well as Eurocentric, Ethnocentric and Westocentric. Most of this earlier literature focuses on the differences between men and women and extremely generalised notions of gender. Internationally this issue of avoiding the differences between women, including women of colour was raised mostly by Afro-American and ethnic minority women (hooks, 1981, 1984; Frye, 1983) in earlier literature. In the past two decades the feminist discourses have become subject to increased scrutiny in relation to their universalising and essentialising of accounts and statements articulating 'woman' and 'women'.

The ethnic minority women and Afro-American women's voices of the West, have now been joined by Indigenous women and what have been termed 'Third World' women. bell hooks argued that, the "vision of sisterhood evoked by women liberationists was based on the idea of common oppression - a false and corrupt platform disguising and mystifying the true nature of women's varied and complex reality" (1991:29). bell hooks' writings¹⁵ have been used by women from a range of cultural backgrounds as a challenge to think about our own issues of marginalisation within the women's movement.

In the past two decades within Australian literature the same issue has been raised by both Indigenous and non-Indigenous women.¹⁶ Aileen Moreton-Robinson is particularly analytical in her discussion and incorporates the earlier work of

¹⁵ See hooks 1981, 1984, 1991, 1992, 1994, 1995a,b, and hooks and West, 1976

¹⁶ See Bottomley, 1991; Flick, 1990; Gale, 1983, 1986; Huggins, 1987, 1994; Moreton-Robinson, 1999; and Sykes, 1991a,b, 1993.

Aboriginal women such as Jackie Huggins. She provides an Indigenous standpoint from which to view feminism in Australia (1999, 2000, 2003) and offers a rigorous explanation to Australian history, race, gender and class issues within Australian feminism. She places a major challenge to the Australian Women's Movement. In her work she presents the Women's Movement in Australia as being essentially 'white middle class women's business' and argues, the position of whiteness is often not questioned by white women. She demonstrates the multiple attributes of whiteness and feminism and the impacts these have on Aboriginal women. Since Moreton-Robinson's (2000) book was circulated, there has been discussion on its contents in a range of forums. I have yet to be party to any open discussions with non-Indigenous women involved within the Women's Movement in the greater Rockhampton area as to how the work of Moreton-Robinson has impacted or could impact on them and the work they do.

The issue of inclusion of Aboriginal and ethnic minority women has become incorporated into what is described as feminist deconstructive postmodernist analyses. One of the problems in Australia and in some regional areas such as Central Queensland is that people in organisations and community have not kept up with the literature and that 'women' themselves have not kept up with the literature and issues. In some instances in dialogue it is still as if we are talking the same issues that were being discussed in the 1970s and 1980s. Aboriginal women and ethnic minority women are still fighting just to be included, let alone heard. From my perspective there are additionally problems inherent within postmodernism itself. The issues generally rest within the use of Eurocentric alterity in relation to other forms of knowledge while stating that one is attempting to give active critique to the premises of Eurocentric thought. In this context, Australia could present a non-Aboriginal female scholar who perhaps uses her Anglo-Australian alterity in relation to Aboriginal women's worldviews in an attempt to provide critique. There is additionally an issue that the Anglo-Australian alterity is tied to a discourse that is redolent with that of a colonial

discourse. Chandra Talpade Mohanty (1988) discusses this issue in relation to Indian women's lives within South East Asia. Henderson explains postmodernism and colonisation as it relates to Aboriginal peoples and states, "postmodern thought, is another attempt by European scholars to regain intellectual control" (2000:75).

Over time, some of the feminist literature has attempted to address differences in what they saw to be women's oppression. There was additionally discussion on the connections between class oppression and patriarchal oppression, Marxism and feminism. While much of this happened in the 1970s and a little in the early 1980s there are still women to be found who will call themselves a 'Marxist Feminist' or a 'Radical Separatist Feminist'. Much of the literature while pointing out that women have been hidden in general history, management, levels of society and objecting to this, continues to hide women from different backgrounds, races, classes, including Aboriginal women. This includes white women's histories, for example, how their experiences were important, their hardship and their overall lives, but they do not detail how they were part of the colonising and how they impacted on and oppressed the lives of Aboriginal women. There seems to be a lack of visibility of Aboriginal women and Aboriginal men within the story of mainstream history or women's history in Australia. It is in the writings of Aboriginal women that further understanding as to the dynamics between white women and Aboriginal women is provided.

Jackie Huggins writes that

Aboriginal women were sent to work as domestic servants and nursemaids in station homesteads and in some cases as stock workers. This work began at thirteen or fourteen years. Domestic service was a cruel time for my mother, like so many women of her generation. The working relation was of master-slave order. The men were addressed as 'Boss' the women 'Mistress'. Many women endured appalling treatment, including beatings and sexual abuse... Rita is reticent to talk about the regular beatings she received from one white mistress. I stumbled on this fact

accidentally when a family friend told me of my grandparent's attempts to get Rita out of the way of that mistress before she killed Rita... (Huggins and Huggins, 1996:34)

Rita Huggins says of her time

When children were sent out to work it was never discussed with the parents. They were told...My first job was from dawn until the late hours of the evening, a daily routine of cleaning, washing, ironing, preparing food and caring for children...We were always given the children to look after, bath them, change and wash nappies, but we were not allowed to discipline them in any way... The days were long and tiring and never changed. All my days was spent helping the white people (Huggins and Huggins, 1996:36).

In past and recent writings by Aboriginal women, white women are everywhere. They are as Moreton-Robinson describes "disembodied, disembedded and dominant subjects in their relations with Indigenous women" (2000:28). What needs to be accepted and understood is that women were not and are not passive in the process of class oppression or race oppression.

Spellman in Yuval-Davis (1997) and hooks (1981, 1984, 1991, 1992, 1995a,b) argue that women's oppression is not a separate and distinct social system which is autonomous of other types of social systems. To focus on all women as such, as being oppressed based on gender, is in fact minimising of the position of women. It most certainly minimises the position of Aboriginal women in Australia. In many parts of the world women, including Australia, have shared and profited from the privileges of capitalist-patriarchy, while Indigenous women within their communities and countries have been marginalised. Women's oppression is endemic and integral to social relations with the distribution of power and material resources. A number of writers have explored the distribution of power and the social relations that have been established.¹⁷ Others such as Mohanty (1995) and Spivak (1988, 1995) particularly explore the distribution of power and the social relations within the context of imperialism and colonisation. Mohanty

¹⁷ Brooks (1997), Yuval-Davis (1997) and Radcliff and Westwood (1993)

articulates that it is possible for all women to align across and participate in “these imagined communities but our centrality to the issue is dependent on our “different, often conflictual, locations and histories” (1991:4).

What I have come to more deeply understand is that although gender, ethnicity and class have different ontological bases with separate discourses they are very much intermeshed. Some of these interplays are highlighted in the works of Spivak (1988, 1995); Trinh T. Minh Ha (1989, 1991, 1995), Mohanty (1995) and others. They are articulated by each other within social relations and cannot be separated out, it is very hard to tease out what is of greater priority just as it is hard to compartmentalise oppressions (Yuval-Davis, 1997). Writers such as Frankenburg (1994, 1997, 2000); Carby (1997); hooks (1981, 1984, 1991, 1992, 1995a,b) and Collins (1997) clearly place issues to feminism around the issues of race as it inter-links with the other forms of oppression. Gender in Australia , as elsewhere, is lived through racism, sexism and classism, and social constructions of race, gender and class in the society. However, as Huggins explains

Despite the predominance of patriarchal rule in Australian society, Australia was colonized on a racially imperialistic base and not on a sexually imperialistic base. No degree of patriarchal bonding between white male colonizers and Aboriginal men overshadowed racial imperialism. In fact, white racial imperialism granted to all white women, however victimized by their sexist oppression, the right to assume the role of oppressor in relationship to black women and black men (1991b:7).

Huggins places white women in Australia in the position as coloniser and oppressor, and asserts that white women need to address their own racism (1991b). In Australia, the concept of a ‘standpoint’ feminism becomes difficult to hold together. Spellman puts it this way,

The notion of the generic ‘woman’ functions in feminist thought much the same way the notion of generic ‘man’ has functioned in Western philosophy: it obscures the heterogeneity of women and cuts off examination of the significance of such heterogeneity for

feminist theory and political activity (cited in Yuval-Davis, 1997:ix)

However despite two decades of argument some of the literature at times still continues to reflect a simplicity of women's experiences and presents the concept of generic 'woman'. Within this universalism of 'woman' and 'women', there can exist inherent racism and ethnocentrism. When undertaking a universalism of women, one can choose to ignore and not address the differential positionings of women who are additionally supposed to be covered by the universalist rules.

Aboriginal women have remained on the margins of feminist debates in this country. Within what exists as the women's movement in Australia, I can not foresee that Aboriginal women's issues will, in the near future, be taken up by the broader group known as the 'Australian Women's Movement'. We will never be a key issue for 'women' and I do not foresee Aboriginal women embracing a collective feminism. Jackie Huggins, in discussing participation of Aboriginal women in the women's movement, made the following statements,

What white women do not realise is that, despite the general diversity of opinions in Aboriginal society, the strong stance that Aboriginal women take against the white women's movement remains universal. Evidence for this there has not been in Australia to date, one published document by an Aboriginal or Torres Strait Islander women who supports the women's liberation movement. There is certainly no discussion of support for it either in Aboriginal community circles (1994:76).

As a result of not embracing the Women's Movement, Aboriginal women often remain on the margins of any broader women's programs that are delivered by women. At times Aboriginal women are almost asked to make the choice between ethnicity and womanhood. How can Aboriginal women do this? Aboriginal women never have ethnicity without the womanhood. To attempt to split ethnicity from womanhood, or womanhood from ethnicity is a European - North American dualistic form of reasoning. With this comes its own divide-and-conquer tactics. In this Aboriginal women could be in triple jeopardy caught in betrayals: she can be

accused of betraying, a particular man or men, or her community or women. She could be seen as a 'manhater'. Instead, a more powerful philosophy is that Aboriginal peoples should stay together to fight against racism and that women would stick together, in unity there is strength. Pitting these against one another does not allow them to exist together. However, Aboriginal women can never have one without the other. Sometimes this philosophical debate becomes lived experience. As I have explained earlier, I feel that at times it is as if women cannot be ethnic or Aboriginal, just woman. Other times it feels as though Aboriginal women can not be woman. It is like bouncing back and forth like a ball, when in fact our essence is really the air within the ball that allows it to bounce.

At times feminism itself can translate to westernisation and further colonisation, where gendered activity is converted to sex-role stereotypes imported from western white stereotypes and applied over and to Aboriginal women. It is not therefore about Aboriginal women's notions of equity. This only serves as additional confusion as to what Aboriginal women may or may not see as oppression, and becomes a new form of the colonising practices of white women. This manifests itself in a range of ways.

One of the ways the notions of white women's equity manifests is the manner in which Aboriginal women's socio-demographic statistics are always 'measured up' against non-Indigenous 'white women's' statistics in Australia. It is white women's principles of equity, which have become central, what we are measured next to. This in itself is inequitable and unjust. This happens to Indigenous women in other parts of the world too (Waldram, Herring, and Young, 1995; Enang, 2001; and Ring and Firman, 1998).

In Australia, Aboriginal women know we are collectively sicker, poorer, less educated, more unemployed, less skilled, face greater numbers of our family in jail, die younger, attend a greater number of funerals in any one year, are subject to

higher levels of violence, racism, sexism, are regarded as marginal, a minority and more, than non-Indigenous women. We will always be in a position of being measured up to the dominant group in Australia. What we must consider as Australian Aboriginal women is do we need or want to be equal in some of these western indicators of what is considered a 'higher quality of life'? Whose determination of what is a 'quality of life' might we be adopting? How far will the western white indicators of what is a 'quality of life' continue to rise, and in this, how far away from our worldviews will it threaten to take us? In some cases will it consume us or merely just accommodate or assimilate us? Is there the possibility of becoming 'captives' in a cycle progressing towards where the dominant culture believes we should be and what we should be? In other cases will it make us better off? What might be the benefits of being measured up in the health realm? These are difficult questions considering that sometimes the being measured up to Australian women, has an advantage, it shows and makes explicit the advantages and disadvantages between Aboriginal women and other women.

There are many examples to be found where the mainstream systems and the women's movement attempt to 'accommodate' Aboriginal women within the realm of 'women'. There are examples to be found when talking with Aboriginal women of where we are asked along to women's events as a guest speaker to read poetry, set up a display of artwork, or speak about spirituality. Much of this focuses on cultural expression and the perceived exotic elements of Aboriginal culture; as some Aboriginal women call it, the "pretty business". There are other examples to be found where Aboriginal women have been asked to give advice on what might make something 'culturally appropriate' or what might 'encourage Aboriginal women to participate'? I have been asked the above and been a guest speaker.¹⁸ I have also seen minor adjustments made to a service and a few Aboriginal pictures stuck up on walls, without any real changes for Aboriginal women. I have also at times been expected to bring forth Aboriginal woman's experience for the benefit of 'helping

white women better understand Aboriginal women'. When I have left some events I have felt that the organisers did their jobs, they ensured that Aboriginal issues were covered and that they and some of the women present need not worry anymore; they had saved their consciences that Aboriginal issues or women have not been left out. At other times when Aboriginal cultural expression took place, I have left feeling that it was a tokenistic gesture and a form of entertainment for those present. The organisers could argue that they had given space to Aboriginal expression and thus observed what they believed was appropriate. From my experience and through talking with other Aboriginal women, I have come to see all of this as a form of casual accommodation within mainstream women's business and white feminism. At times a form of tokenism is operating, where those from marginalised groups, in this case Aboriginal women, become almost trapped soothers for others who continue to deny their own privileged positions. It falsely leads Aboriginal women into believing that the women's movement is seriously attempting to make changes and deludes those in the women's movement that they are really trying to change. I have not witnessed or participated in a forum where the very essence of what constituted that women's site, or service or held that group together was up for discussion; how it or they could be more inclusive, how could we all explore what we mean by feminism, what do we mean by more appropriate or more open for participation by Aboriginal women. This does not mean that it has not happened elsewhere. I believe that this would allow for some cross-cultural feminist efforts to be explored. Some experiences are expressed in the works of Bagar and McDermott (1989), Christensen (1997), hooks (1990) and Carby (1997).

Attempts to Re-instate, Re-claim and Re-empower

I know that certain things are present to make us 'remember to remember'. The concept of 'remembering to remember' as already noted, comes from the work of Cajete (1994). Cajete explains that images remind us who we are, all that we are, constantly. We construct story, song, art, pictures that all make us remember to

¹⁸ See Fredericks, 1993, 1995a,b,c,d, 1996, 1999b,c, 2000a,b, 2001a,b,c,d,e,f,g; Fredericks and Croft,

remember. Much of what non-Indigenous Australian society like us to recall from memory is the 'exotic' elements of Aboriginal culture and the 'pretty business'. Colonisation is now also part of what we must remember. It is also part of what we are, who we represent, the sum of all of us, our history, our present and our future. Images, stories and art surround us to remind us to remember this too. In the history of Australian colonisation, Aboriginal women's knowledge could not be heard. Aboriginal women could not formally bear witness and were refused a place of authority and voice that would allow us to be a subject in that history. Aboriginal women have remembered this and have been reclaiming a place in that history and rebuilding connections that have not been able to be suppressed by imperialism or colonialism. What needs to be remembered by the women's movements is that imperialism and colonialism are part of our history also, and it is this along with the other parts of who we are as Aboriginal women that must be heard. I make the point here that when some of the Aboriginal women's analysis, stories and experiences of the women's movement, feminism, history and hardship have been shared in forums or with individuals, I have seen the analysis faced with anger, criticism and hostility by some non-Indigenous women.

Across Central Queensland Aboriginal women have been speaking out and articulating what they want and need as small groups and as a large group of women. Large Indigenous women's forums have been held for women from throughout the Central Queensland region. These have been organised by the Aboriginal and Islander Community Resources Agency Inc. (AICRA). There has been the following meetings: 1994 in Rockhampton; 1995 at Cool Waters, Capricorn Coast; 1996 in Rockhampton (Fredericks, 1996), 1998 in Biloela (Biloela Women's Group); 1999 in Rockhampton (Fredericks, 1999b) and 2001 in Hervey Bay. These meetings have included many issues that involve women, such as domestic violence, children's issues, care of the Elderly, women's physical health, spirituality, justice programs and maintenance of culture and identity. Sometimes discussion has focused on topics

2002; Fredericks, Croft and Lamb, 2002; Fredericks and Hornagold, 1996.

such as women's health centres, women's legal services and women's shelters that are provided for the general community of women. Some of the issues raised by Aboriginal, Torres Strait and South Sea Islander women in Rockhampton in 1996 are as follows, "... we need a "place of our own" that is safe, trusting, comfortable, supportive, without fear or worry, without fear of being bashed, abused, without racism, without non-Aboriginal people applying their values. A place for Indigenous women" (Fredericks, 1996:30). In reference to the Women's Health Centre, the women present said "the Centre is funded for all women", "Some of the women with the Centre don't like men" "men are part of our families too" (ibid. 1996, 24). Discussion followed about how Indigenous women wanted an Indigenous women's place for some services.

In the above statements, note the use of the words such as 'without racism', 'without non-Aboriginal people applying their values', 'A place for Indigenous women' 'men are part of our families too', these are all about what Aboriginal women have experienced. The women present additionally knew what they wanted and articulated that although a woman's place is within the community that 'is funded for all women' it is not servicing all women, including Aboriginal women. It is this articulation that demonstrates the capacity of different cultural identities of Aboriginal women to come together to form a voice and to speak out openly for Aboriginal women's needs. This type of articulation provides glimpses of an empowerment process at play whether women's groups or broader society recognises this or hear other issues. When Aboriginal women are heard, another form of empowerment is at play.

Feminism has been a source of analysis that Aboriginal women may borrow to search for answers for Aboriginal women. There are some connections in the various forms of social oppression, which give women connection and a sense of sharing some issues. This is why at times feminism may be a source of comfort for Aboriginal women. Feminism has additionally assisted some Aboriginal women to make sense of parts of our stories. Aboriginal women's theorising comes from

Aboriginal women's experiences of multiple interrelated oppressions, which include classism, racism, sexism and homophobia. Examples of which can be found in the works of Huggins (1998), Moreton-Robinson (1999), Holland (1996) and others. Aboriginal women's attempts to understand the complex issues of oppressions and to find and work towards solutions could be viewed as both reactive and proactive. From the feminist literature, elements of this process of theorising and activism could be said to be feminist in nature, all the while it is based within Indigenous struggles that pre-date this modern written articulation of feminism around the world. The literature does provide another way to view the Indigenous woman's struggle and offers some strategies that might be useful in the struggle. While Aboriginal women may find comfort at times in the women's movement and utilise theories and strategies found within feminism, it does not mean that the answers for Aboriginal women come from the feminist movement or feminism or that being engaged with the feminist movement means that Aboriginal women have embraced feminism. Feminism could be said to be one vehicle of many for the Indigenous struggle for re-instating and re-empowering who we are as Aboriginal women.

I believe we need to talk about re-empowering from the perspective that the process of colonisation, which subordinated us as Aboriginal women has been a process of disempowerment. There are some really strong Aboriginal women within Aboriginal society, empowered within their own culture and within their own community; it is within and through broader Australian society that they are disempowered. There are also Aboriginal women who are disempowered by other Aboriginal people through violence, abuse and continued trauma within their communities too. This is due to situational, cumulative and intergenerational trauma as a result of colonisation¹⁹ and as a result of family, community and dominant culture cronyism.²⁰ When I argue for the use of the term re-empowering, I in part challenge broader Australian society to let Aboriginal women be Aboriginal women and to engage our rights and responsibilities as Aboriginal women. I put forward that we must be able to do this

¹⁹ Greg Phillips, 2003:23.

²⁰ See Trudgen, 2000:196

individually and collectively. Further to this that re-empowering additionally implies rebuilding and reviving women's spiritual and cultural practices accompanied by healing.

I see that part of the answer to this re-empowering has been the reclamation of power by Aboriginal women. As Aboriginal identity and all that involves in an Aboriginal woman has been imposed or taken away through power, it can only be reformulated or re-gained by taking power back. More Aboriginal people are naming what Aboriginal identity is, how it manifests, and the experiences, rights, roles and responsibilities of Aboriginality. There are those who are undertaking this through the legal and political rights arenas both nationally and internationally, those who write about it through analytically researched academic papers challenging the status quo, and others through creative narrative prose. There are others who undertake artworks, including visual and performing artworks. Aboriginal Australian peoples are also claiming back the right to self-government, use Aboriginal governance structures and Customary Law. We know that because Aboriginal peoples never ceded, we never gave up these rights. Despite the prolonged suppression of cultural, political, social and human rights, the dispossession, murders, rapes, removal of children, poisoning and enslavement, and the colonial aim of disinheritting us from our land that was given the term *terra nullius*, we have survived. This is articulated in all forms of reinstating, reclaiming and reconstructing.

Through a process of commemorating and remembering the past, Aboriginal women have been reconstructing a useful legacy for the present. This is being done via Aboriginal women artists, writers, speakers, activists, community workers, those undertaking oral history and family history research projects, families, Elders, and scholars and those committed to reviving spiritual and cultural practices. The recovering of meaning and responsibility of Aboriginal womanhood is being enacted by these women and shared. In gathering evidence to name Aboriginal women's experiences, the reality and diversity of lives, the facts may be sometimes muddled

and the memories a little unclear. However, the telling of the facts and memories even if a little muddled and unclear have the capacity to offer healing power. The telling of our stories provides a sense of our individual and collective stories in the naming of that that has been distorted, erased and altered to suit the needs of the coloniser. What may also be considered 'factual' and 'clear' based on research findings (that is, anthropological, medical, and scientific), is drawn from information developed at the time the events took place and may also be biased from the viewpoint of the teller, which was generally those who had power, the colonisers in many shapes and forms. This form of articulating by Aboriginal women I believe is part of the resistance of Aboriginal women to the on-going impacts and processes of colonisation. It is also about Aboriginal women's knowledge and finding their individual voices and their collective voices to articulate that knowledge. It is also about healing some of the deep soul wounds of colonisation and contributing to the healing of others.

Conclusion

This chapter has explored issues of Aboriginality from a range of perspectives, including government, non-Indigenous and Indigenous peoples. It has demonstrated that despite our inherent right to be Indigenous women, we have been and are still fighting for the realisation of this right. Based on this fight, we are often the subject of ridicule and obstruction. We still encounter discrimination, do not enjoy the full rights of Aboriginality and are denied the dignity to be Aboriginal women in our own Country. This has happened since the onset of colonisation. It has been the subject of many rallies and protests over the years, one of the most famous being 26th January, 1938, which marked the 150th Anniversary of the British (white) seizure of this Continent. In the process of governments trying to determine who we are, we have been at times forced to become like slaves to policies and programs that continue to state who we are, what we are entitled to and determine our political and social lives. All the while there has been a persistence of large numbers of Australian non-Aboriginal people and governments to reject the legitimate status of who Aboriginal people are, who we say we are, what we represent and what rights and

interests we might enjoy along with what obligations and responsibilities we must undertake as Aboriginal peoples. It is little wonder that Aboriginal people view much of what governments do and say with anger and contempt, as a cynical manipulation of our lives. There will be without doubt on-going struggles by Australian Aboriginal peoples to have the Constitution and governments recognise who Aboriginal people are as Indigenous peoples of this Continent.

Along with this rights discourse, I have discussed a number of other discourses including discussions of civilisations, ethnicity, culture, multiculturalism, postcolonial identities, assimilation and the emerging discussion of white race privilege in Australia. These are all discourses in their own right and all are partially constructed from the notions of racism and feminism as presented in this chapter. In terms of Australian Aboriginal culture and the sense of being an Australian Aboriginal woman, I have established from some of the literature, that Aboriginal women are meant to be either Aboriginal or not Aboriginal, and at times woman or Aboriginal. However, this overlooks the historical, political and social context and consequences for Aboriginal peoples. The issues of feminism, race, class, gender, sexuality and classism are all intermeshed and are highly complex in how they interrelate with one another. They cannot be presented in the simplistic way nor applied individually to address the complexity of the life situation of Aboriginal women.

Chapter 4

What ‘em thing call’d ‘ealth?

Introduction

The National Health and Medical Research Council (NHMRC), states that “Aboriginality is itself a health hazard” (1996a:24). It is a sad for me to read that in one of the most industrialised, ‘first world’ countries my ethnicity and my culture are a hazard to my health; merely having been born in this continent read or hear about themselves or their people in this way? Yet it was not always like this on this continent recently called ‘Australia’. Racism directed through the processes of colonisation created the situation, and racism maintains it. Thus it is not Aboriginality that is a health hazard, but overt and covert racism, which positioned and still positions Aboriginal peoples.

The British began to physically colonise Australia in 1788. Prior to colonisation, Australian Aboriginal peoples had complete control over all aspects of their lives including their ceremony, spiritual practices, medicine, relationships, management of land, systems and law, gender based relationships and activities. Aboriginal peoples were able to exercise self-determination and self-management as sovereign peoples in all areas of life, something Aboriginal peoples still strive to restore today. Aboriginal peoples were able to determine, monitor and evaluate their own sense of being. The National Aboriginal Health Strategy (NAHS) outlines that prior to colonisation, Aboriginal peoples “were able to determine their ‘very-being’, the nature of which ensured their psychological fulfilment and incorporated the cultural, social and spiritual sense” (National Aboriginal Health Strategy Working Party 1989:ix). This is very much what we as Aboriginal Australians are still struggling for today in contemporary Australian society.

The processes of colonisation in Australia have greatly impacted on the health and well-being of Aboriginal peoples. Some of these were outlined in the previous chapter and will continue to surface throughout this thesis. Since colonisation, Aboriginal health conditions have consistently been identified as sharing 'third world' standards (Hunter, 1998:1). Some describe the health status as 'fourth world' (O'Shane 1993:53). Aboriginal peoples without a doubt have the worst health of any other identifiable group in Australia. Hunter states that this is "the result of the past 200 years of dispossession and dislocation of Aboriginal families and communities" and also argues that, "the right of native title holders to negotiate over developments on their land is intrinsically linked to improved Aboriginal health in Australia" (Hunter, 1998:2). Aboriginal health is directly related to the past and is tied to the neglect, inhumane treatment and the continued processes of colonisation. I argue that unless attention is given to address the systemic perpetuation of the positioning of Aboriginal peoples, 'fourth world/ third world' standards will prevail and wellness and health will remain well below those of the first world.

The current situation, will be briefly outlined in this Chapter, demonstrates why drastic and immediate action needs to be taken. Policy makers, governments, service providers, researchers and bureaucrats have agreed that some gains have been made, however the urgency that was with us in the past is still with us. For example, while the statistics relating to Aboriginal infant mortality show an improvement over the past twenty years, the number of Aboriginal infant deaths in relation to non-Indigenous infant deaths is still higher (Bhatia, 1996; Bhatia and Anderson, 1995; Sagers and Gray 1991:100). There have been considerable increases in the number of deaths of Aboriginal people through heart disease, diabetes, injury, violence and respiratory diseases (Hunter, 1999:1). Aboriginal deaths in custody have increased despite the findings of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC, 1991) and the programs that eventuated from that Commission. There has been an increase in the rates of suicide in Aboriginal communities.

In the previous chapter, I outlined the issues around the concept of Aboriginality particularly focussing on Aboriginal women. I outlined some of the philosophies of being an Aboriginal woman. In this chapter I outline the current health status of Aboriginal peoples and what Aboriginal health is, as defined by Aboriginal peoples. Where I have been able to source literature written by Aboriginal women, I will present what health means to them. I begin by providing an overview of what is seen as health in an Australia context as defined by the literature. Second, I provide an historical overview of the health of Aboriginal peoples and an overview of our current health status. I discuss what Aboriginal peoples have determined is their interpretation of health. From here, I explore briefly the issue of empowerment and how it relates to Aboriginal peoples within a health context. I conclude by exploring the intersection in Rockhampton between Aboriginal women and the women's health movement in Rockhampton.

Broader Health Talk

What is referred to when the Australian government and Australian people talk about health? Most literature sources the work of the World Health Organization (WHO), its Constitution and definition of health. The WHO was established in 1948 as an agency of the United Nations to deal with international health issues. As an agency it is made up of some 190 countries, working together as member states to promote the health of the world's people (Curtis & Taket, 1996:250). The WHO works from a Constitution which contains a platform for the organisation's ideology and governs how it operates. The Constitution states that, "Health is a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity" (WHO, 1958 cited in Roemer, 1986:58). The Constitution outlines that, "Governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures" (WHO, 1958

cited in Roemer, 1986:58). Australia is a participating member state of the United Nations and WHO and therefore is party to the WHO Constitution.

Despite the WHO statements and the Constitution as with other international agreements Australia is party to, this does not imply that Australia necessarily follows all measures when relating to all of its Australian peoples. The amendments to the Native Title legislation have been branded as discriminatory internationally, and as Mick Dodson and others have stated, Australia has a long way to go towards recognising Indigenous Australian rights and sovereignty (Dodson, 1998:18-29) Taylor, 2001). Since the end of World War II, there has been a significant growth in the Australian health system, without however a significant growth in the health status of Australian people or Aboriginal Australians (Wass, 1998:8). For example, there is evidence that in large industrialised countries, excessive funding has been spent on developing the medical technology that has benefited only some, but at the same time, others have not been able to access basic health care services (Roemer, 1986). In Australia large amounts of monies have been spent on health systems and technologies accessed by a few people, while others predominantly living outside the large metropolitan areas or without monies, struggle to access basic health services. I did not compare what was available in Rockhampton to other regional centres or larger urban centres in this research.

During the 1960s and 1970s concern grew internationally over the growth of health care systems, increasing health disparities between industrialised and developing countries, and the fact that few countries had acted on the broader economic and social aspects of health, such as reducing poverty, improving housing and food availability and stopping political oppression (Wass, 1998). The single biggest determinant of health is poverty (Wass, 1998:8) and this is evidenced in Australia in that there are direct correlations between poverty of Aboriginal peoples and their health status.

The WHO published a document titled *Global Strategy for Health for All by the Year 2000* (WHO, 1981). In response Australia established the Better Health Commission in 1985 to investigate and report on the health status of Australians, including factors that impact on health status and ways for the government to better address health issues. This was subsequently detailed in a 3 volume report (Better Health Commission, 1986). The Commission's terms of reference included the need to give "specific attention to sectors other than health, and to at risk population groups" (Nutbeam, Wise, Baumen, Harris and Leeder, 1993:7). The Commonwealth prepared a Draft Plan in response, which outlined ten goals addressing causes of death, disease and disability in Australia (Nutbeam et al., 1993). A Health Targets and Implementation Committee was established which was given responsibility for developing national health goals and targets and to plan the implementation of their attainment. The document this Committee produced (Health Targets and Implementation Committee, 1988), was the first attempt in Australia to develop goals and targets for improving health and inequalities in the status of Australian health. Nutbeam et al. state,

The Health for All Australians report contained a thorough exploration and synthesis of knowledge on the health status of Australians, of the perceived needs of the community, and of the infrastructure, funding mechanisms, and direction required to improve health status (1993:8).

The document's overall goal was to emphasise "the need to influence determinants of health beyond behavioural risk factors and to reduce unjust inequalities in the health status of Australians" (Nutbeam, et al., 1993:3). Historically, Australia has had little experience in accomplishing this.

From this report, some states developed state plans, based on their interpretations of the national goals and targets and agreed to commit further funding to the national

monies allocated via the National Better Health Program. I have been unable to ascertain whether Queensland developed any specific policy in regards to the national document. Nutbeam et al. who undertook a review to locate experiences in the states and territories in National Targets and Goals, do not mention any Queensland examples (1993:9).

The document *The Health for All Australians* repeatedly addresses the need to tackle inequalities in the health status of Australians, such as those inequalities examined in a research paper titled *Enough to Make You Sick: How income and environment affect health* published by the National Health Strategy (NHS) (1992). (It is not to be confused with the *National Aboriginal Health Strategy* (NAHS)). The NHS itself was established in 1990 to identify ways of improving the effectiveness of the Australian health system and to contribute to Commonwealth-State/Territory agreements on funding for health. The *National Aboriginal Health Strategy* report supported many of the findings and statements within the NHS regarding the correlation between low incomes and poor health status, along with poor housing, water supply and waste disposal. The NHS reinforced throughout the report the impact of these issues on different population groups and particularly that it was these factors which significantly contribute to the high incidence of disease and ill-health in Aboriginal communities (1992). Further to this, the NHS Report argues that language issues, cultural barriers and geographic distances provided barriers to equal access to health care services (1992). The NHS served Aboriginal peoples interests in attempting to address Aboriginal health needs, and reinforced what Aboriginal peoples had been saying about health, accessing health care services and the broader determinants of health for Aboriginal peoples.

Nutbeam et al. (1993) reviewed the health goals and targets of Australia through examining the progress of the promotion of better health in Australia, refining a framework and structure for setting goals and targets, proposing a new set of goals and targets and finally identifying how some of the basic options for implementation

of the goals and targets (1993:2). In addressing health inequalities, the authors make three observations. Firstly,

... requires a balance of action by individuals and of action by and for the whole community.

Secondly,

... much of the social action will be outside the boundaries of the health care system, and will require close consideration of the health impact of decisions taken in other sectors such as housing, urban development, transportation, and education.

And thirdly,

... the health system itself will need to respond positively to the challenges implied by those unjust inequalities - both in the range and direction of services provided (Nutbeam et al.,1993:13).

This analysis of reflection on the past policies, attempting to set goals and targets for achieving healthy people and striving for better health, was not restricted to Australia.²¹

Is the situation of poor health status any different for Indigenous peoples and women in other parts of the world? In other industrialised nations such as USA, Canada and New Zealand, the health of Indigenous populations has improved over the past three decades. The NHMRC (1996a:20), Ring and Firman (1998:528-533) and Ring (1998:639) all make the point that Indigenous peoples in Canada, Aotearoa/ New Zealand and USA are approaching the average health of these nations. Runciman and Ring note that the health of Indigenous Americans is “considerably better than

²¹ In 1992 the Department of Health in the United Kingdom produced *The Health of the Nation: A Strategy for Health in England*, which includes targets for improved health (UK, 1992). In Canada, the Ontario Premier’s Council on Health: Panel on Health Goals for Ontario established health goals within *Health for All Ontario: Report of the Panel on Health Goals for Ontario* (Spasoff, 1987). The United States of America (USA) their first document in 1980 titled *Promoting Health/Preventing Disease: Objectives for the Nation* (United States Public Health Service, 1980).

that of their Australian counterparts” (1994:23). The Australian House of Representatives Standing Committee on Family and Youth Affairs, found, that the “poor health status of Indigenous Australians stands in stark contrast to that of the Indigenous populations of New Zealand, Canada and the United States” (2000:5). What resonates true for Indigenous Australians is the acknowledged lack of significant improvements.

The Aotearoa/New Zealand, Canada and United States examples, cited in the Report, demonstrate the importance of a commitment to providing adequate resources for community controlled primary health care, environmental services and encouragement of improved education (Australian House of Representatives Standing Committee on Family and Youth, 2000:6). The community controlled primary health care approach encompasses community involvement in decision making, development and delivery of health care, along with the emphasis on the social model of health and health promotion. Environmental health in many communities is particularly poor. Ring and Firman have attributed the improvements in other countries, to the fact that Treaties have been utilised in the development of health services and their integration with social and economic issues, for the Indigenous people of New Zealand, the United States and Canada (Ring and Firman, 1998:528-533). Ring argues that increases in Indigenous health are not just symptomatic of time required (as I have often heard stated by government officials) rather a lack of effort (1998:639). Ring provides Aotearoa/New Zealand as an example in which,

... the mortality of the Maori population in the 1970s, which was then about the level of mortality now experienced by Australia’s Indigenous population, fell by a third in a decade. The lack of progress in Australia is simply that, a lack of overall progress, despite a number of isolated examples of success (1998:639).

Ring (1998) and Ring and Firman (1998) link the improved health status of other Indigenous populations to integrated development and action that acknowledges and attempts to work across the complexities of issues within Indigenous people's lives, such as housing, education and health. There is political recognition of Indigenous peoples and their rights through the utilisation of Treaties. This is not to say that the Indigenous peoples of Canada, Aotearoa/New Zealand or the USA have gained full power to exercise their Indigenous rights under the Treaties or that there are not inequalities still present within and across those countries. In some cases there may have been denials of rights. I spoke of this in earlier chapters around the issues of Aboriginal identity. It would be more accurate to state that they are denied their rights but to a lesser degree than Australia's Indigenous people. They are more able to exert influence under the Treaties, Maori in Aotearoa/New Zealand have been particularly successful in some areas under the Treaty. Despite the mixed successes and failures to influence change in these other countries, there are a few lessons here for Australia if it is to make any gains in improving Aboriginal health status: Aboriginal people must be given full recognition of who we are and all that encompasses as Aboriginal peoples. Failure to do this, to place Aboriginal peoples' rights centre stage and for the Australian public to compromise some of its power, will see Australia continue to linger behind Canada, USA and Aotearoa/New Zealand in terms of its Aboriginal health statistics. The answer is not for the Australian Government to just develop a treaty with Aboriginal Australians. In Australia, a treaty does not create rights in domestic law until the Australian parliament passes what is termed "enabling" legislation (Pritchard, 1998:16). As Pritchard points out, the requirement of this legislation is known as the requirement for an "act of transformation" (1998:16). It is worth noting however, in the absence of legislation within domestic law, that international law can influence domestic law. There are Indigenous women across the world who suffer ill health at rates much lower than the broader populations in which they are located. In all incidences we are all measured against the dominant culture, the values and indicators of health. I am not advocating that we should always be measured up next to non-Indigenous populations. What I do believe is that there are some indicators that could be

considered benchmarks and when compared they provide some value to this debate. For example, how the recognition of the right to an Indigenous identity and the power of Treaties can influence the way in which health care is planned, developed and implemented. The Australian House of Representatives Standing Committee on Family and Youth report itself identifies community controlled primary health care as a major factor in contributing to improvements in Aboriginal health status (2000:6). This means Aboriginal people having control and making decisions. This places a challenge to the health system, departments and the broader health community. It additionally raises questions for us as Aboriginal people, do we have the people on the ground to do the jobs we need them to do in the health sector?

Moreton-Robinson (1999:33) raises some interesting points in discussing Aboriginal people when challenging the dominant values, with regards to land ownership. Some parallels can be drawn across to the question what is health? Along with health service delivery and policy, interactions with government, institutions and agencies. Moreton-Robinson states that, “the white Australian centre [dominant society] does allow access to ‘others’, but this depends on appealing or adhering to the rules of the culture and showing willingness to accept compromise” (1999:33).

In almost all situations, it is Aboriginal peoples who must extend this compromise and always on white terms, that is from the white basis from which it is offered. We have yet to see an extension of compromise from white people based on Aboriginal terms. Thus while Aboriginal people have defined health, general health service delivery is based on white terms, the values, beliefs and assumptions underlying health in achieving this definition of health which are those of the dominant, the Australian white centre and broader white centre. Thus Aboriginal people are forced to affirm the values of the colonialist and at times are asked to sacrifice Aboriginal worldviews and values in order to pursue good health via access to health services. More often than not, Aboriginal people are forced to validate the colonial mythology and asked to conform with the ‘Australian’ version of health offered through

generalist health services. Once again the system forces Aboriginal peoples to give up the inherent and alienable rights to an Aboriginal worldview, as under the United Nations documents.

The Australian Government and the Queensland Government have integrated knowledge from Canada, Great Britain, the United States of America (USA) and Europe within its governance structures, policies relating to justice, law and health. Frequently at health conferences, one witnesses presentations from health professionals from Canada and the USA on new social policies, new understandings of the public health agenda and so forth. In this way, health policy direction has been developed from overseas experiences, from health promotions and programs in the USA, Canada or Great Britain. Australian knowledge may also be extended to the USA, Canada and Great Britain. However, the Australian and Queensland governments have not extended the same status to Aboriginal knowledges and systems. It has not given importance to Aboriginal health and well-being systems as truly valid and as a basis for policy change. Despite the years of consultation and all the knowledge gained of Aboriginal health and well-being systems, Aboriginal systems remain on the periphery, always on the edge. As Moreton-Robinson describes, the “political and economic institutions within the centre, having defined Indigenous people as outsiders, have never fully accepted the claims of Indigenous people to share in central values or to defend these values faithfully” (1999:34).

If Aboriginal peoples were not on the periphery, and regarded as outsiders, the values and beliefs held by Indigenous peoples would not be typed in italics as a definition of health but fully incorporated within the policies, legislation and other documents. Aboriginal values and beliefs would be embedded in Australia’s institutions and in the social practices of everyday life. Aboriginal peoples would not be subjected to a system that seems to perpetuate colonialism’s iron law. Aboriginal people’s beliefs about health would be incorporated within Australia’s beliefs about health.

Where does this take us in terms of Aboriginal health? How does one measure what ‘a complete state of physical, social and mental well-being’ is? How does one incorporate what WHO emphasised in 1986 through the *Ottawa Charter for Health Promotion* that health is a ‘resource for life and not the object of living’ (WHO, 1986). The Ottawa Charter essentially outlines that health is a lifestyle and the environment in which we live. It includes everything about ourselves, our being, our shelter, food, income we receive, access to education and freedom from political oppression. The Aboriginal understanding of health will be explored in the following section of this chapter.

What do Australian Aboriginal people mean by the English word, health?

It is stated in the National Aboriginal Health Strategy (NAHS) by John Newfong that “In Aboriginal society there was no word, term or expression for ‘health’ as it is understood as in western society” (cited in NAHS, 1989:ix). In looking at an Aboriginal perspective of one’s life and world, it is difficult to comprehend that one can section off or dissect one element of one’s life as ‘health’. Health in essence is everything about life, all aspects of a person’s life including land, environment, physical body, community, relationships and law. Newfong states that the word health “as it is used in western society almost defies translation but the nearest translation in an Aboriginal content would probably be a term such as “life is health is life” (cited in NAHS, 1989:ix). The NAHS provided the following definition of Aboriginal peoples’ perception of health, which is most commonly referred to in reports and presentations: “Health is not just the physical well-being of the 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” (NAHS, 1989:ix). For Aboriginal peoples this means,

Health is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity (NAHS, 1989:ix).

More recently the Queensland Aboriginal and Islander Health Forum (QAIHF) Corporate Plan contained the following statement regarding the health of Aboriginal peoples.

Health for Aboriginal peoples is cultural well-being. Cultural well-being is the integrity and harmony of physical, social, political, environmental, economic, ideological and emotional inter-relations which operate at the individual, family and community levels and constitute the essence of our Aboriginality (QAIHF, 1999:1).

Thus the underlying concept linked to the overall health of Aboriginal peoples is Aboriginality itself. The definitions above all call for a holistic approach to health. The statement was made by QAIHF based on the statement of NACCHO, formerly known as NAIHO. NACCHO issued a *Manifesto on Well-being* from which all policy direction and work is directed (1997a,b). NACCHO has taken on the commitment to ensure Aboriginal health is on the international agenda as well as the national agenda.

Ian Anderson, raises the paradox that many studies in the past have focused on the use of “biomedical derived concepts” and that these concepts are applied to the “analysis of Aboriginal health issues” (1996: 64). This is despite the same studies at times quoting the NAHS definition of health, often in italics. Anderson states that “Health differentials, or other markers mobilised in health status analysis, do not necessarily measure those aspects of well-being which Aboriginal people consider significant” (1996:64). Anderson explains that this is “an important issue considering most interventions in Aboriginal health are a community development process which mobilises community wisdom and experience” (1996:64). Anderson has written numerous articles exploring questions and matters concerning Aboriginal health (1988, 1994a,b). What can be gained from the work of Anderson is that

Aboriginal health and well-being is both a complex and a simple issue. It involves, in essence, the total sum of being, all senses of being, all that is, all that makes an Aboriginal person an Aboriginal person. Failure to recognise this by health services and governments and failure to change the way research and health services are delivered will result in the health status of Aboriginal peoples remaining the same.

Anderson warns that health professionals need to be “aware of the complexity of relationship between biomedical concepts and Aboriginal notions of well-being” (1996:64). Aboriginal peoples do not have a problem with the Aboriginal defined concepts of health. Some of the concepts additionally sit comfortably within other sectors of the community too. It is possible that someone can be physically ill yet at the same time be a functioning, happy, well Aboriginal person. A person can be well in terms of their Aboriginality, their relationships with other individuals, family members, community people, and be making choices about their lives and enjoying life. Some people with a disability may have difficulty with their disability, but that does not mean they are unwell. Some people have diabetes, yet they lead full healthy lives, living with their diabetes. People with a mental illness have periods of wellness and periods of unwellness. The mental illness does not go away, it is still present. In past interactions I have been involved with a number of people who are homeless, who drink larger quantities of alcohol and sometimes use other substances, socialise with others, connect with family when they need to and at times do present as ‘sick’ or ‘not good’, that is physically or mentally unwell. They see themselves as ‘not good’ and it may be that they have a cut, scabies, broken limb or have an infection. They will seek assistance if they are ‘not good’. Thus they have a sense of their own well-being and a sense of unwellness/illness/ sickness. In both senses of unwell and wellness, they can be disempowered by society at large because of who they are as Aboriginal people.

There are also those Aboriginal people who may know they are unwell, but may present as if there is nothing physically wrong. The person knows they are unwell,

that they do not have a good sense of well-being and are not in good health. Nothing can be found even after samples are taken and tests completed, yet there are issues that are making that person unwell. Some times they are not mental health issues, but cultural issues. I write 'not a mental health issue' as these ways involve more than the individual person and the person's mind, but involve, the person in relation to one or more others. It is a process. It is also a process that biomedical science does not know how to 'handle'. Biomedical science has tended to concentrate only on the physical, and such processes often push the western, rational, logic, ethnocentric mind and ways of practicing medicine. Some Aboriginal individuals may seek Aboriginal 'traditional' medicines for an illness and others may utilise both western biomedical forms of medicine and Aboriginal medicine. Within the greater Rockhampton area, Aboriginal individuals utilise western medicine along with Aboriginal forms of medicine as well as therapies and practices termed 'alternative therapies'.

When I turn towards other non-Australian Indigenous peoples for their concepts of health, I come face to face with similar concepts of health and well-being. As Makaere stated when she was addressing what health meant to her and other Maori,

While it is important to raise health levels and increase employment opportunities, there are other indicators of Maori well-being. If I were very healthy and wealthy all those things top those indicators - but if I had no connection with my people, no language, if I didn't identify in some way with the Maori struggle, then what would be the point? I would be completely useless. I might be well, but in terms of my Maoriness, I would not be well at all (Makaere quoted in Ellis, 2001:10).

For Ani Makaere, her Maoriness forms the basis of her well-being, her health. These are not things such as health status, employment or money, but things that give her identity: her people, language, culture and connection. She additionally identifies that it is also about identifying with the Maori struggle, the struggle within the

contemporary New Zealand context, “Our modern history is important just as our pre-invasion history is important. It is all relative to who we now are as peoples within the contemporary world” (Makaere quoted in Ellis, 2001: 10).

From colonisation to now, a look back at Aboriginal Health

Prior to 1788, Aboriginal Australian peoples generally had a relatively good lifestyle and generally good health (Saggers & Gray, 1991: 59), and Thomson claims that when Australia was invaded in 1788, Aboriginal Australians were “physically, socially and emotionally healthier than most Europeans of that time” (1984: 939). This is additionally stated in the National Aboriginal and Torres Strait Islander Health Strategy, Consultation Draft (2001: 5) and other sources.²²

The information relating to pre-invasion health of Aboriginal peoples is based upon historical records, impressions and the observations made by European explorers and presents a consistent picture regarding the health of Aboriginal peoples. Captain Cook, said to have ‘discovered Australia’ in non-Aboriginal historical accounts, outlined on several occasions the status of Aboriginal peoples he observed, “of middle Stature straight bodied slender-limb’d the Colour of Wood soot or of dark chocolate... Their features are far from disagreeable” (Clark, 1966:51). Phillip, Australia’s first Governor’s view of the land mass, is outlined in Stone (1974: 20) and had similar impressions as did Eyre, an European explorer writing on the Murray river area, who described the Aboriginal people of that area as “almost free from diseases and well-shaped in body and limb” (quoted in Cleland, 1928). There are many other similar accounts from historical records (Elphinstone, 1971: 295, Dampier in Abbie, 1976: 5).

²² Information regarding the health status of English people from the nineteenth century can be found in the work of Engels (1892/1973:130-133). The work of Moodie (1973), Saggers & Gray (1991), Thomson (1984) and others support this view.

The National Aboriginal and Torres Strait Islander Health Council (NATSIHC) (2001:3) and Franklin and White (1991:3) report there were probably high rates of infant and child mortality. This was also true of European cultures at the time. Prior to invasion, Aboriginal peoples were solely responsible for carrying out health practices through traditional healing practices and using healing practitioners. The health practices carried out were embedded within cultural and spiritual values of Aboriginal peoples (NATSIHC, 2001:5), and what has been established is that Aboriginal peoples were of generally good health prior to invasion and the subsequent colonisation.

Colonisation had a profound impact on Australia's Aboriginal peoples. The invasion, with the establishment of the British penal colony at Botany Bay, began a destruction of Aboriginal lifestyles and cultures through Australia's colonisation and involved killings, massacres, removal of children, peoples and lands (Blainey, 1994; Evans, Cronin & Saunders, 1975; Lippmann, 1994; Rintoul, 1993; Rosser; 1985). Past government policies and practices, interventions, colonisation processes, missions, massacres, separations, abuses were focused on denying rights - the right of 'Aboriginal peoples being Aboriginal peoples', that is, the right to live as Aboriginal peoples, practice culture as Aboriginal peoples and exist and be Aboriginal peoples. Such policies were premised on assumptions of Aboriginal peoples as 'heathen', 'uncivilised', 'primitive' and 'immoral' (Henderson, 2000). It was thought that separating children from their families and giving them to white families, white missionaries and white institutions would make them white.^{23, 24} Documents of the early 20th Century reveal the belief that Australian Aboriginal peoples would be exterminated or assimilated as time went by (Kidd, 1997) and that these policies were in everyone's (including Aboriginal peoples) best interests.

²³ Read, 1999; Rintoul, 1993; The Human Rights and Equal Opportunity Commission's (1997) Bringing them Home Report provides an account of these practices and effects.

Some of the practices mentioned above have led to the complete eradication of some Aboriginal cultures and almost the complete destruction of others. The destruction that began in 1788 continues to impact on Aboriginal peoples lives, cultures and health and well-being today. Removal of children was still happening well into the 1970s, hence is within the living memory of Aboriginal peoples. The 1996 Census showed that there were 360,000 Indigenous Australians [Aboriginal and Torres Strait Islander peoples], which represented approximately 2 percent of the total population of Australia (Australian House of Representatives Standing Committee on Family and Community Affairs, 2000:3). The Report states that,

Despite improvements in certain areas, the health and well-being of Indigenous Australians has failed to keep up with the overall improvements in the health and well-being of non-Indigenous Australians, so that the level of disadvantage faced by Indigenous Australians has continued to grow over time (Australian House of Representatives Standing Committee on Family and Community Affairs,2000:3).

The NATSIC states that, “the ill health of Aboriginal and Torres Strait Islander peoples exceeds that of any other sector of Australian society and the causes can be partly attributed to the impact of colonisation on the health of Aboriginal and Torres Strait Islander peoples” (2001:5). It further states that the, “Acts of dispossession, introduced diseases, loss of traditional foods and lifestyle, forced resettlement, loss of social cohesion, separation of children and the actions of health and welfare services reflect this impact” (NATSIC, 2001:5). Aboriginal peoples also know the impact that the history of colonisation has had on them and what it means in terms of health status. For many Aboriginal peoples the destruction included and still includes attempts to destroy the basic human right of naming who Aboriginal peoples were and are, identity and rights to cultural heritage.

²⁴ In Canada similar processes occurred through the removal of Aboriginal children from their communities and placing them in residential schools (Founier and Crey, 1997).

The recent reports, policies, practices and interventions, and national/state/territory, regional health and mental health strategies, health reforms and many others are about our health status as Indigenous people. As a collective, they go further than ever before in linking the impacts of colonisation, social and emotional well-being issues and general health and well-being for Aboriginal and Torres Strait Islands peoples. These issues are still current and still need addressing.

While the macro picture is beginning to emerge, there is still no micro understanding. Questions that remain include: What do we know about current Aboriginal health statistics? What do we know about Aboriginal health statistics in Rockhampton and Aboriginal women's health statistics in Rockhampton? This research has explored the impact of some of these documents on Aboriginal peoples and Aboriginal women. Other broader research has taken place, for example, the National Aboriginal and Torres Strait Islander Survey (NATSIS) was conducted in 1994 as part of the Federal Government's response to the Royal Commission into Aboriginal Deaths in Custody. The survey carried out by the Australian Bureau of Statistics (ABS) was the first of its kind asking Aboriginal and Torres Strait Islander peoples across Australia questions on the social, demographic, health and economic status (ABS, 1995). The survey revealed that between 1988 and 1994, the rate of death from all causes had decreased by 10 percent among all Australians and yet had remained almost static for Aboriginal men and *increased* for Aboriginal women (NHMRC, 1996a:20, ABS, 1995). It revealed that the improvements that were made were as a result of a decline in infant mortality. The survey demonstrated that the gap was widening between Aboriginal peoples and Australians and that the picture was even worse for Aboriginal women. Nearly a decade later this picture has not really changed (ABS, 2001).

The NACCHO position on Aboriginal Women's Health contained in the NACCHO Manifesto on Aboriginal Well-being, outlines that health for Aboriginal women is linked to the restoration of Aboriginality, dignity, respect, roles, responsibilities,

self-determination, participation, coming to terms with law, lore and culture and to regaining “a state of well-being at least equal to that which existed prior to colonisation and as referred to in the NACCHO definition of health” (1993:13). In the statements of the NACCHO Manifesto the positioning of Aboriginal women’s health is clear and concise. The underlying premise of these statements being that the cultural and human rights of Aboriginal women are tied to the health and well-being as Aboriginal women. This is in essence what underpins this research project: *unless* Aboriginal women are empowered and affirmed as Aboriginal women, few gains will be made in their health status. If Aboriginal women continue to be marginalised, to have their sense of Aboriginality marginalised, and eroded and be further disempowered, then their health will continue to be fourth world. While the definitions are placed out there by Aboriginal people and while we are asked to articulate what will work for us, it is very difficult to gain programs and funding allocations to match these definitions and/or articulations.

The 1994 NATSIS evaluation survey showed that maternal and infant mortality rates were still higher than for non-Indigenous Australians. Although infant mortality rates have generally declined for both Aboriginal and non-Indigenous people in the past 25 years, the Aboriginal rates are still three to four times higher than non-Aboriginal Australian rates for hospitalisation (ABS, 1995, NHMRC, 1996a). What is alarming for Aboriginal women is that there are still higher rates of still birth, neonatal and post-natal deaths accompanied by low birth weights of their children (ABS, 1995, NHMRC, 1996a, ABS, 1997, 2001, NAHS, 1994, Australian House of Representatives Standing Committee on Family and Community Affairs, 2000). In 2000, the Australian Indigenous Healthinfonet showed “the Indigenous mortality rate of 13.6 infant deaths per 1,000 live births was 3.0 times the non-Indigenous rate of 4.6” (2002a, 24 May:4). The average birth weight for an Aboriginal child is 3140g compared with an Australian average of 3349g (NAHS, 1994:6). For those Aboriginal women who bore their children the picture is also frightening, for the NHMRC states,

... although maternal death is an uncommon event, it is substantially more common among Aboriginal and Torres Strait Island women than among other Australian women. About 30% of maternal deaths occur in Aboriginal and Torres Strait Island women who contribute only about 3% of confinements (NHMRC, 1996a: 20, Australian Institute of Health and Welfare, 1996: 22).

The Queensland Government (Queensland, 1997a) states that “25% of Aboriginal mothers were under 20 years compared to 6% of other mothers” (other women who were mothers in Queensland (1997a:1). Further to this, 13 % of Aboriginal babies were born under 2500gms (the WHO definition of low birthweight) compared to 6% of Caucasian babies (1997a:1). While the babies born do not fare very well, when one asks how do the mothers fare, the situation is not better. The Australian Indigenous HealthInfonet notes that, “for direct maternal deaths, the ratio for Indigenous women was 13.0 compared with 5.1 for non-Indigenous women” (per 100,000) (2002a, May 24: 6). The HealthInfonet and other documents do not address why this difference exists. But these are significant findings. Few midwifery or obstetrics programs contain curriculum content that specifically addresses Aboriginal issues of birthing. Aboriginal women are more likely to die as a result of childbirth than non-Indigenous women and their babies are more likely to have low birthweights and die before or after birth. Some programs have been established to specifically address this issue, for example the Ngua Gundi birthing program in Rockhampton, which focuses on education for young pregnant women and girls and provides support during pregnancy, birthing and after the new baby is born (Dorman, 1997).

The NHMRC Report states that hospital admission rates were found to be 50% higher for Aboriginal women than for other Australians and this was, according to the NHMRC, to be “a substantial underestimate” (1996a: 20). The chronic health diseases and issues of asthma, diabetes, ear problems, kidney problems, trachoma and circulatory diseases are experienced at higher rates than among the Australian

population as a whole (NHMRC, 1996a: 20, ABS, 2001). Public health, mental health and the impact of communicable diseases, including HIV/AIDS, have added to these alarming statistics. The Australian House of Representatives Standing Committee on Family and Community Affairs (2000:4) outlines that three out of every four deaths among Indigenous Australians now result from one of the following:

diseases of the circulatory system (heart attacks and strokes);
injury and poisoning (road accidents, suicide and murder);
respiratory diseases (pneumonia, asthma and emphysema);
neoplasms (cancers); and
endocrine, nutritional and metabolic disorders (diabetes)”

How do these statistics compare to other Australians and in particular other Australian women? Indigenous women are twice as likely overall, to have cardiovascular disease than non-Indigenous women; 1.7 times more likely to get coronary heart disease and 13 times more likely to get rheumatic fever (Australian Indigenous HealthInfonet, 2002a, 24/5:7). Rheumatic fever can have long-term effects on the heart muscle leading to heart problems in adult life. Indigenous hospitalisation rates due to respiratory disease, are twice that of non-Indigenous people, and respiratory disease is the second most frequent cause of hospitalisation for Indigenous women after pregnancy-related admissions (p.8). Injury is the third most frequent cause of death amongst Indigenous women and within this attribute, suicide rates are 1.4 times higher for Indigenous women, and homicides 7 times more likely than for non-Indigenous Australian women (p.8).²⁵ Aboriginal and Torres Strait Islander women are dramatically less healthy than Australian women and Australian people.

²⁵ The recently published *Aboriginal and Torres Strait Islander Women's Task Force on Violence Report* (Queensland, 2000) addresses the increasing levels of family violence and injury caused by violence (within Queensland).

While the health status for Aboriginal women remains poor, there have been some changes, for example, Aboriginal adult morbidity patterns have changed over the years. Historically the causes in excess mortality were a result of acute infections and communicable diseases. The leading causes of mortality are significantly different to what they were some twenty or fifty years ago (Saggers & Gray, 1991; Reid & Trompf, 1991; Australian House of Representatives Standing Committee on Family & Community Affairs, 2000:4). The Australian Indigenous Healthinfonet suggests that based on Census estimates and projection,

Indigenous males born in 1998-2000 could be expected to live to 56.0 years, almost 21 years less than the 76.6 years expected for all males. The expectation of life at birth of 62.7 years for Indigenous females was more than 19 years less than the expectation of 82.0 years for all Australian females (2002a).

Remember that this is the projected life expectancy for recently born Aboriginal and Torres Strait Islander people, and is not the currently held expectation of life that relates to people born prior to 1998.

In the past ten years, there has been a rapid increase in the number of recorded incidences of kidney disease and renal failure (Australian House of Representatives Standing Committee on Family and Community Affairs, 2000:5). This rapid increase is causing Aboriginal peoples to express concern about the future of their health and access to renal dialysis machines, which tend to be maintained within larger regional hospitals and big urban centres. Renal dialysis is vital for survival. Rockhampton District Hospital has a number of renal dialysis machines: those who live in Gladstone (120kms south), Woorabinda, [which is a Deed of Grant in Trust Community (DOGIT) of some 1000 Aboriginal people (200 kilometres south-west)] or Blackwater (200 kilometres west) must travel to Rockhampton 3 times a week to access the machines. Those who live further away and need dialysis must relocate

permanently. The increases in the susceptibility to kidney failure could be linked to childhood illnesses and trauma, along with complications for people who have diabetes. The Aboriginal and Torres Strait Islander population has higher levels of diabetes than the non-Indigenous population, and programs have been developed in an attempt to address this illness (King and Wilson, 1998). In Northern Australia, it is estimated that Aboriginal people experience renal failure at a rate fifteen times higher than the total Australian population (Australian House of Representatives Standing Committee on Family and Youth Affairs, 2000:5).

These types of health issues are not only to be found in the Northern Territory or remote parts of Australia. Aboriginal health does not get better the closer it gets to regional centres. A number of reports note “the overall health outcomes for Indigenous Australians in urban areas is as poor as that for Indigenous Australians in rural or remote areas” (Australian House of Representatives Standing Committee on Family and Youth Affairs, 2000:5) and that “Indigenous Australians continue to be the most disadvantaged in the country, no matter where they live” (Australian House of Representatives Standing Committee on Family and Youth Affairs, 2000:4). This can be understood to mean that even those Aboriginal peoples who do have access to large regional or urban centres and the health systems available, continue to struggle to gain access to health care measures and services.

So what is the situation in Rockhampton? In the “1991 Census there were 1642 Aboriginal and 229 Torres Strait Islander people living in Rockhampton, which represents 3.1% of the population” (Harper and Taylor, 1997:12). It is noted that one-third (33%) of these were aged less than 13 years of age that equates to approximately 617 Aboriginal and Torres Strait Islander people under the age of 13 (Harper and Taylor, 1997:12). Harper and Taylor additionally make the statement that “The age distribution of the Aboriginal and Torres Strait Islander population in Rockhampton, and Australia in general, is similar to that of residents of under-developed countries, e.g. many of the African nations” (1997:12). There are no

specific references or sections to Aboriginal peoples within the Profile that clearly separate out Aboriginal and Torres Strait Islander statistics of illness, hospital admissions, death rates, communicable diseases and health risk factors from the population of Rockhampton.

Another Rockhampton report (Rockhampton District Community Health Services, 1997) tables issues for discussion such as: worsening nutritional status and increasing risk of nutrition-related disorders such as diabetes, heart disease and hypertension, and drug and alcohol abuse as a way of coping with unresolved issues (1997:67):

Reduced life expectancy in Aboriginal and Islander community is causing mental health problems. People fear early death, cannot look forward to life after work. Whole family is affected by health problems and death of family member (Rockhampton District Community Health Services, 1997:68).

The Aboriginal women participants were conscious of the reality of a shortened life expectancy in comparison to non-Indigenous women, but they did not articulate a fear of death (see chapter 6). There are no other surprises within the Report that shows the health status and risk factors of poor health for Aboriginal and Torres Strait Islander peoples is no different to other Aboriginal and Torres Strait Islander peoples in the State (Queensland, 1997b) or country (Australian House of Representatives Standing Committee on Family and Youth Affairs, 2000).

What can be ascertained is that Australian Aboriginal women experience greater incidence and levels of illness throughout their lifetimes. Due to individual, family and community issues including health issues, Aboriginal women have less time to enjoy life and retirement when compared to other Australian women. I remember when I heard an Aboriginal woman friend of mine say that she was going to retire at 45 years of age and her work colleagues were stunned. She was 43 years old at that

time and her colleagues remarked that she 'had years left in her'. What they did not know is that she had lost three babies before any of them reached 5 years of age, seen the passing of a sister and brother, been adopted as a child, lived in violent relationships and had a range of liver and kidney health problems. She was taking stock of her life and planning for some enjoyment. One of the realities that backs up this woman's taking stock is that under current policy, Aboriginal peoples can be admitted into an aged care support program from 45 years of age. Ironically, Aboriginal peoples cannot access superannuation at the same time. Thus some of us die before we can access the benefits of superannuation contribution and may therefore make the choice not to make any extra voluntary payments to superannuation schemes but to utilise the money while we are alive. Further to this, I have witnessed some Aboriginal people who have experienced ill health over an extended period of time, object to their employers forcibly having to pay monies into a superannuation scheme that they will not be able to access. This is not to say that some Aboriginal women do not live long lives and in which they provide care for their and other's grandchildren and undertake community responsibilities.

The fact remains that Aboriginal women have poor health and this continues despite government attempts to make progress on our health status. At times it is difficult to believe that this will change and to envisage a time when this will not be the case, with some health issues the statistics may become worse. The Australian Indigenous Health Infonet suggests that "the disparity between Indigenous and non-Indigenous health, at least measured by mortality, has widened in recent years" (2002a, 24/05:12). Stanley and Wilkes also suggest that the gap between Indigenous life expectancy and non-Indigenous life expectancy is "widening, and constitutes a serious challenge to Australia" (1998:1).

The Australian, state and territory governments can no longer blame time for this reality. Australian Indigenous health status is significantly different to the situation for Indigenous peoples in New Zealand, Canada and USA, who have made

considerable gains in health status over the same time period. Queensland (2002a) Health's recent 20-year strategic vision and implementation plan includes numerous statements regarding the lack of progress in Australia in relation to Indigenous health. The document states that this lack of progress "appears to be due to causes such as lack of effort to address underlying determinants and infrastructure issues that underpin such progress" (Queensland, 2002a:17). It is also stated, that "Queensland should aim to achieve, within the next 10 years, one-third reduction in mortality that was achieved by Canada and New Zealand in the 1970s" (2002a:18). I read all of this with great disappointment. Canada and New Zealand, along with the USA, have shown that it can be done within one generation; moreover that part of the answer is in formal recognition of their Indigenous peoples and their rights as Indigenous peoples. Australia has no treaty obligation and the legal concept of *terra nullis* prevailed until 1990 when it was challenged in the Australian High Court ("Mabo" decision). The term *terra nullis* implies that no one owned this land prior to invasion and colonisation. This was challenged when Eddie Mabo lodged a Native Title claim for Murray Island, and the Court ruled in his favour. I am not entering into the discussion here of whether or not we should have a treaty, I am merely using it as a symbolic representation of the positioning of Australian Aboriginal peoples. We need to be formally recognised as Indigenous peoples with the right to be Indigenous within Australia and be allowed to exercise our rights through self-determination and self-management. Stanley and Wilkes link health improvements to reconciliation, self-determination and cultural revival and maintenance (1998: 2). We must be empowered and re-empowered in this process.

(Dis)Empowerment through Health Practice?

The processes of colonisation, dispossession and what could also be termed disempowerment during the process of invasion and contact made Aboriginal peoples dependent. This dependency was reinforced by the controls, institutions, laws and systems that the colonists imposed on Aboriginal peoples.²⁶ The

²⁶ See Rowley, 1970; 1973, Kidd, 1997; Evans, Saunders & Cronin, 1988

missionaries who came in service to 'save the wretched' and to 'civilise', also imposed their own systems, ways and rules on Aboriginal peoples.²⁷ The interventions intermittently introduced by governments served to re-traumatise and disempower Aboriginal people over and over again. The Royal Commission into Aboriginal Deaths in Custody Report (1991) and the Human Rights and Equal Opportunity Commission's 1997 report *Bringing them Home*, on the "Stolen Generations", publicly highlighted the issues as never before and they gave Australian society a further understanding of the situation and the disempowerment experienced by Aboriginal peoples. The history and traumas of colonisation has produced effects that are still being felt by Aboriginal people today (Phillips, 2003).

Empowerment can be demonstrated to have its roots in the civil rights and women's movements of the 'social action ideology' of the 1960s and the 'self-help' ideology of the 1970s (Kieffer, 1984). Rappaport describes the aim of empowerment is "to enhance the possibility for people to control their own lives" (1981:15). In this, there is no distinction between people and groups. Thus there is no distinction between Aboriginal and non-Aboriginal peoples, Aboriginal women and non-Aboriginal women. In the 1980s it became popularised in community psychology and ideology (Rappaport, 1987). Rappaport argues that empowerment cannot be measured and that it can only be considered case by case each unique context (1987:121-148). This may prove difficult with the kind of data required by epidemiologists and administrators in hospitals, due to requests for standardising statistics required in order to demonstrate that 'the targets have been met'. It becomes even more difficult to measure today with governments switching to evidence-based funding models.

The other words often discussed or mentioned from the late 1980s, are the 'Ottawa Charter'. The *Ottawa Charter for Health Promotion* (WHO, 1986) has come to be

²⁷ See Phillips, 2003:94-95, 116-117

the memorandum for Health Promotion as the basis of operation. It is within the Ottawa Charter for Health Promotion where one finds the use of the word ‘empowerment’ which in turn began a plethora of writing on the issue of empowerment as it relates to health (WHO, 1986:ii). The Charter outlines the essence of health promotion as the “the process of enabling people to increase control over, and improve, their health” (1986: ii). The people, the WHO statement is referring to is the individual and the community, as evidenced that it further outlines,

... concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies (WHO, 1986:ii).

The individual operates on their own but is entwined within the community.

Some writers (Braithwaite and Lythcott 1989; Breslow, 1992) propose empowerment should be the goal of every health promotion program. In the 1990s, the concept of empowerment began to be translated and interpreted across a range of disciplines and across the spectrum of the individual’s life. Empowerment became significant as it identified the individual as being a citizen, an individual within both political and social environments (Rissel, 1994). The concept of empowerment according to Rissel, “still lacks a clear theoretical underpinning with key elements articulated and supported by research findings” (1994:40). All major writers on the subject discuss this point along with the difficulty in measuring empowerment, for example, how much a person becomes empowered, the level of community empowerment, can a person be too empowered, where does empowerment cease, remain unanswered questions. Other writers, such as Rissel (1994), discuss the empowering nature, empowering manner and empowering elements of projects. Rissel argues these may be an abuse of the term empowerment and without appearing to consider what empowerment means or entails (1994:40).

A closer look at the word empowerment in health and well-being literature reveals the word being used over and over again in a range of settings and with many different forms of application. This causes a level of difficulty in gaining a deeper understanding of exactly what empowerment is as it relates to health. The lack of an agreed definition has additionally meant that the term has been repeatedly used in ways that could be regarded as misappropriated, confused, incorrect or *ad-hoc*. Despite this, many health policy documents worldwide, including Australia utilise the term empowerment.

In the complexities of definitions I have found the following provide useful guides as they all share one common feature that empowerment is a process.

Empowerment is a process by which people, organisations and communities gain mastery over their lives (Rappaport, 1985: 15-21)

Psychological empowerment may be generally described as the connection between a sense of personal competence, a desire for, and a willingness to take action in the public domain / sphere (Zimmermann and Rappaport, 1988:725)

Empowerment refers to the development of understanding and influence over personal, social, economic and political forces impacting life situations (Schulz, Israel, Zimmerman and Checkoway, 1995:309)

Empowerment is the ability to act collectively to solve problems and influence important issues (Kari and Michels, 1991: 719/720)

Empowerment is a social-action process that promotes participation of people, organisations and communities towards the goals of increased individual and community control, political efficacy, improved quality of life and social justice (Wallerstein, 1992:202).

There is a noticeable shift within these definitions over time and a splitting between individual or citizen or psychological empowerment and organisational or community empowerment. When I view the above definitions, I can see how these philosophies have been incorporated into policies of health that relate to Aboriginal and Torres Strait Islands peoples nationally and in Queensland (Queensland, 1994b,

1995b; 1998a, b, d, 1999a,b; to name a few). Some of the definitions seem to be too simplistic when applied to the Aboriginal and Torres Strait Islands primary health care movement and the reasons for the establishment of Aboriginal and Torres Strait Islands community health services almost 30 years ago. Although empowerment may be simplistic in terms of what is implied, the process remains very complex.

It is important, Rissel (1994) points out, to make the distinction between psychological empowerment and community empowerment (1994). While the following quote is lengthy, it is worthy of inclusion here. Rissel explains,

... psychological empowerment can be defined as a feeling of greater control over their own lives which experience following active membership in groups or organisations and may occur without participation in collective political action. Community empowerment includes a raised level of psychological empowerment among its members, a political action component in which members have actually participated, and the achievement of some redistribution of resources or decision making favourable to the community or group in question (1994:41).

From Rissel's explanation it could be expected that this research will bring both psychological empowerment for women who are involved and community empowerment for the process of bringing about improved access to health service for Aboriginal women in Rockhampton.

Empowerment within the context of community and community development can be defined as noted by Wallerstein and Bernstein as,

... a social action process that promotes participation of people, organisations, and communities in gaining control over their lives in their community and larger society. With this perspective, empowerment is not characterised as achieving power to dominate others, but rather to act with others to effect change (1988:380).

Wallerstein adds that this social action process is about working "towards the goals of individual and community control, political efficacy, improved quality of

community life, and social justice” (1992:198). She argues that empowerment is an important promoter of health and that powerlessness, or lack of control over destiny, is a broad-based risk factor for disease, therefore ill-health (1992:197-205).

It is worth noting that one cannot empower in the sense as ‘do to’ ‘do to others’ ‘do for’ or ‘give’. Canadian author Ron Labonte argues that people can only empower themselves (1989:87) and he describes through several texts how building on processes of empowerment and ways in which organisations, specifically health and well-being organisations, can work in ways that are more empowering (1986, 1989, 1991a, b, 1996a, b). His works reinforce that it is the results of self-awareness, self-growth and resources that empower - not the services provided. This is why there can exist so many services for women and so many programs that state they ‘aim’ to improve health status for women. In addition why governments can provide monies for specific programs and yet, the health, social and economic status of Aboriginal women and peoples, remains fairly much the same. Policy decisions and funding cannot just be based on health strategies which don’t explore or address the systems and theories that keep us in ‘our place’. Phillips utilising the work of Pearson states that

... underlying such policy implementation is that the ‘authoritative’ government health systems (including western systems of health knowledge production and theory) retain power and control over Indigenous funding and therefore interventions, and quality of life, all the while altruistically professing to implement humanitarian, up-to-date, ‘best-practice’ policy (2003: 35)

For me the concept of empowerment is in essence about increasing people’s power over things influencing their lives. I think the social-action process and the education model of Wallerstein (1992); the shared power, where both professionals and clients are active participants in the relationship of developing empowerment and the collaborative process espoused by Wallerstein and Bernstein (1988), are useful as they link in with the broader thinking about health, well-being and quality of life along with the individual and community. I believe that any sense of what

empowerment means to Aboriginal peoples or the effects that empowerment strategies have in working with Aboriginal peoples needs to come from the understanding that we were once sovereign peoples. We did have complete control over all things that influenced our lives. We lost this however, through colonisation, imperialism and dispossession, as we became increasingly disempowered as individuals and as communities. From this understanding along with the traumas and re-traumatisation, disempowerment and sense of powerlessness that has been experienced as a result of our history, we need to look at our re-empowerment. The writings on empowerment previously discussed do not specifically mention Aboriginal people or Indigenous peoples within their countries. The context in which I use the word in relation to Aboriginal peoples could also be utilised for other peoples that have experienced disempowerment through genocide, racism, colonisation or imperialism, for example or slavery in the USA.

Tsey and Every (2000) who evaluated Aboriginal empowerment programs state that empowerment is an ecological construct which “implies a synergy, or interactive changes, at the levels of the individual (psychological empowerment); the organisation (organisational empowerment, and the wider community (community empowerment)” (2000:511).²⁸ Tsey and Every (2000) based their understanding of empowerment on the social action process of Wallerstein (1992). They discovered in the analysis of their study that “participants had started using their enhanced personal empowerment to constructively engage structural challenges, both at the workplace and in the wider community, in ways that was previously impossible” (2000:513). Furthermore that in assisting individual participants, through personal empowerment, they increased their capabilities – that is, enhanced their “awareness, resilience and problem-solving ability- thereby making them better able to improve their sense of wellbeing and those of the people around them” (2000:513). That is, empowerment has a direct relationship to the health and wellbeing of people and that

²⁸ Phillips also makes mention of Tsey and Every in this context (2003:35).

the empowerment of Aboriginal people is vital in improving the health of Aboriginal peoples.

In her work with Aboriginal health workers in South Australia, Hecker states that, “empowerment is a process that enables disadvantaged people to increase their control over events that determine their lives” (1997:784). She adds that “Empowerment cannot be given or taught but is something people do for themselves” (1997: 784). Hecker utilises Mick Dodson’s words and asserts the need for empowerment of “Aboriginal people so that they can take responsibility for their own situation and then act to change is central to improving Aboriginal health” (1997:788). Anderson (1994a) emphasises the importance of self-determination too when he states that “[i]mprovements in health, especially for minorities such as Aboriginal communities, can not be realised in isolation from processes of self-determination. Aboriginal empowerment is fundamental to achieving improvements in health status” (1994a:32). Self-determination, empowerment and health status are intricately linked.

The community-controlled health sector has grown extensively in the last 25 years with Aboriginal leaders demanding greater control over health care. Tsey and Scrimgeour (1996) argue that the community-controlled sector can be built upon so that it becomes a funder-purchaser-provider separation model,²⁹ which might “contribute to a more efficient and equitable allocation of resources for service delivery, and at the same time enhance Aboriginal self-determination in health” (1996:661). They put forward that Aboriginal community-controlled health services are already operating as budget-holders as they are provided with government funds for primary health care activities within communities, and describe how the reform

²⁹ A model of a health care market consisting of a single funder, a series of community consumer organisations and a variety of health service providers. The model has been used by Maori organisations in New Zealand to increase Maori control over health care (Tsey and Scrimgeour, 1996:661; Scrimgeour, 1995).

in New Zealand has occurred though a shift in resources towards primary health care at the community level (1996:661-663). Tsey and Scimgeour state that the government would need to ensure “sufficient resources are directed towards Aboriginal health to reduce the discrepancies in health status” and that a resource-allocation formula would be necessary to ensure that each community receives its fair share” (1996:663). The purchaser-provider model may be a way to greater effectiveness, maximise health outcomes and to increase self-determination.

Wiseman and Jan (2000), who explored vertical equity,³⁰ argue that “achieving increases in the level of resources, improvements in the way services are used and potential improvements in the health and welfare of the community, are dependent in part on the *raising* of expectations of that community” (2000:229). Therefore community members identify needs and convey these needs to funding bodies for services and programs. Thus according to Wiseman and Jan, resource allocation can be via human agency. Wiseman and Jan put forward that in order for this to happen economists need to consider that “priority setting, in relation to Aboriginal health and probably more widely, cannot be undertaken in isolation from cultural and institutional considerations prevalent at any one time” (2000:230). They advocate for the pursuit of “procedural justice as the basis for vertical equity where the focus is on the fairness of how things are done rather than on the distribution of outcomes per se (i.e. distributive justice)” (2000:217). This too offers a form of empowerment in terms of taking responsibility and control through the process of doing and of having the resources to do it.

Black and Mooney (2002) additionally discuss vertical equity. They explain that health care equity has tended to stop at horizontal equity (how equals are treated in relation to one another) and state that we may need to look towards vertical equity (unequal, but equitable, treatment of unequals) (2000:201). Black and Mooney

³⁰ The “unequal, but equitable, treatment of unequals” (Wiseman and Jan, 2000:217)

present the levels of funding for Aboriginal people in Australia and argue that this does not compensate for the high levels of need. They argue that if “greater emphasis were placed on vertical equity, and how people in different positions are treated relative to one another, there would be greater possibility of achieving equity in health care” (2002:201). In this way the community may wish to allocate resources taking into account a wider set of values and goals that are relevant to the community in achieving equity in health care (Black and Mooney, 2002:201). The work of Black and Mooney is based on a communitarian philosophy, which they advocate provides “Aboriginal communities greater opportunity to develop respect, self-worth and autonomy. It would be a useful system that acknowledged the tragedy, terror and oppression we have caused these people, while at the same time fostering their own holistic health” (2002:205). Aboriginal people would become the moderators of the health outcomes relationship. Black and Mooney identified the need for Aboriginal agency and autonomy, and the connections towards improving Aboriginal health.

What can be ascertained from the literature is that the existing Aboriginal community controlled health sector, can be built upon and enhanced, and provide a vehicle for empowerment and improved health outcomes. There are challenges ahead for the sector in moving further towards self-determination and empowerment. Tsey identified one of the challenges as education of Aboriginal people. Tsey sees the “lack of formal education as a barrier to Aboriginal social and health improvement” (1997:77) and provides examples where Aboriginal people are continually in trainee positions and thus relegated to the administration officer and bookkeeper positions not finance officers, health workers not nurses and doctors, and program workers and not diabetes educators, nutritionists, optometrists, audiologists and podiatrists. Tsey outlines that generally within community controlled organisations there will be a “small number of senior Aboriginal managers” ... “in association with a board of management” who are “responsible for policy development and the day-to-day running of the organisation”... next in line is

a “predominantly non-Aboriginal professional staff” (doctors, nurses, visiting professionals, anthropologists, lawyers, teachers, pharmacists, researchers) and then “predominantly Aboriginal people” (health workers, field officers, liaison officers, Indigenous education workers and teacher aides, language workers, research assistants) (1997: 80). The monetary gains of high salaries and other benefits of working in communities adds to the advantage of the non-Indigenous middle strata and to the disadvantage of Aboriginal peoples, as the monies must be derived from the Aboriginal organisational budgets or Aboriginal program funding sources. Tsey (1997) relates this stratification of income distribution based on educational attainment and levels of skills to where workers live, and their health status, arguing that “higher income equals better health” (1997:80). Furthermore he poses the question, “What type of role models are we creating for black children?” The aim of Tsey is not to undervalue the roles of Aboriginal workers but to raise concerns about the possible negative effects of the stratification of employment within organisations. Tsey suggests that for Aboriginal people “it is the ability ... to capture a significant proportion of the middle-income level incomes, not only in their own organisations, but also in the mainstream, that would translate into improved health” (1997:80). Under this stratification there is a power dynamic which is always present, one in which Aboriginal people are the recipients and non-Aboriginal people the service providers with the assistance/ aide/ liaison Aboriginal people.

McTaggart explored issues around Aboriginalisation in education and identified that in the process of empowering Aboriginal peoples, there needs to be a process of disempowerment that comes to non-Indigenous people within Aboriginal domains. For example, within Aboriginal education settings, the empowerment of Aboriginal people means that non-Indigenous peoples should move out of key roles. This includes “Teaching, principalship and conventional kinds of consultancy – and into a variety of support roles which avowedly and explicitly carry the seeds of their own obsolescence” (1989:41). This principle could be carried across into the health

sector and result in Aboriginal people moving into key roles, taking responsibility and control.

We need to explore the current system of funding, relationships between the governments and our organisations, the programs, services and monitoring systems. It is not simply as easy as getting people educated and then slotting them within the current health system. This does not address the theoretical frameworks and methodologies on which the health system is built and the programs and services delivered. Phillips (2003) states that

... [f]ailing to encourage the redefinition of theoretical bases, rather than just health strategies themselves, is seen as not only as setting programs up to fail, but as a covert form of cultural and structural violence. That is, the implication underlying such policy implementation is that the 'authoritative' government health systems (including western systems of Indigenous funding) and therefore interventions, and quality of life, all the while altruistically professing to implement humanitarian, up-to-date, and 'best-practice' policy (2003:35).

At present time, the current system has the capacity to continue to traumatise and re-traumatise people through systemic violence and its authoritative nature. Aboriginal health will not improve if Aboriginal people continue to be told what to do and how to do it. As is evidenced from the literature for Aboriginal health to improve it must be linked to Aboriginal people taking control and responsibility and is intricately linked with our self-determination and empowerment.

Redbird specifically addresses the issues for Indigenous women when she states, that "[i]f the erosion of sovereignty comes from disempowering women, its renewed strength will come from re-empowering them" (1995:135). She states, "[e]mpowerment' has become a buzzword. Its overuse and misuse trivialises an important idea". I agree with Redbird. Empowerment for Aboriginal peoples and

Aboriginal women comes from re-empowering ourselves as the sovereign peoples of this continent, in this we claim back who we are as Aboriginal peoples. In this, we become the human beings once more who were self-determining, self-governing and sovereign. Empowerment is linked within the pre-invasion concepts of Aboriginality (within the context of pre-invasion) just as our disempowerment is within the context of post-invasion. We are the sum of our history and not merely remnants of part of our history. We know we were once empowered and strong as sovereign Aboriginal peoples. We can be again. The question along the way is how do we work towards healing the pains and responses to trauma and addressing this in moving towards empowerment?

Brazilian educator Paulo Freire outlined that the first step in the process of empowerment is the raising of critical consciousness (1973). People need to see the causes of their problems and how they are rooted within the structures in which they daily live. In this, empowerment becomes the vehicle for people to place challenges before themselves, to their own internalised powerlessness, and to develop opportunities to gain a sense of control within their lives, including the environments in which they live. I believe that Aboriginal peoples and Aboriginal women have a sense of what is classist, racist, sexist, white privilege and their positioning within the scheme of things and this sense is understood at a range of levels. There is additionally a sense of powerlessness that can be felt that is being experienced by individuals, within groups and at times across communities. At times one can almost see, smell and touch the powerlessness someone is experiencing. In this research, I asked the question regarding an understanding of whether health services recognise their positionings within the structures and the positioning of Aboriginal women's lives; and whether health services can provide an environment and services that can establish the ingredients for empowering processes and empowerment for Aboriginal women. Demonstration of both of these is via the voices of Aboriginal women's experiences of accessing those health services. A closer look at the Australian

context of health and empowerment may reveal more that is useful for health services in providing services to Aboriginal women.

USA researcher Nina Wallerstein's (1992) Empowerment Education Model is appropriate to reflect on at this point in the thesis. Her model advocates for an approach that engages "people through a group dialogue process in identifying their problems; in critically assessing the social, historical, and cultural roots of their problems; and in developing action strategies to change their personal and social lives" (1992: 203). She states that others may call this approach 'problem-posing', 'transformational', 'libratory', 'democratic' or 'civic competence' (1992: 203). Freire used the term liberation in his highly successful literacy programs; he makes it evident throughout his book that the purpose of education should be human liberation (1973). The first step in this process put forward by Freire as told by Wallerstein is "listening" (1992: 203). Listening to "people's life experiences and making participants into co-investigators of their shared problems in their community" (1992: 203). She explains that this involves a continued participatory process, which may bring to the surface issues or experiences of emotional and social significance. The second step is developing a "dialogue" around the issues that were brought up during the listening phase. The dialogue becomes a place of critical thinking, and analysis takes place as to the "root causes of one's situation in society -the socio-economic, position in society, cultural, and historical context of personal lives" (1992: 204). From here the critical thinking turns into strategising for individual and social action, this process has the capacity to unite people as members of a group or community in working towards the changes articulated from the participants. The third step is called the 'educational dialogical approach', which require the facilitator to be able to incorporate people's experiences and pose the questions that draws out the experiences into an analysis and an understanding of people's roles to challenge (1992: 204). Finally, that all actions should be determined by the participants themselves.

I recognise some of the aspects from the Model and from Freire's work within the research methodology of this research project and within numerous ways in which Aboriginal peoples work within communities. I have come to understand that the research process itself was empowering. The work of Wallerstein, Freire and Labonte can be adopted in part to suit the Indigenous liberation struggles for self-determination, self-management and sovereignty. Further to this, and of great importance is the need for healing and regeneration of Aboriginal people and Aboriginal women. If this country is genuinely trying to move towards improving our health status it will foster and encourage empowering processes including healing, cultural revival and regeneration within individuals, groups and communities and the Aboriginal community as a whole. It would need to shift from a relationship with us as Indigenous peoples, that is, of patronage, control and interference, to one that is about addressing racism, equal and respectful partnerships, support, cooperation and respect for us as the Indigenous peoples. In gaining greater control over our lives it will be possible to increasingly become more responsible for our own health and healthier lifestyles.

Rockhampton Women's Health and the Lived Experience

In the 1970s the women's movement gathered momentum encompassed under the broader women's health movement. During the same time a number of health developments were taking place including the community health movement, the Aboriginal community health movement, and the focus on 'consumers' within the health field. The women's health movement was able to utilise the new directions in 'public health', the terms of liberation and injustice, to successfully become stakeholders in the direction of health in Australia (Broom, 1999: 2). As a result, a number of women's health services, programs and centres were established throughout Australia.

The women's health philosophy according to Wass (1992: 51) is based on the premise around women's bodies, that women cannot control their lives until they

control their bodies. Thus some feminists who were active in the Women's Movement in the early phase focused on woman-only health centres where women could make decisions in regards to their own bodies and health care. This also included concepts of sexuality which Tong argues for radical feminists was crucial (1989: 110). Tong suggests that as sexuality is part of a woman's identity, a violation of a woman's body is a violation of that woman's identity and of her autonomy over her own body (1989: 110). She places the position of radical feminists that they perceive heterosexual relationships as legitimising domination and subordination linked to male and female behaviour of dominant and aggressive and submissive and passive (1989:110). I will argue that these relationships symbolise and reflect western patriarchal viewpoints of relationships and perceptions of male and female behaviours, and where western patriarchal ideology of male and female behaviours are not adopted or practiced and where cultures may practice their own gendered realities. Across cultures differences and sometimes similarities may be enacted within these behaviours and practices.

The women's health movement in the initial stage focused in part on gynaecological and reproductive concerns and especially highlighted access to contraceptive measures. The movement later went on to incorporate a wide range of health issues and health care. In recent times there have been further developments within the women's health movement, which have seen some variance between services, programs and centres. Some of the differences include the levels of participation by women, balance between clinical, health promotion and education programs, well-being programs, sexual assault counselling, programs specifically for younger women, older women, 'complementary therapies' (which are additionally termed as 'alternative therapies'), lesbian and/or bisexual support programs and a range of other programs. The women's health movement has generally adopted the social model of health and the primary health care model of health care delivery. These models, while linked, extend well beyond the reductionist and individualistic

approaches that are so entrenched within the traditional biomedical model of health care.

The Federal Government under Bob Hawke, a Labor Prime Minister acknowledged the inequalities that Australian women experienced within the health system and in 1989 the National Women's Health Policy (NWHP) was published and launched. This was developed after a "20-year process of lobbying by women's groups to make the health system more responsive to the needs of women" (Wass, 1998:33)³¹. The NWHP was a result of an extensive consultation process with women's groups throughout Australia and was "built on the recognition of the social model of health and the impact that the social environment has on health and health choices" (Wass, 1998:33). The overall thrust of the NWHP is directed at reproductive health and sexuality; health of aging women; emotional and mental health; violence against women; occupational health and safety; health needs of women as carers; and effects on women's health as a result of sex role stereotyping (Australia, 1989). The key action areas identified are: improvements in health services for women; provision of health information; research and data collection on women's health; women participating in decisions on health; and training of health care providers. At the time the Policy was launched the only States which did not have women's health centres were Queensland and Tasmania. Women's health centres were placed on the Queensland agenda after the election of Wayne Goss, a Labor Premier in 1989 (Broom, 1991:81). Goss defeated a conservative National Party, which had been in power for much of my earlier life.

³¹ The 20-years prior to the National Women's Health Policy (1989) witnessed Elisabeth Reid appointed as an advisor to Gough Whitlam, Labor Prime Minister in 1972; an International Women's Year during which monies were directed towards women's health; a national advisory committee established to assist in decision-making; and the first national women's health conference (Adelaide, 1975). 1975 additionally saw the establishment of some women's health centres and the Commonwealth Department of Health adopt the women's health agenda.

The Queensland State Government developed the document *Towards a Queensland Women's Health Policy - Social Justice for Women*, for the purpose of preliminary planning (1992). This document details the socio-economic status, housing situation, health status, life expectancy, infant mortality and morbidity, and fertility rates of women and in particular the situation of Aboriginal women (Queensland, 1992: 3-8). The Policy states that,

Women have a right not only to access and receive appropriate health care but also to actively participate in their own health care and having their cultural background, socio-economic status, age or geographic location given special consideration. This must be recognised in policy and program development and its service delivery (Queensland Government, 1992:22).

It further outlines that “special care must be taken when considering the specific needs of identified groups” and identifies that the “two important groups of women in this respect include those of different cultural backgrounds and women with a physical or mental disability” (1992: 23). Later within the Policy it identifies one of the emerging key directions for women’s health in Queensland is “Improving of health status of Aboriginal and Torres Strait Islander women” (1992: 24). Thus two of the issues highlighted within the Queensland Policy of 1992 is that Aboriginal women’s health needs to be addressed by funding drawn from the Policy; and, in delivering services to women, Aboriginal women need to be given consideration.

Program responses from the Queensland Policy and the NWHP took the form of women’s health centres, mobile women’s health programs, sexual assault programs, women’s cancer prevention programs and alternative birthing programs. Weeks identified that women’s services developed from two different sources, one being as a direct result of the women’s movement responding to women in crisis, for example, women’s refuges, and the other from women in the community coming together for self-help, to network and for social action on issues (1994: 36). When funding became available via both Commonwealth and State governments, women aimed their activities towards accessing the funds. The Rockhampton Women’s

Health Centre (WHC) celebrated its 10th year of service to women in Rockhampton and Central Queensland in 2001. In its 10 years of operation it has received both State and Commonwealth funding.

Some services such as the Rockhampton WHC have focused primarily on what is generally termed 'well-being' programs such as empowerment, self-esteem, surviving sexual abuse and sexual assault support programs. The Rockhampton WHC additionally offers 'alternative therapies' such as Reiki, Reflexology and Aromatherapy. The Rockhampton WHC provides a minimal clinical service specifically for rural women, offered by a Registered Nurse. Centre newsletters and annual reports are evidence of programs available (WHC, 2001). Other Queensland women's health centres offer more clinically focused services (such as Brisbane, Townsville). As Centres are community-based organisations that are driven by women members, women staff and women volunteers, the services available from these centres are thus established by women for women. There is, however, a question that needs to be asked, which women direct the services and the centres? My experience with a number of women's health centres leads me to believe that it is women who appear stronger, who know how to utilise resources, lobby and who are more vocal and more often than not women who are middle-class and white. I have noted that Aboriginal women may have some goals that run parallel to those of other women, for example, on issues such as violence against women, problems with the biomedical model of health, and sexuality. However, this does not mean that we are included in ways that encompass Aboriginal worldviews.

Moore (1997) undertook an analysis of the establishment of the Gladstone Women's Health Centre and provides an understanding of how such centres operate in terms of service delivery, issues addressed, employee profile and client satisfaction.³² She failed to address Aboriginal women's issues or how Aboriginal women and women

³² Gladstone is approximately 1 hour south of Rockhampton.

who are other than Anglo-Australian have their needs met. In this, she demonstrates the problematic nature of some WHCs and the Women's Movement.

The women's health agenda needs to work towards incorporating the health and well-being needs of Aboriginal women. Women's health policy documents, women's health centres and women's services that generalise about all women's oppression minimise the position of different groups of women. Aboriginal women are one of the groups of women who become marginalised as a result of this. As I have argued elsewhere in this thesis, women's oppression is not a separate and distinct social system that is autonomous from other types of social systems. When one looks at the history of Aboriginal peoples, one comes to understand that Aboriginal women have been subjected to a range of oppressions, with gender being only one. By the marginalizing of Aboriginal women in this way, Aboriginal women's needs are sometimes overlooked and another year goes by when a service happens for 'women', programs happen for 'women' and Aboriginal women are not included. Aboriginal women have repeatedly raised the issue of oppression by Australian women throughout the history of the women's movement.³³ Links can be drawn to the women's health movement from the women's movement.

The evaluation undertaken of the Rockhampton Women's Health Centre in 1999 by Kraack shows that there is not a great deal of ethnic diversity among women who use the Centre. The Evaluation reveals that,

... 95% of women surveyed were of English or European origin. No Torres Strait Islanders use the centre. Only 2 [A]boriginal women completed the survey suggesting a very low number of [A]boriginal clientele. There are also few women of NESB[non-English speaking backgrounds] using the centre only one is registered in the survey (Kraack, 1999:11).

³³ See the works of Flick, 1990; Huggins 1987, 1994, 1998; Moreton-Robinson, 1999, 2000, 2003.

The Evaluation additionally revealed, “The largest group using the centre are women 35-44 years of age, making up 27% of consumers” (Kraack, 1999:11). The document contains a section titled “Women of Non-English Speaking Background” (p18) but no section on Aboriginal and Torres Strait Islander Women. The material contained in the section on Non-English Speaking Background Women comes from women who were identified as mainly being from the Philippines. Another issue that needs consideration here which is not reported within the Evaluation nor any Annual Report, is that the majority of the women workers in centre could all be said to be ‘white’, representing the ‘norm’, the standard service group and the general population. This could also be said of the Management Committee. I acknowledge that from time to time this may change pending recruitment of staff and election of members onto the Management Committee.

In the section titled ‘Confidence to Make Referrals to WHC’ which was based on asking other health and welfare services about their referral process to WHC, one respondent stated

To know that the Women’s Health Centre can work effectively with Aboriginal women much better. It has let my service and women down. Aboriginal women do not like to go there. Not all but some will ring Brisbane’s Women’s Infolink rather than go to the Rocky Centre;

It would be good to have some Aboriginal workers, even sessionally; and

Women need to be more aware as workers. How come other mainstream services attract Aboriginal clients but not the Women’s Centre? it is about sensitivity, care, understanding (Kraack, 1999:21).

Service providers additionally identified some issues around the Women’s Health Centre’s service provision for Aboriginal women within the following statements,

Aboriginal women have said it is a place for white women, they do not feel comfortable; and rude in the past, racism - subtle and straight out racism, too white, need more people from different

cultural backgrounds to make the place more diverse, maybe an Aboriginal worker (Kraack, 1999:23).

Employ Aboriginal workers, cross-cultural training, not just for 1 or 2 days, it needs to be ongoing. The workers need to get out in the broader community: hardly see them unless 9-5pm; and maybe staff could receive training in cultural issues and somehow work to change the Centre's image that it is just for white women (Kraack, 1999:24).

There is the suggestion put forward by service providers that employing an Aboriginal worker would assist in access. A similar suggestion was made by an Urban Indigenous Hospital Liaison Officer in the Kirk et al (2000a) study, "We need to have skilled Aboriginal workers, and in order to succeed, I believe that we need to integrate some of it into mainstream organisations" (2000a:5). Further to this, a Remote woman stated "A lot of our people don't feel comfortable using a lot of the services because they are too white oriented, they are based on white models of practice, I think that needs to change" (Kirk et al. 2000a:3). Thus the issues are not just isolated to the Rockhampton WHC, but it is a problem that arises elsewhere with women's services and services for the general community.

The general comments repeated in Kraack are as follows,

"Lots of Aboriginal women do not have a car or petrol or money"
"Get an Aboriginal worker"
"There are some terrific women around town and some terrific black women, Indian women, Asian women how [come] none work there"
The service is not culturally appropriate for Aboriginal and Torres Strait Islander women. I would not refer a ATSI woman to your service" (Kraack, 1999:24).

It is noted that one of the respondents in the Evaluation recognised that there were "some terrific women around town". I am unsure whether this is a reference to their skills and ability levels as the remainder asks how [come] none work there? Moreover, one other respondent (another service provider) states that they would not refer any Aboriginal or Torres Strait Islander woman to the service.

The Kraack report provides some recommendations as to how the issues can be addressed,

It is important for the WHC to address [A]boriginal issues and issues of cultural sensitivity. The perception of some service providers is that WHC is culturally insensitive. This must have a significant impact on the numbers of [A]boriginal women using the service. Consultation with the [A]boriginal community is essential. A focus group discussion with [A]boriginal women would also be very useful and informative (Kraack, 1999:27).

The recommendations really don't go far enough considering the feedback given through the evaluation process as documented within the Evaluation compiled by Kraack.

The 1997-1998 Annual Report of the Rockhampton Women's Health Centre makes little reference to Aboriginal women aside from Woorabinda (a Deed Of Grant in Trust Community, previously an Aboriginal Reserve or 'mission', 200 kms south-west of Rockhampton) and Darumbal Youth Service (an organisation specifically for young people in Rockhampton). The 1998-1999 Report states "We are committed to improving connections with both young women, Aboriginal, Torres Strait Islander women, and women from non-English speaking backgrounds" (p5) and there are further references to involvement by Aboriginal women in programs. The 1999-2000 report and the 2000-2001 Annual Report reveal that there were some slight improvements in the areas of access by Aboriginal women. There was a slight increase in the number of contacts with Aboriginal women. There is a question with the reporting mechanism of the WHC, whether each contact with an individual Aboriginal woman who is participating in a program or counselling, is reported as multiple contacts by the same person or multiple contacts, for example, numerous women.

It is clearly evident that while there have been some improvements in the Rockhampton WHC's service delivery to Aboriginal women, there are still gains to

be made. Aboriginal women will continue to resist the homogenising forces of feminism and the Women's Movement. If the Rockhampton Women's Health Centre itself, as a community of women, does not address some of the issues raised by Aboriginal women around the inclusivity of the organisation, nothing will change.

The Women's Health Movement has been successful in addressing some of the issues around violence against women through education and networks, increasing women's control over their bodies and highlighting the inappropriateness of the biomedical model of health for women. Aboriginal women have specifically benefited through birthing centres and birthing programs. Some Aboriginal women still experience extremely high levels of violence and sexual violence within their lives and communities. The Aboriginal health movement has made gains in Australia since the 1970s in delivering services based on a primary health care approach, in fact prior to mainstream society. In terms of women's health centres and the Rockhampton women's health centre, there are still issues in terms of participation, decision-making and delivery of services and programs. The Centre has kept fairly much to the philosophy and goals of the original *National Women's Health Policy* (NWHP) of 1989 and to the *Towards A Queensland Women's Health Policy* (1992). Both the State and Commonwealth policies have been updated and changes have occurred but the thrust of the more recent policies are still the same. Aboriginal women's health needs still remain seriously unaddressed and it is evident that the original emphasis on Aboriginal women's health in the Queensland Policy of 1992 has not been given the same emphasis within the Rockhampton WHC.

Conclusion

This Chapter sought clarification through an exploration of broader discussions of health and Aboriginal understandings of health. The Chapter has explored the commonly used Aboriginal Australian understanding and statements of health utilised by NACCHO and QAIHF. These are the same statements repeatedly quoted

in health publications by governments, academics, organisations and individuals. While they are utilised it does not mean that the understandings behind these statements are embraced or implemented within the contents of the documents or broader Australian society.

Within this Chapter I have provided a brief overview of the health status of Aboriginal peoples and Aboriginal women and that Aboriginal women collectively have the poorest health of any other group of women in Australian society. Some of the literature explored within this thesis draws links between health status and Indigenous rights, treaties and empowerment. These concepts highlight the need for change within Australian society and for Aboriginal peoples too. Aboriginal women need to be ready to accept the responsibilities of being re-empowered and for a collective group of women who have long been oppressed and marginalised this will additionally be difficult. It will additionally mean that shifts will need to be made within the Women's Movement for Aboriginal women. This Chapter has demonstrated that shifts and changes are required in a range of sectors if Aboriginal women's health status is to improve and if Aboriginal women are going to become the empowered, sovereign women that we once were and that we can be again. The following Chapter begins to explore how health policy in relation to Aboriginal women has been shaped over the years. Furthermore, it discusses what shifts and changes are required in policy for the future.

Chapter 5

*“politicians come and go, promises come and go, but we,
we’re still here”*

Introduction

The previous Chapter asked a number of questions including what is Aboriginal health? and what is Aboriginal well-being? It additionally explored concepts of Aboriginal well-being and wellness and Aboriginal women’s well-being and wellness. One of the major overriding struggles within the Aboriginal health arena is for the consultation on, development of and implementation of policies that will bring forth, enact and result in *Aboriginal* definitions and concepts of health and well-being. The reality for Aboriginal peoples in Australia is that the Aboriginal definitions of health and well-being may never be enacted by the Australian government and various institutions. The reality for Aboriginal women is that unless the health and well-being issues of all Aboriginal peoples are addressed, Aboriginal women’s health and well-being needs will never be addressed.

Aboriginal women are often marginalised within women’s health policy and even sometimes within Aboriginal health policy. In the marginalising of Aboriginal women in women’s health policy, Aboriginal women remain on the periphery and therefore the needs of Aboriginal women remain on the periphery and are often ignored. This research suggests that Aboriginal women may feel conflict within themselves if they stand up for their own health needs when they are aware that the health needs of Aboriginal men and Aboriginal children are an equal priority. Therefore, it is important that the health of all Aboriginal peoples be discussed, articulated and struggled for by Aboriginal women and Aboriginal peoples.

This Chapter explores some of the issues within health policy as it has related to Aboriginal peoples and Aboriginal women. First, it asks briefly what is health policy and comes to some conclusions about how such policy relates to Aboriginal peoples. Secondly, it begins to expose some of the written and some of the often, unwritten historical policies that have influenced the health of Aboriginal peoples. Thirdly, it details significant events within the Aboriginal health policy domain from 1989 to the present as a way of highlighting the issues. Throughout, I explore where Aboriginal women have been encompassed and where Aboriginal women have been marginalised or excluded.

The reason for the selection of the time period from 1989 to the present is due to the major changes within the Aboriginal health arena evident from an examination of this time frame. This period identifies significant milestones in Aboriginal health from the point of view of Aboriginal peoples and the articulation of issues relating to the health of Aboriginal peoples. It has witnessed changes in discourse of race, ethnicity and culture, ideology and the development of specific programs based on groups and needs of groups. Further to this, there have been major shifts within the national and international arenas around Indigenous peoples rights, health status and standards of living and these have been tied to subsequent agreements. Consequently, this has resulted in a plethora of research projects, reports, papers and policies. Along the way, as will be shown, while Aboriginal people were dissected into body parts, by the policy makers, researchers and report writers (e.g. eye health, sexual health, renal disease, diabetes, mental health), this became increasing so during this period. This was despite arguments that they were attempting to examine Aboriginal health in an holistic manner. Importantly, in the same time frame, Aboriginal peoples have been required to make some tactical changes and increasingly become more international in the struggle for the right to health. These shift changes are critical to the argument this research presents that the way health services are planned, developed and delivered need not only be a review but to be changed.

What is Health Policy?

Palmer and Short define health policy as the “courses of action that set of institutions, organisations, services and funding arrangements that we have called the health care system” (1989:22). Short states that it “includes action or intended actions, by public, private and voluntary actors (individuals and organizations) that have an impact on health” (1997:66). Health policy thus may refer either to a set of actions and decisions, or to statements of intention (Short, 1997:66). It additionally includes what actions governments say they will take and courses of action that sets of institutions do, what they do, and what they do not do. From this description by Palmer and Short, one could say that a simpler statement about health policy may be ‘what someone, some group, some government decides what should happen, what will happen, how will it happen and then checks that it did happen and how well it happened’. Other definitions of what policy encompasses: setting the policy agenda, policy development, policy formulation, policy implementation, policy delivery, policy evaluation and policy monitoring (Yeatman, 1998:16). Health policy can also just be decided upon in Parliamentary Cabinets and could be called decisionistic (see Majone, 1991) and/ or executive, that is, directed from the top of government down towards the people that are governed over by the government. The creation of health policy does not necessarily involve those who are affected by it. Aboriginal women have witnessed a plethora of policy models.

Policy development is an ongoing process. Gardner (1997) suggests policy is about political parties who gain power, and then attempt to implement policies developed from their ideological and values bases. In addition, policy development is a result of knowledge on existing policies, and how this knowledge can be meshed with the existing policies. Once policies are developed, work begins as to how such policies can be translated into programs, initiatives and schemes that can be implemented, adapted, reviewed, evaluated and from which reports can be developed. Policy-making is sometimes complained about and as some would say ‘bitched’ about. It is described as *ad-hoc*, reactive and according to some following particular political

agendas. As Gardner asserts in response to descriptions of policy-making as being *ad hoc* “this criticism reflects a misunderstanding of the process, which is by its very nature ‘for a purpose’” (1997:1). She maintains that when it appears *ad hoc*, reactive or ill-thought out, this is probably due to political considerations. Policy is often problematic in its implementation, as at times the information on which policy is developed may be flawed and the subject of the policy may be indefinable. Over the years, there has been a range of ideas put forward to improve the policy process, which have included models detailing decision-making and organisational analysis, where changes were incremental.³⁴

One of the difficulties regarding policy making is the short term approach that is taken due to the election process at times. As a result policy direction and policies change equally as quick. In Aboriginal affairs every political party has a different approach based on their philosophies and understandings of disadvantage, marginality, opportunities, State responsibilities or user-pays/market ideology. Outcomes in the policy domain can result in large shifts within short time frames. Health is not isolated from political processes even though it is based within demographic and epidemiological models of data collection and social planning processes.

The national health policy in relation to Aboriginal peoples has essentially been shaped and developed over the past 30 years by both major political parties. Within this same period we witnessed the emergence and strengthening of the Aboriginal community controlled movement, which has continually placed challenges for governments and policy development in the health arena. This coupled with Aboriginal peoples on-going struggle for liberation, and the changes in government policy regarding the rights of Aboriginal peoples, have additionally brought shifts. Along the way the Australian public’s attitudes towards Indigenous peoples has altered and is evidenced in some ways through service delivery, acceptance by many

³⁴ See Ham and Hill, 1986; Hill, 1993; Gardner, 1995; Gardner and Barraclough, 1992, 2002; Davis et.al.1993; and Palmer and Short, 1994.

of Aboriginal specific programs and by the willingness of some workers to undertake cross-cultural awareness training. The following section will outline some historical reflections on health policy and Aboriginal peoples. It serves to further understand the context in which Aboriginal women have lived and within which this research is based.

A Glimpse at some Historical Reflections on Health Policy and Aboriginal Peoples

Health policy in Australia's post-invasion history has involved politicians, governments, church groups, special interest groups, health professionals, allied health professionals, business people and individuals. Some have been executive, that is, made by Federal and Queensland Cabinets, although this term could be broadened to include those policies that have been decided upon by heads of churches and other institutions. They included, policies relating to the establishment of national programs and Queensland based programs such as the Trachoma Program and the Tropical Medicine Program, and policies of the Inland Mission, Lutheran missions and religious instruction.

Religious denominations carried out questionable health and healthful practices, being perpetrators of violence and a range of abuses including treating Aboriginal peoples as animals. The oral histories such as those told by Perkins (1975, 1993), Henry Fourmile (1993) and others (Kidd, 1997, Rintoul, 1993) provide evidence of maltreatment. Henry Fourmile, for example, was in a church mission and lived in the male dormitory where he was forcibly placed at 10 years of age,

... we were just treated like animals... Lunch was a piece of bread and a plate of soup, if you were lucky. Sometimes it was rotten really, some of the rancid soup. It was only good for animals ... but we ate it. And tea was another slice of bread and syrup and a cup of tea. And this we had for seven days a week (Fourmile in Rintoul, 1993:115).

Phillips who undertook a study within a small Aboriginal community in north Queensland explained that one middle-aged man, had witnessed “as a child and teenager, the missionary, sometimes called a supervisor, as “judge” of the people, meaning he presided over the affairs of the community, even the newly elected Community Council, until the early 1970s” (2003:95). The missionaries controlled who lived where including the dormitories, who married who and when, who could travel in and out of communities, how much food each person got in terms of rations, and the type of education each person received.³⁵ Other institutions were set up specifically for children (Beresford and Omaji, 1998:21). The churches and government run institutions and communities generally prohibited the practice of cultural ceremonies and language.

Others, including health professionals, police officers and government administrators also carried out questionable practices and “operated in concert to suppress local Aboriginal sovereignty, steal their lands, and destroy their languages, cultures and social cohesion” (Phillips, 2003:93). These are broadly documented.³⁶ Phillips (2003) states that not only did “colonisation produce situational traumatisation, such as seeing relatives shot or taken away, but it also produced cumulative trauma as a result of shame and self-hate, and intergenerational trauma as a result of unresolved and unaddressed grief and loss” (2003:23). The work of Atkinson (1998), Atkinson and Ober (1995) and Atkinson et al. (1996) discusses intergenerational trauma and unresolved grief and loss, which impacts on people within Central Queensland and Rockhampton.

The work of Kidd is important as she was given permission to access files directly from within the Queensland Government (1997). She draws on archival primary

³⁵ See Evans, Saunders and Cronin, 1988; Evans, Cronin and Saunders, 1975; Kidd, 1997, Manne, 2001; Read, 1999; Reynolds, 1993; Rintoul, 1993; Robinson, 1997; Rosser, 1985.

³⁶ See Evans, Saunders and Cronin, 1988; Evans, Cronin and Saunders, 1975; Kidd, 1997; Manne, 2001, 2003; Read, 1999; Reynolds, 1993; Rintoul, 1993; Robinson, 1997; Rosser, 1985.

source documents about the treatment of Aboriginal peoples, staff within the Department, government processes, administration of reserves and missions, and policies related Aboriginal peoples. The practices as discussed above took place within Aboriginal communities across Australia but *not* within non-Aboriginal communities in Australia. They were not unique to the colonisation of Australia but took place in other parts of the world where colonisation took place.³⁷ Phillips states that “An Old Man who is still living in the community saw police shooting Bama for their land when he was younger” (2003:94) and that an elderly lady told him that, “the teacher was using the radio to tell the policeman to come and get us half-caste ones” (2003:94). Sandra recounts her own removal in 1958

We were told to get in the car and we did. We trusted the policeman. I thought he was taking us for a ride ... we screamed at the policeman to stop the car I didn't see my mother for another twenty-nine years. I will never forget the fear I experienced in that car on that day, it was absolutely devastating ... Every function (at the institution she was taken to for children) was systematically organised. It was like rounding up the cows. Every detail of our daily lives was done to a plan. It was a way of controlling kids. It disempowered us. It took away our thought processes. You didn't think of doing anything different because you would get the stick (Sandra quoted by Beresford and Omaji (1998:19).

Events and practices such as the ones presented here are still within the living memories of Aboriginal peoples, Aboriginal families and Aboriginal communities. They contribute to current attitudes towards health professionals, health care delivery, religious people, teachers, law and order workers and government officials. It also needs to be said that if it is in the living memory of Aboriginal peoples, it must also be in the living memory of some non-Indigenous Australians.

³⁷ For example Canada (Waldram, Herring and Young, 1995), Aotearoa/New Zealand (Smith, Linda Tuhiwai, 1999; Sutton Beets, 2000), the Pacific Region (Marsh, 2000; Suaalii, 2000; van Tright, 2000), Kenya (Ngugi wa Thiong'o, 1993) and the Latin American Region (Bose and Acosta-Bellen, 1995; Radcliffe and Westwood, 1993).

Australia has never had a specific health policy on the cleanliness of individuals, the whole concept of dirt has been associated with Aboriginality in Australia's modern history. Aboriginal people were constantly taught about cleaning, scrubbing and bathing. It became the main focus of mission life and the responsibility of institutions and Aboriginal women who worked as domestics.³⁸ An advertisement from the 1920s for 'Nulla Nulla' soap featured a drawn Aboriginal woman's face with dirt written on a sign hanging around her neck, a white woman's hand holding a Nulla Nulla above the head appearing to hit the Aboriginal woman on the head and the words 'Knocks dirt on the head' (Fallon, 1999). Complaints made about 'dirty Aboriginal people' kept Aboriginal children out of school, if it was said that the children were neglected they could be removed from families and segregated (Beresford and Omaji, 1998:96). The practice of removing children continued through the 1950s and 1960s under child welfare legislation in most states and allowed missionaries, government officials and others to additionally restrict contact between Aboriginal children and their parents and culture (Beresford and Omaji, 1998:96).

Historically government departments had specific policies for Aboriginal peoples relating to health, movement, marriage, schooling, in fact every facet of Aboriginal peoples lives. Rules were often stricter, and the consequences more severe, on reserves or missions that were specifically established by government and church groups for Aboriginal peoples.³⁹ Elkin, a Church of England Priest and anthropologist who travelled extensively throughout Australia visiting reserves, made numerous representations to the government over the treatment of Aborigines (Kidd, 1997). The term 'inmate' came to be used widely used at the time missions were established, its use implies some sense of the way Aboriginal peoples were

³⁸ See Huggins and Huggins 1996; Nannup, et.al (1992); Williams, 1999; Ward, 1987, Reynolds, 1990:207-213.

³⁹ See Kidd, 1997, Phillips, 2003, Evans, Cronin and Saunders, 1975, Read, 1999, Reynolds, 1989, 1993, Rintoul, 1993, Cope and Kalantzis, 2000.

treated and regarded. Older documents such as Church based newsletters from Woorabinda (and other past reserves) housed at the resource collection at the Institute of Aboriginal and Torres Strait Islander Studies in Canberra reveal the term, as do the personal accounts of women such as Huggins and Huggins (1996:5). Cope and Kalantzis (2000) state that the Aboriginal welfare and reserve system was “so authoritarian as to amount in many cases almost to incarceration” (2000:25) and one which “Aborigines were put into the same category as prisoners and lunatics in a society which was busily setting up ‘modern’ institutions to remove every manner of social evil and to keep these evils out of sight, and, therefore, out of mind” (2000:25). The colonisation of Australia is filled with evidence of the distinctions and demonstration of power between jailer and inmate. Examples such as children being housed in fenced dormitories (Huggins and Huggins, 1996:28), permission being required from the Protector of Aborigines for Aboriginal people to leave the missions and reserves and then having to carry papers with you (these were later called dog tags by Aboriginal people), strict monitoring of Aboriginal reserves (Reynolds, 1989: 81-93; Phillips, 2003) and “to which any Aboriginal [person] under the Act could be transferred at the direction of the minister” (Kidd, 1997:49).⁴⁰ Kidd uses the term “policing” (1997:49), Huggins and Huggins used the term “surveillance” to refer to the way Aboriginal peoples lives were monitored and documented.

In the past ‘inmates’ were sent from one reserve to another for ‘bad behaviours’, for example, Nellie Sheridan was sent from a reserve to another reserve for back-answering a white nurse in 1935 (Rintoul, 1993:200). Others were sent to reserves because of the particular colour of their skin. Rita Huggins explains that the “old people from Cherbourg and Woorabinda always told the story that the ‘full bloods’ were sent to Woorabinda and the fairer-skinned to Cherbourg” (Huggins and Huggins, 1996:10). Every facet of many Aboriginal persons lives was documented and recorded in files. The people who were responsible for the documenting were

⁴⁰ See also Huggins and Huggins, 1996:35

frequently involved in directions about what would happen for, with and about Aboriginal people within their environment or fed the information up the line of supervision or management. Sometimes no documentation occurred, evidence of this is that for some Aboriginal peoples who have since died and for some who are still alive, there are no records, no birth certificates, no death certificates or there are only pieces of information available. The implementation of policy and legislation, along with decisions made on behalf of Aboriginal peoples and the behaviours of Aboriginal peoples were often recorded on Aboriginal people's files. What was additionally recorded was all information related to behaviour, illness, diseases, infections and cause of death (Kidd, 1997). Aboriginal people in all facets of life were under surveillance.

In Queensland, many of the government files that were kept on individuals can now be sourced (by family members) through the John Oxley Library. Jackie Huggins recounts when she and her mother sought to access her mother's personal files in 1990.

When I first made enquiries about seeing my mother's file, I was made to watch across a huge desk as two white public servants turned the pages. Watch, not touch... These gatekeepers behaved as if the files were their personal property whereas they are in fact part of my people's inheritance... Finally, with the assistance of a newly appointed Aboriginal member of staff, we saw the file. We had been forewarned that the file could contain hurtful material and to remember the times in which it was written and the paternalistic nature of those who wrote it... Nothing could really have prepared my mother for the experience of reading her files. The first entry is 1942 and the last 1974 – thirty-two years of surveillance (Huggins and Huggins, 1996:5)

Within these files, church records and other government files, evidence can be found of health policy responses to Aboriginal peoples. There were also some commonalities in health policies for example in the 1920s designated Aboriginal hospitals were often old tin sheds. Some Aboriginal hospitals were in older buildings given over when a newer building was given to the general Australian public. Up

until the 1930s Aboriginal people were only allowed to use the designated Aboriginal hospitals. Some hospitals had designated areas specifically for Aboriginal people. Maggie Morris, New South Wales, in sharing her story explained that, “Up at the hospital, they had two rooms for Aboriginal people... It was called ‘Dark town’. They had other wards for white people” (Rintoul, 1993:281). Up until the 1960s Aboriginal people could still expect to be refused medical treatment or to wait in a segregated area to see a doctor (Saggers and Gray, 1991:125). Aboriginal women in Rockhampton still refer in general conversation to a past time when they were congregated at one end of the maternity ward when admitted to the Rockhampton Base Hospital to birth. Biskup (quoted in Saggers and Gray, 1991:124) provides an experience of an Aboriginal woman who was admitted for a postnatal operation who could not get assistance with washing herself from the non-Indigenous staff, even after asking. Often Aboriginal peoples were left to do some of the care of each other.

In the past nurses were non-Aboriginal people. Within hospitals white nurses had enormous control and were the health managers as many are today. At times nurses controlled who got to see a doctor, who got medication and even who got what names, for example Julie Whitton explains that she was 51 last birthday and that “A nurse chose my name. My mum said she was going to call me Ida, but this nurse wanted to call me Juliet. That happened with a lot of Aboriginal people”. She now calls herself Julie (Rintoul, 1993:266). Nurses today in many Aboriginal rural and remote communities still have control of who gets to see a doctor (whether the doctor is in the community or is part of the flying doctor service) and access to medication.

Since the time of invasion until approximately 1989 strategic planning in Aboriginal health was not necessarily in the best interests of Aboriginal peoples, but rather in the interests of the non-Indigenous population. There was little if any attention paid to Aboriginal women’s health. The attention that was paid focussed around the

subject of reproduction and issues of prostitution, exploitation, abuse and venereal diseases (Kidd, 1997:104-105). There was a time when Aboriginal women were forced to move from traditional cultural birthing on the land to birthing within medical system structures and facilities. I have been unable to find a direct reference to a particular point in history when this happened. We (Aboriginal women) do know broadly that this has caused contemporary issues and problems around Native Title. In terms of Aboriginal women today, this is tied to issues of identity along with Indigenous women's rights of birthing in one's Country, one's ancestral home place. There have been a small number of pilot projects established in some communities predominantly in north Queensland for community birthing (NAHS, 1989), funded by Queensland Health. There are numerous communities who would additionally benefit from having such projects. There have additionally been a limited number of programs established within Aboriginal communities to assist Aboriginal women in having good pregnancies. In Rockhampton there is such a program named Ngua Gundi (Dorman, 1997; Wilson, Wellburn, Perkins, Ray and Pointon, 1997). This program and other similar programs have struggled in past years to secure on-going funding resulting in a recommendation in 1999 from the Senate Community Affairs Reference Committee into childbirth procedures (Commonwealth of Australia) that the, "Office of Aboriginal and Torres Strait Islander Health provide recurrent funding to ensure continuity for existing antenatal programs for Aboriginal and Torres Strait Islander women and to establish new programs in areas of need" (1999:5).

The Ngua Gundi Program in Rockhampton (Dorman, 1997), which is funded by the Queensland Government, still faces issues of funding security, as do other such programs. While these programs have been established and such a recommendation was tabled in a Senate Committee report it does not mean that Aboriginal women's health is being given the attention it deserves or needs. As figures I quoted in the previous Chapter demonstrate Aboriginal women are still the most disadvantaged and still have the poorest health status of any other group of women in Australia.

Policies which enact the establishment of a limited number of birthing centres, merely touch the surface of the issues.

We do know historically that as a result of Aboriginal women's relationships with non-Aboriginal men that a range of issues additionally impacted on Aboriginal women's health, for example, the policies that surrounded the removal of 'half-caste' and 'quarter-caste' children from Aboriginal women. This was done in hospitals, communities, on the street and through the church and governments. This is documented in the report from the *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (Commonwealth of Australia, 1997) and documented elsewhere (Croft, 2001, 2003; Kidd, 1997; Read, 1999; Rintoul, 1993). While they were not health policies per se, they directly related to the health and well-being of the Aboriginal women and the future health of Aboriginal children (Reid and Trompf, 1991; Saggars and Gray, 1991). Furthermore, they were instances of situational traumatisation, which have added to intergenerational trauma (Phillips, 2003:23) and thus the overall health of Aboriginal women.

Historically if we explore issues connected to women's rights and the women's movement and the policies that eventuated, there is no or little reference to Aboriginal women. Aboriginal women are generally incorporated within general policies for 'women'. The problems with this were explored within Chapter 3, which argued that women's health policies in relation to Aboriginal women historically, have been ignored until recently. At the time of writing there is still no Aboriginal women's policy position within the Queensland Health Department to specifically work on Aboriginal women's health issues.

What needs to be remembered is that Aboriginal women's experiences of the Australian health system since invasion is via a lived experience that an Aboriginal woman owns or a member of her family owns. These memories are still vivid, may still be discussed and operate as reminders to 'assist people to remember' as with

other cultural processes. Sometimes the trauma may be turned inwards as a result of having no way of dealing with the experiences and events in their lives. Further to this, as a result of past experiences and trauma people may just believe everything will turn out bad or be the same as before.⁴¹ Consequently any new policy may be seen and be treated by Aboriginal women and Aboriginal peoples as another attempt by governments to ‘whitewash’ Aboriginal health issues and Aboriginal lives. It may, from an Aboriginal point of view, become ‘just another policy’ that joins the dozens of policies written on Aboriginal peoples lives since the time of invasion. The important aspect of whether a policy becomes just another policy or not, is whether Aboriginal peoples have contributed to the policy through formulation, active consultation, development and writing and whether Aboriginal peoples will be involved in an evaluation of the policy at a later stage. In 1989 a landmark in Aboriginal health policy in Australia occurred which did just that. This landmark is outlined in the next section.

The National Aboriginal Health Strategy (NAHS)

The National Aboriginal Health Strategy Working Party was established in December 1987 and produced the *National Aboriginal Health Strategy* (1989), which is most commonly referred to as NAHS. The NAHS was an important milestone in the history of Aboriginal health in Australia. It is significant in that it was the first time that representatives from Indigenous communities, the Commonwealth and the State and Territory governments came together to collectively work on any national policy for Aboriginal peoples in Australia. The Working Party comprised two Commonwealth appointees, eight State/Territory representatives and nine community representatives (Wooldridge, 1990c:2102; Gibson, 1990:2656). Michael Wooldridge, the Federal Opposition Minister for Health at the time, stated that it was “a high tide mark in Aboriginal health” (1990a:2659). While stating this he also questioned some months later why the

⁴¹ See Phillips, 2003: 96-97

action had not “matched the rhetoric” (1990a:2659) and why hadn’t appropriate monies been allocated in the federal budget (1990c:2102). Inaction seemed to become synonymous with the NAHS.

The National Aboriginal Health Strategy Working Party that was established in 1987 had a set of Terms of Reference to which they were required to work. These were established by the Commonwealth Government and were as follows,

- a. Report on Commonwealth / State and community funding arrangements, including financing of primary health care services and social health programs in Aboriginal communities.
- b. Develop strategies to achieve improvements in the short and long term, taking into account specific health problems, health service provision, administrative and funding arrangements, Aboriginal participation, research and data collection and ongoing monitoring.
- c. Develop strategies to maximise the involvement of Aboriginal people in their own health care.
- d. Consider intersectoral co-ordination including Commonwealth, State local and health service agency responsibilities.
- e. Develop a mechanism to monitor progress towards achieving targets, taking into account performance indicators developed as part of the policy.
- f. Provide an interim report to the Ministerial Forum on Aboriginal Health in 1988 and a final report to the Ministerial Forum in 1989 (National Aboriginal Health Strategy Working Party, 1989:ix).

As is evident from the above Terms of Reference the task set before the Working Party was enormous. The Terms are extremely broad and as such a wide range of understandings about what the NAHS was about, what it would reveal and what the

outcomes would be. The Terms of Reference are, as Siggers and Gray state “all-embracing and somewhat restrictive in scope” (1991:140). In addition they provide “for a critical examination of current Aboriginal health problems and is not prescriptive about strategies to achieve improvement” (1991:40). One of the enormous difficulties with the Report was the amount of information given, gained and examined and the prioritising of all of this information. Each State tendered a submission to the National Aboriginal Health Strategy Working Party. Each submission offered similar programs targeting similar issues such as diabetes, hepatitis B, nutrition, substance abuse, women’s health and children’s health. All States, however, had different ways of providing the programs and of reporting on the programs.

Mr Slater from the Department of Community Services and Health explained that the National Aboriginal Health Strategy was “being funded 50% by the Commonwealth and 50% by the States” when asked by Senator Peter Baume during a Senate Estimates Committee meeting in 1988 (Australia, 1988:124). One of the ongoing difficulties that surfaced with the NHS was that while there was agreement on a coordinated approach between state, territory and federal governments there were problems getting a commitment of monies from some of the states (Wooldridge, 1990a:2659). Gibson, the Member for Moreton spoke strongly to the NAHS and the position of the states and the federal government in a speech he delivered to the House of Representatives,

Accept the responsibility that adoption of the National Aboriginal Health Strategy entails and commence this process without delay. There are two discrete areas of funding allocations which are required. The first, which covers the bulk of the recommendation of the Joint Ministerial Forum, involves the immediate restructuring and increased provision of direct health services. These do not involve significant additional funding but do require additional contributions from both States and the Commonwealth. Both levels of government need to respect their own responsibilities and be forthcoming with their funding.

The strategy requires all levels of government to provide Aboriginal and Torres Strait Islander communities with basic

facilities such as housing, water, sewerage, electricity and roads to the level that the wider Australian community takes for granted. The strategy must be a cooperative effort, and I repeat my earlier point that it will need substantial financial commitments by the States and Territories also. The Federal Government must negotiate meaningfully with those governments to establish their contribution.

Until this commitment is forthcoming, there can be no solution for the crisis in Aboriginal health. Aboriginal Australians will continue to suffer and our commitment to the achievement of genuine social justice will be meaningless rhetoric for our original Australians.

(Gibson, 1990:2656)

On the same day in the House of Representatives, Hulls, the Member for Kennedy added,

The report of the working party on a National Aboriginal Health Strategy makes the critical point that, no matter how sound the strategy or how broadly it is supported in the community, it will fail if there is a lack of political will and commitment on the part of governments. I want to assure those in the working party and all Aboriginal and Torres Strait Islander people that this report will not be left to gather dust on my office shelves. I call upon my colleagues in the Parliament and at all levels of government to recognise the need to fund and implement the strategy immediately to bring a halt to the path of disease and early death that so many Aboriginal children have already started out on...An essential component of the national Aboriginal Health Strategy is the need to transform living conditions of Aboriginal and Torres Strait Islander people by a massive financial commitment by governments at all levels. This financial commitment must be met (Hulls, 1990:2660)

The following year saw little funding from the states directed towards the NAHS. Robert Tickner, Minister for Aboriginal and Torres Strait Islander Affairs, stepped up his lobbying, as did other members of Parliament.

All governments will be judged now and by history on whether they honour their expressed commitments to these policies. For example, there can be no more pressing need at this moment than for State and Territory governments to join with the Commonwealth to meet our obligation to implement the national Aboriginal Health Strategy (Tickner, 1991: 4498).

There were on-going difficulties with gaining the funds from the states and for them to match the funding of the federal government. It was known publicly that the NAHS could only ever be fully funded when agreements between the Commonwealth and the States were in place. Hulls (a parliamentary member from Queensland) makes mention of Queensland as being one of the problem states,

The report of the working party on a national Aboriginal Health Strategy makes the critical point that no matter how sound a strategy, or how broadly it is supported within the community, it will fail if there is a lack of political will and commitment on the part of governments. I do not think that the cross-party political support can be emphasised enough; in fact, I believe that the value of such cross-party support for the process of reconciliation has been highlighted recently by the irrational and, some may say, racist response of some Queensland members of parliament ... All Australians-Aboriginal and non-Aboriginal suffer as a result of the level of political debate that we saw in Queensland, where unfortunately there is not cross-party political support on Aboriginal issues (Hulls, 1991:4827).

Gibson added to the discussion regarding the states,

... the national Aboriginal Health Strategy, the Hawke (Labor) Government has recognised that action is needed to the tune of committing \$232m of additional Federal funds over five years to addressing the health needs of Aboriginal people. In October last year in this House I moved a private member's motion ... calling on governments at all levels to be forthcoming in allocating resources to implement the recommendations of the national Aboriginal Health Strategy. Only the Federal Government has responded. When will the States fulfil their responsibilities?

What is needed now is a real commitment, not just words, because nice words and no dollars have been a feature of government activity in Aboriginal affairs for too long. What is needed is not a flowery and ideologically sound commitment by State governments to the health strategy. What Aboriginal people quite rightly expect is that, in something of a break with the past, there will be an actual dollar commitment to keeping Aboriginal children alive longer, to keeping Aboriginal communities healthier, to keeping Aboriginal people out of hospital, and to addressing the appalling deficiencies in community infrastructure that give rise to the quite shocking health problems faced by Aboriginal people (Gibson, 1991:4842).

After several years of trying to secure funding commitments for NAHS from the states and territories, Ticker, made the following statement on the 10 March 1994,

But the fact is that, under the current system, those agreements, those commitments with State and Territory Governments are not forthcoming. The services that are provided by local Government and States and Territory Governments to all the citizens of the States and Territories are not being provided to Aboriginal people.

So, the Commonwealth is in the position ultimately of doing something about that if changes can't be brought about by other means. And that means using the power of the Commonwealth dollar to require that principles of access of equity be applied by State and Territory Governments. Or it means, if we abandon all hope- - which I don't- - but if we abandon all hope that State and Territory Governments and Local Governments fulfilling their role, then we have to explore the potential of directly funding Aboriginal communities and Aboriginal organisations to bring about the change in those Aboriginal communities.

Like I say, I am increasingly attracted to going down that path, to explore options that are going to increase empowerment and control by local communities and by Aboriginal and Torres Strait Islander people at the regional level (Tickner, 1994:2).

Exactly two months later, on the 10 May 1994 the Federal Minister for Human Services and Health, Carmen Lawrence, and the Federal Minister for Aboriginal and Torres Strait Islander Affairs, Robert Tickner, announced that \$500 million would go towards Aboriginal and Torres Strait Islander health to be split between expanding community controlled Aboriginal health services and environmental infrastructure (Tickner and Lawrence, 1994a). The government had worked a way around the states and territories but did not excuse the states and territories for non-commitment of monies. They issued a further press release in December 1994 regarding the evaluation of implementation of the National Aboriginal Health Strategy (Tickner and Lawrence, 1994b). They stated that the report had “confirmed their view that in order to meet the health needs of indigenous people there was a necessity for significant reforms to the methods by which Commonwealth, State and Territory Governments provided services and community facilities” and that “all Governments have not provided a fair share of resources for Indigenous health

(Tickner and Lawrence, 1994b). They additionally added that, “the Commonwealth must use the full force of the power conferred on it by the 1967 referendum to drive a greater national effort to provide equality in health outcomes for Aboriginal and Torres Strait Islander people” (Tickner and Lawrence, 1994b).

For Aboriginal and Torres Strait Islander people the NAHS was the first time that we were able to input into a national document as a collective. It was the first time the voices of Aboriginal peoples were provided in such a way that Aboriginal peoples felt they were listened to and that notice would be taken of what was said. Within communities Aboriginal peoples expressed optimism that what was happening was a sign that things were changing in terms of the way the government was going to do business with us. It was articulated and felt by me that we were finally getting a say in providing direction for us on issues that affected us and our lives. This was important from a participation perspective, as an empowerment tool and in government recognition that we must speak for ourselves on our health issues. For other Australians who have been able to articulate their points of view and operate from a position of always being able to gain a listening audience due to their privileged position in Australia, it may be difficult to understand the significance of the NAHS, to and for Aboriginal peoples. Ian Anderson, explains that,

Whatever criticisms are made about the NAHS - as it was envisaged in the working party report, or as it was subsequently implemented - it remains a significant achievement in the history of Aboriginal Health. For the first time, a national strategy was developed in consultation with [I]ndigenous communities. For the first time, all stakeholders seemed to share some consensus about strategic directions in Aboriginal health (1997c:120).

Anderson makes reference to the implementation of the NAHS. This is one of the greatest disappointments still discussed by Aboriginal peoples at conferences and in health circles. The NAHS despite the efforts and statements made by bureaucrats and politicians including those quoted above was never funded to the level it should

have been. It became clear that the commitment and funding from all states and territories and the federal government was never forthcoming in terms of the levels it should have been.

Some of the positive changes for Aboriginal health during the past thirteen years can be traced back to the NAHS indirectly or directly, however, as a result of NAHS or as a result of community activism, recognising priorities, politicians, bureaucrats and the media cannot be ascertained. From my reading of the NAHS and the Evaluation of the NAHS Report (1994), as I discuss below, even in 2002 there are many aspects of the NAHS that have still not been implemented. The commitment by all parties was never forthcoming.

The NAHS contained many statements which when I read it for the first time in 1989, brought tears in my eyes. I have no doubt it made other Aboriginal peoples react in this way too. I am clear that the tears came not from a sense of sadness but from a sense of feeling ... finally! The NAHS acknowledged Aboriginal history and the traumas and health problems experienced by Aboriginal peoples as a result of that history. It recommended alleviation of acute existing health problems along with suggesting fundamental changes on preventative health care to effect longitudinal changes and improvements in Aboriginal health. It stressed the vital role of Aboriginal community controlled health services operating alongside mainstream health services, along with emphasising inter-sector collaboration. It insisted that health service provision alone could not and would not address Aboriginal and Torres Strait Islander health status. The NAHS was comprehensive in its approach and placed forward suggestions and recommendations, arguing the case that these would also be a more cost efficient approach.

The NAHS stated that,

Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity (1989:ix).

It was,

Not just the physical well-being of the 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 (NAHS, 1989:ix).

This was the first time that such a statement was contained in a national report. An Aboriginal health concept became embedded in a national document, and there was the acknowledgment within the statement that it was not just about the provision of Australian health services or an absence of illness. The NAHS contained words that could be interpreted to mean that our health was about our whole sense of being as Aboriginal peoples. This statement has become very powerful in that it has subsequently been used over and over again by Aboriginal peoples and others, most Aboriginal health reports produced by successive governments since 1989, regardless of whether they are Commonwealth, state or territory-based and by Aboriginal and non-Aboriginal researchers writing on Aboriginal health. The statement has been utilised by Aboriginal peoples to work with governments with the aim to deliver more comprehensive health services and primary health care services. I have found no better statement in the course of this research that contains the same message or that better describes what is Aboriginal health.

The NAHS statement and later statements, encompass all Aboriginal peoples, including women, and addressed many issues central to their health and lives. A Chapter within the NAHS document *Women's Business* (1989:179-190), focuses on health awareness, education, promotion, family planning, birthing centres, early first pregnancy, antenatal and postnatal care and cervical and breast cancer screening

programs. It additionally made a number of statements regarding the mainstream health services. *Women's Business*, clearly stated that "Health for Aboriginal women is not seen in the context of "white women's" issues or problems, but as part of their overall well-being, which is inextricably linked to that of their families and communities" (1989:179). Further parts of this section within the chapter outlined that women's business, "is not normally discussed openly or widely in a public forum, however women's health issues need to be debated widely by Aboriginal women first before agreement can be reached on comprehensive, representative strategies" (NAHS, 1989:179).

The writers of the NAHS argued that there needed to be separate men's business meetings and women's business meetings before decisions are made on such matters, which would then be taken to a joint meeting. They additionally made the statement that "This is not to say that women's health issues can be isolated from general health issues affecting men, children, families and community at large" (NAHS, 1989:179). This links back to the overriding statement of what is health as expressed in NAHS.

The NAHS was an important document for Aboriginal women, it was the first time in any national policy published for public circulation that Aboriginal women's ownership of Aboriginal women's issues was clearly articulated, explained and supported. Aboriginal women, men and children have always known about Aboriginal women's business just as they have always known about Aboriginal men's business and community business. Aboriginal women's business of tradition, culture and ceremonies as a separate but still part of the whole of Aboriginal community life always ensured that this was known and is still known. NAHS stated that "while many Aboriginal people do not live traditionally, these traditional Aboriginal formats for discussion are the ones with which the majority of Aboriginal people feel most comfortable" (NAHS, 1989:179). This addressed the issues for urban Aboriginal women and Aboriginal peoples who are not seen by non-

Aboriginal Australian society as living an ‘Aboriginal life’ yet undertake practices which are clearly Aboriginal practices.

At present the *National Aboriginal and Torres Strait Islander Health Strategy Consultation Draft* (National Aboriginal and Torres Strait Islander Health Council, 2001) document is being finalised in terms of implementation. This document will be discussed in a later section. However, it is relevant to note here that on page i of the Strategy it states that “The principles and approaches underpinning the *National Aboriginal Health Strategy* are still vital today”. *The National Aboriginal Health Strategy*: was a landmark in health policy for Aboriginal and Torres Strait Islander peoples. What followed during the next six years was a period where the NAHS was explored and where the Commonwealth, state and territory governments took stock of the ‘Aboriginal health issue’, contemplated how they would implement the NAHS and began to implement it. This six year period will be explored within the next section of the Chapter.

Taking stock after NAHS

As established, the implementation of NAHS became an issue from the launch of the report. There were issues around what would be implemented, how it would be implemented, funding levels for the NAHS and who would be responsible for NAHS. Very little in terms of significant events within the Aboriginal health arena however, occurred between 1989 and 1993. A search through the Australian Parliament Hansard archives reveals time and time again questions were raised about the funding levels and progress of the negotiations with the states, including Queensland. Within the Hansard documents there is a series of questions on notice, speeches and bills relating to the NAHS. Woodridge makes some of the earlier speeches, making reference that the “NAHS, which outlines a wide-ranging plan for providing Australian Aboriginal communities with effective access to proper health care seems to have disappeared off the face of the earth” (1990b:3416). Within the

same speech he quotes a letter from the AMA as saying that they have written to the Prime Minister “to highlight the inaction on this vital initiative” (1990b:3416). Other lobbying came from Hulls (1990, 1991), Gibson (1990, 1991) and Tickner (1991).

A NAHS implementation plan was never developed, and the implementation was grossly under funded, resulting in only a few changes on the ground for Aboriginal peoples. This section covers three significant events that took place between 1993 and 1995: the release of the Evaluation of NAHS in 1994; the transfer of responsibility of the national Aboriginal health portfolio from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the Commonwealth Department of Health and Human Services in 1995; and the Declaration of the Year of Indigenous Peoples and Decade of Indigenous Peoples commencing in 1993. These three events are set within contexts of politics and all three saw changes to policy and direction in health provision to Aboriginal peoples.

The NAHS was evaluated in 1994, five years after its release and the first five of the evaluation committee’s fourteen major findings outlined the disappointing lack of achievement:

The National Aboriginal Health Strategy (NAHS) was never effectively implemented.

All governments have grossly underfunded NAHS initiatives in remote and rural areas if the objective of environmental equity by the year 2001 is to be attained.

There has been a lack of accountability for implementation of June 1990. NAHS Joint Ministerial resolutions and inadequate program management information where Commonwealth NAHS funds have been applied.

ATSIC has been a convenient scapegoat for inaction and the failure of governments to deliver (Australia, 1994:3).

A National Council of Aboriginal Health, was established to oversee the implementation of NAHS, but lacked political support from Commonwealth and state/territory ministers and ATSIC (Australia, 1994:3).

The final two statements in the Executive Summary of the NAHS Evaluation read,

The Commonwealth objective of 'gaining equity in access for Aboriginal and Torres Strait Islander people to health services and facilities by the year 2001' - if taken to include 'environmental health facilities' (for example, housing and essential services) - is unattainable at both current and projected levels of funding;

Health statistics show that Aboriginal and Torres Strait Islander peoples are so far behind the rest of the Australian community that equity considerations demand national large-scale affirmative action programs in environmental health (Australia, 1994:4).

The NAHS Evaluation made links to broader societal and community issues that directly related to the health, well-being and quality of life of Aboriginal peoples. Aboriginal women as a collective live in some of the most remote and isolated places in this continent, others live with no water, electricity or adequate sewerage systems and live predominantly in government homes and lowly priced rental accommodation which often need repairs. Some Aboriginal women live in town camps with extremely limited facilities. There are direct links to environmental issues and a person's health (NAHS, 1989). At the time of writing (2002), the Federal Government has not met its equity objective as quoted above. Aboriginal women still live in conditions that are unequitable when compared to other Australian women. It is also important to state that ATSIC can no longer be made a scapegoat for the Government's inaction. It was previously responsible for health

but ceased to have a national portfolio responsibility in 1995. This is now explored in more detail particularly as it caused some unrest at the time. From this time of transition, the emerging community health approach can be seen as developing. One such example is now described in more detail: The Bidjerdii Community Health Service story is interwoven within the next few paragraphs as it is set within the landscape of this research and gives a greater context to the policies and changes at hand during this time.

The Department of Aboriginal Affairs (DAA) had sole responsibility for funding and administering all Commonwealth programs relating to health for Aboriginal peoples from 1984. The Aboriginal and Torres Strait Islander Commission (ATSIC) came into being and assumed the programs and functions of DAA in 1990. ATSIC was enacted by the ATSIC Act, which provided the means to undertake reshuffles of Government administration and save the Aboriginal Affairs portfolio from anonymity within the super-departments. In addition it established community representation through regional councils across Queensland and Australia. Just prior to this the NAHS had identified that the Rockhampton and Central Queensland Region was in need of an Aboriginal and Torres Strait Islander community controlled health service (1989). ATSIC commissioned the *Central Queensland Regional Council Health Survey 1993/94* (Gehgre Aboriginal and Torres Strait Islander Corporation and Gongon Consultancy Pty Ltd, 1994). ATSIC also commissioned a feasibility study for the establishment of the Bidjerdii Community Health Service Rockhampton (Bidjerdii Community Health Service, 1995). Members of the Central Queensland Aboriginal and Torres Strait Islander Community worked to establish the *Bidjerdii Aboriginal and Torres Strait Islander Corporation Community Health Service Central Queensland Region* during 1994 and 1995. At that time I was living in Rockhampton and was aware of the developments and the drive of members of the community. ATSIC was supporting the developments until 1995 and had little, if any, involvement in the health and well-being of Aboriginal peoples. Anderson notes it had “a peripheral involvement

in the administration of Aboriginal health programs” (1997c:123). In recalling this time frame Anderson explains that the transfer was “followed by considerable argument, and lobbying by Aboriginal health services and their umbrella organisation, the National Community Controlled Health Organisation [NACCHO], for a better system of administration” (1997c:123).

At the end of the 1994-95 financial year the Department of Health and Human Services assumed administrative responsibility for Aboriginal health programs and substance abuse programs from ATSIC. This shifting of portfolio responsibilities was an ALP initiative. There was confusion at the time as ATSIC ‘signed off’ a range of new services prior to the transfer on the 1 July 1995 for the responsibility of health and substance abuse portfolios. What I refer to with the words ‘signed off’ is that the Minister and executive management responsible for ATSIC had signed a prepared document listing a number of proposed services and existing services to receive grant monies. This document was part of the agreement for the transfer process. It was on the 31st June 1995 that the Bidjerdii Aboriginal and Torres Strait Islanders Corporation Community Health Service Central Queensland Region was signed off by ATSIC. This meant that the Commonwealth Department of Health and Human Services had to keep this commitment to funding an Aboriginal and Torres Strait Islander Medical Service (AMS) in Rockhampton. What was ‘signed off’ could be seen as opportunist by ATSIC to get funding for services or a hindrance for the Commonwealth Department of Human Services and Health, as it meant the Department had to keep commitments, which did not necessarily involve the same processes that the Department undertook within its own planning cycles. The Bidjerdii Aboriginal and Torres Strait Islanders Corporation Community Health Service was physically established by the end of 1995 with the Department of Human Services and Health taking credit for the funding of the service. While the Bidjerdii Community Health Service was physically established it is worth noting that it was funded as a minimal health service. It never received and has still not

received the funding levels comparable to that of other Aboriginal medical services based on population size, geographic region or the health problems found.

For some Aboriginal peoples the transfer to the Commonwealth Department of Health and Human Services was seen as an attack on ATSIC, an erosion of ATSIC's role and an attempt to mainstream Aboriginal peoples' health. For other Aboriginal peoples it was seen as the Commonwealth Government trying to bring about tighter controls over Aboriginal health and to link Aboriginal health to the resources that were within the Commonwealth Department of Human Services and Health. One could argue that ATSIC was still a department within the Commonwealth structure, and hence the Commonwealth could at any time, have taken more control of the health portfolio, even through ATSIC. Moving it across departments made the implementation of health programs 'easier' from a controlling perspective, and a less political process for the Government. Dr Naomi Mayers, an Aboriginal health administrator and one of the founders of the Aboriginal Medical Service in Redfern, Australia, made the statement in an interview on The Health Report, Radio National that,

It's a bureaucracy within ATSIC and over the past three years we've found out that it's not the appropriate way to go for health. No improvements are going to be made if it continues under ATSIC, because there's no health expertise in ATSIC, and it's just the whole bureaucracy, it just doesn't allow for you to plan or do anything that would improve Aboriginal health (ABC, 1994:1).⁴²

While ATSIC did not have expertise in health, the Department of Health and Human Services had extremely limited expertise in primary health care or working in consultative and negotiating processes with Aboriginal and Torres Strait Islander peoples.

A process was envisaged where the Commonwealth Department which is now the Department of Health and Aged Care would begin to sign off on framework agreements with Commonwealth representatives and representatives from various State and Territory governments and non-government agencies. This process exists today and in Queensland's case the Queensland Health Department, ATSIC, Department of Health and Aged Care and the Queensland Aboriginal and Islander Health Forum (QAIHF) are party to the agreements under what is referred to as a 'Partnership'. Central Queensland is currently one of the four QAIHF representatives at the 'Partnership table' when issues are discussed. The current process ensures that issues such as housing, environmental health infrastructure and other relevant issues are brought to the table and worked on as they relate to the health and well-being of Aboriginal peoples. Aboriginal women through QAIHF as community based representatives are party to this mechanism and thus have a voice, it is limited, but still a voice. Reflecting back over the years since the transfer from ATSIC to the Commonwealth Department of Health and Human Services, which has now become the Department of Health and Aged Care, I see numerous changes. These changes include increased financial and managerial accountability, a greater focus on data collection and improved planning processes although there are still some problems with priorities, regions and funding cycles. These changes have additionally meant that Aboriginal peoples on the ground operating and working in Aboriginal health services have been required to increase their level of skill and capacity. Being a board member of a health service is involved it can be time consuming, challenging and demanding. It is also voluntary. During the time these changes to the health portfolio were occurring, the United Nations General Assembly resolution 48/163 proclaimed that the period from 1994-2004 be established as the International Decade of the World's Indigenous People. Another resolution established the Program of Activities for the Decade. From here the World Health Assembly carried a resolution with a view to, "strengthening international co-operation for the solution of problems faced by Indigenous Peoples

⁴² Similar statements were also made on Radio National's AM show, Myers, 16th May, 1994:1

in areas such as human rights, the environment, development, education and health” (Indigenous Working Group, 1999:1).

At the commencement of this decade the United Nations prepared a *Draft Declaration on the Rights of Indigenous Peoples*. It was agreed at the Geneva Declaration meeting and contained in the Geneva Declaration that all the rights, philosophy and principles contained in the United Nations Draft Declaration on the Rights of Indigenous Peoples and all other instruments dealing with human rights, that is agreements, statements, compacts, arrangements are “essential for the attainment of the health and well-being of Indigenous Peoples” (Indigenous Working Group, 1999:2). Australians are party, through the Federal Government, to the Draft Declaration on the Rights of Indigenous Peoples and to other instruments by their membership and participation within the United Nations. Some of the human rights treaties to which Australia is a signatory to include the International Covenant on Civil and Political Rights, the Convention on the Elimination of All Forms of Racial Discrimination and the Convention on the Prevention and Punishment of Genocide (Bennett, 1999:49). As Australia is a signatory to these treaties and other documents, Australia it could be assumed accepts all the responsibilities and obligations under law (Bennett, 1999:49). As a result of this, Australia has done and will increasingly receive pressure from the international arena over the status of Aboriginal health and well-being. There will be further pressure relating to land and water rights, rights to practice culture and the processes of law as they relate to Aboriginal peoples. Mick Dodson, an Aboriginal lawyer and long term activist, outlined how the international standards link “with contemporary concerns of Aboriginal and Torres Strait Islander peoples” (Dodson in Pritchard, 1998:18-31). Bennett briefly highlights some of the activities of Aboriginal Australians offshore along with the criticism received from non-Indigenous politicians as a result (1999:48-50). In the struggles at this international level the world’s Indigenous activists and lawyers learn from one another’s strategies and are able to develop new strategies as a collective of people who are marginalised and denied rights in many geographic localities throughout the

world. The stories of other Indigenous peoples are part of our story and our story is part of their stories. Many Indigenous peoples throughout the world have experienced processes of imperialism, racism, colonisation and enslavement and brutal treatment where the rationalisation for this came from within the dualistic framework of the “superior” white Europeans or British in opposition to “inferior” Indigenous people.

What the United Nations resolution did for Australian Indigenous people was to further open up gates at the international level for us to be able to apply pressure to the Australian Government on issues relating to Aboriginal health and all other aspects of our lives. It also allowed regular dialogue with Indigenous peoples from other parts of the world. Australia is already working within the world stage organisations that represent health professionals and other groups who have deep concerns regarding the positioning of Aboriginal peoples, for example the World Organisation of National Colleges and Associations (WONCA), essentially an organisation for individual health professionals primarily general practitioners. It is important to note that Australia’s Indigenous delegations to the United Nations always contain a mixture of Aboriginal men and Aboriginal women and that there are always times when men meet with men and women meet with women. Other Indigenous peoples in other parts of the world additionally have concepts of women’s domains and men’s domains, although they are set within their own cultural frameworks. What is important is that Aboriginal women, as well as Indigenous women in most parts of the world are recognised for being Aboriginal women with their own rights as Aboriginal women.

Aboriginal peoples have been actively speaking in international forums around the areas of health, education, rights, law and Indigenous rights. One clear example is *The Coolangatta Statement On Indigenous Rights in Education*, which was commissioned by the 1993 World Indigenous Peoples’ Conference on Education held in Woollongong, Australia. The central focus of the Coolangatta Statement is

the principle that “Indigenous Peoples have the inalienable right to be Indigenous, which includes the right to self-determination”. Simply this means the right of Aboriginal peoples to be Aboriginal peoples in the past, present and in the future. This right is also connected to the health and well-being of Aboriginal peoples as Indigenous peoples. This relates back to earlier statements in this thesis regarding our rights to be empowered, sovereign peoples. The Coolangatta Statement and all the other international efforts inspired Aboriginal women and Aboriginal peoples to believe that we could achieve if we combined our efforts. It also gave us a collective voice that with other Indigenous peoples of the world, who were in there fighting for the bigger struggle of Indigenous rights. The United Nations statements gave some Aboriginal peoples words to use in their everyday lives and struggles back in their own communities. The increasing internationalisation of the Aboriginal Australian movement has become an important part of modern Aboriginal political activity that “offers some hope when internal pressure can seem so uncertain of success” (Bennet, 1999:50). The continued internationalisation of Aboriginal issues may be what assists us in the long-term.

This section has outlined, through some examples, the significant events in the area of policy from 1989 - 1995. It was a time of taking stock of what was happening and to prepare for the changes ahead. There would be changes because of the way in which control of the Aboriginal health portfolio had changed, because of meetings being held nationally and internationally within Aboriginal and Indigenous peoples affairs, and because of increased pressure on governments particularly in regard to health. This period of time was exciting whilst also tiring and reflective. I was in my twenties and looked forward to being in my thirties and being an active Aboriginal woman within the struggle for better health for Aboriginal women and Aboriginal peoples. I attended and presented a paper at my first International Indigenous Women’s Conference in Aotearoa/New Zealand in 1995 and I attended my first International Indigenous peoples Conference on Education (Woollongong) in 1993. I believed that I would increasingly become involved within the Indigenous

movement in the years ahead. The following section explores the issues from 1995 until 2002 and the time at which this thesis is submitted.

1995 - 2002: Lots of Action but how effective is it?

Since the Department of Human Services and Health and its subsequent names (it changed names several times during this period of time as portfolios were exchanged, Ministers changed and elections won and lost) took responsibility for the national Aboriginal health portfolio, the changes in policy and programs have increased. This activity has flowed through to the Queensland State Government to the Zone, District and identified Community levels. This section looks at significant events in the area of policy and explores issues around community consultation, as this has become a significant factor in all policy involving Aboriginal peoples health in Australia, Queensland and the District of Rockhampton. Firstly, I will discuss the on-going international work that been heightened as Aboriginal Australians gained greater knowledge of how to best utilise international networks and how to bring pressure towards policy direction. I then briefly outline some of the current developments taking place. Finally, I discuss some concerns around the concepts of social capital and capacity building as they relate to Aboriginal health. I enter into discussion on these concepts as they are now being applied to Aboriginal health directly or indirectly through a range of forums.

Aboriginal Australians were represented via a NACCHO delegation that presented a paper at the *Third Rural Health Conference* held in Kuching, Malaysia in May, 1999. The Conference was hosted by the World Organisation of National Colleges and Associations (WONCA), essentially an organisation for individual health professionals primarily general practitioners. It draws its membership from 53 countries and has official links with the World Health Organisation (WHO). A keynote address was provided by Puggy Hunter, the immediate past Chairperson of the National Aboriginal Community Controlled Health Organisation (NACCHO). It is noted in the NACCHO Newsletter for October, 1999 that “emphasis on recurring

messages of Indigenous health gave many delegates permission to speak, from countries where such freedom of speech in support of marginalised peoples is not respected” (p.15). The freedom of speech at this conference came as a “direct result of Puggy’s stirring presentation regarding issues that affect the health of Aboriginal peoples and Torres Strait Islanders in Australia”. It is worth noting here that NACCHO and other delegates were successful in once again maintaining Indigenous issues firmly on the international agenda.

At the Conference a Statement was developed that detailed the concern of participants with regard to the health status of Indigenous peoples throughout the world. The Statement has become known as the *Kuching Statement on the Health of Indigenous People*, was unanimously accepted by 250 delegates and was later presented to the WHO. The Statement includes reference to the fact that the health status of Indigenous peoples in many countries is significantly worse than that of the population as a whole; Indigenous people largely represent the most marginalised and poorest subpopulations of the world; and many of the health problems of Indigenous people arise from a disadvantaged socio-economic status (NACCHO, 1999,4:15).

The Kuching Statement puts forward an agenda for all governments and health professionals and includes strategies under the headings of rights, Indigenous involvement, health professional involvement. The Kuching Statement draws important connections between the human rights and health. It additionally states that “the health and welfare of [I]ndigenous women requires special attention” (NACCHO NEWS, October, 1999, No.4 (p15). I saw this as a significant development in the proceedings, that there were connections drawn between our health, welfare, human rights and our positioning as Indigenous women. For me, it said “yes, they are starting to get it that our health is about our Aboriginality”. It is not about being disadvantaged because we are Aboriginal women but because we have been and are dis-empowered from our right to be Aboriginal women.

Aboriginality and our right to be Aboriginal women is woven within our health status just as our health status is woven to us being Aboriginal women and our continual struggle to be Aboriginal women.

The Statement is provided in full in NACCHO NEWS October, 1999, No.4, (p15). The Kuching Statement was added to the *1997 Durban Declaration of Health for All People* to reflect the priority of the health of Indigenous people throughout the world. The *Kuching Statement on the Health of Indigenous People* (1999) was added to the earlier developed *1997 Durban Declaration of Health for all People* (which Australia is party to). This process embedded the document within a higher profiled and often quoted document within the World Health Organisation (WHO). While the document was formulated later and added to an older document, it is still the document that is referred to by people and governments. The goal of Health for All by the year 2000 was far from being met.

In the same year (1999) NACCHO delegates attended the International Consultation on the Health of Indigenous Peoples, held in Geneva, Switzerland from 23-26 November. This international meeting was organised by the WHO. At this meeting a Declaration was prepared titled *The Geneva Declaration on the Health and Survival of Indigenous Peoples*. The Declaration is several pages in length and reaffirms Indigenous self-determination, and aims to remind member states of their responsibilities and obligations with regards to Indigenous health under international law. What needs to be understood is the amount of work being undertaken by Australia's Aboriginal peoples to get to the position of placing issues on the world stage. There is wide consultation, negotiation, writing, preparation and travel away from the continent that is also one's ancestral belonging place. Aboriginal women are active in fighting for Aboriginal women's rights, Aboriginal peoples rights, Aboriginal children's rights and health rights. Aboriginal women are part of the consultation, negotiation, writing, preparation and travelling away in this fight.

Aboriginal women through this process are re-empowering themselves through contemporary cultural processes and mainstream processes.

In the same year (1999) the Queensland Aboriginal and Torres Strait Islander Health Forum (QAIHF), a representative body of all Aboriginal and Torres Strait Islander Health Services in Queensland, issued a new Corporate Plan. The QAIHF Corporate Plan contained as its central statement what Aboriginal peoples identified as health,

Health for Aboriginal peoples is cultural well-being. Cultural well-being is the integrity and harmony of physical, social, political, environmental, economic, ideological and emotional inter-relations which operate at the individual, family and community levels and constitute the essence of our Aboriginality (QAIHF, 1999:1).

Thus the underlying concept linked to the overall health of Aboriginal peoples is Aboriginality itself. This statement made by QAIHF is based on the statement made by NACCHO formerly known as NAIHO. NACCHO issued a *Manifesto on Well-being* from which all policy direction and work is directed. In more recent times NACCHO has taken on the commitment to ensure Aboriginal health is on the international agenda as much as it is on the national agenda. The NACCHO position on Aboriginal Women's Health contained in the NACCHO Constitution (1997:13) and taken from the NACCHO Manifesto on Aboriginal Well-being, outlines that health for Aboriginal women is linked to the restoration of Aboriginality, dignity, respect, roles, responsibilities, self-determination, participation, coming to terms with law, lore and culture and to the regaining "a state of well-being at least equal to that which existed prior to colonisation and as referred to in the NACCHO definition of health" (1997:13).

In the NACCHO 1997/98 Annual Report some of the broader goals of the *Manifesto on Aboriginal Well-Being* included: the reinstating of physical, social, emotional and cultural well-being of each Aboriginal individual; educating non-Aboriginal health care providers about the factors that impinge upon Aboriginal well-being;

influencing policies, programs and laws which impact on Aboriginal well-being; ensuring self-determination and self-management of health services; obtaining adequate funding; acknowledgment that Aboriginal peoples have never ceded sovereignty; that colonisation is responsible for the current state of ill health; and that there is responsibility in assisting Aboriginal people achieve a state of well being at least equal to that which existed prior to colonisation (1998:13). NACCHO through its Annual Reports has demonstrated that it is still fighting for these goals for Aboriginal and Torres Strait Islander peoples.

In the time since the move of the national Aboriginal health portfolio from ATSIC to the Commonwealth Health Department (1995) we have seen Australian Governments (both Federal and State or Territory) produce an enormous number of reports, policies, practices and interventions. As a collective, these documents go further than ever before in linking the impacts of colonisation, social and emotional well-being issues and general health and well-being for Aboriginal and Torres Strait Islands peoples. I argue however, that they do not go far enough in demonstrating or delivering strategies for enacting the NACCHO definition of health and well-being, that is the Aboriginal definition of health and well-being. The outcome from all of this activity should be in increased health status and whether Aboriginal peoples will achieve the level of health that Aboriginal peoples have stated Aboriginal peoples want. It is not an unrealistic desire nor is it unrealistic to achieve, but will require a shift from the dominant powerbase, a shift in the way health services are developed and delivered.

As is evident from the names of the reports and policies many dissect the health of Aboriginal peoples into body parts. Our every body part becomes almost the subject of a policy or report. For example, our eyes, what we put in our mouths, our sexual practices, the state of our minds, where we are physically located, our overall health, and then reported on through indicators as to how much, how often and who. Puggy Hunter quoted in NACCHO NEWS, explained, “You talk about funding holistic health. You’ve got funding for the kidney, funding for the eye, funding for the ear -

tell me have you got funding for the arsehole?” (September, 2001:12). Puggy often spoke publicly about the ‘body part’ approach to health that did not really address an Aboriginal concept of health. The body as in governments and how governments work with issues is broken up into parts, sections and divisions, sometimes referred to as ‘silos’. In many ways this is also how the Commonwealth Government and the State and Territory governments are now examining Aboriginal health. The dissection of our bodies continues while at the same time reports proclaiming that they aim to deliver a holistic health care service model through using an Aboriginal concept of health.

The process of developing the number of health reports and policies produced in the past seven years, and their implementation, includes governments undertaking ‘consultation’ with Aboriginal peoples. Governments do this to validate, substantiate and justify their actions and the resultant programs. At times they get it right and other times, despite the consultation, they get it wrong. In this process of being involved in ‘consultation’ and validating the body part research and reports generated, are we being conned into a process of slowly accepting the body part approach to health? Is it believed by Governments that we will become assimilated to the western bio-medical health approach all the while we play a role in this assimilation through consultation? I explore the issues surrounding consultation later in this chapter.

In 2002, health policies for Aboriginal women and Aboriginal peoples are still very often written as separate, contain cultural references, and may state the Aboriginal health domain ‘needs specific strategies’, has ‘inter-cultural sensitivity’, and health professionals need to recognise that ‘working with people from other cultures presents a challenge’ and so on. Many of the policy documents I examined within this research revealed little comprehensive dialogue regarding the inter-connections between racism, classism, white privilege or ethnicity that extend beyond being ‘culturally sensitive’, that is really exploring the multiplicity of dynamics taking place between ‘health workers’ and ‘consumers/clients/ participants’. In this I

believe they do not place the responsibility on those with power to look at themselves in the mirror at how they gained that power.

Current Trends

Within the current health documents and the health documents in draft form being circulated for comment in 2002 the words collaboration, inter-sectorial collaboration and partnerships are 'hot buzz words', the latest terminology. There are also discussions still taking place on 'building social capital' across communities and between governments and communities. This concept originated in the late 1970s and was first introduced through economics as a way to identify the social resources that would be of use in developing human capital. In itself, the concepts associated with social capital seem seductive in what they can offer the health arena, however, they can also lead to greater ambiguity within communities with lots of talking and no actions. Stephen Leeder a leading health academic in Australia highlights the problematic nature of social capital if it is not understood, analysed or implemented with measurable and knowable elements (1998:10). Labonte states, "building communities, or increasing our stock of social capital, is a process, not a 'thing'. We never arrive where we want to be. We only journey closer to it, and journey better with experience" (1999:432). Labonte outlines what it can mean for health practitioners, academics and researchers and policy makers. While he does state that it is simply another term in which the struggle is present between "how we ought to live in complex societies: market individualism or communitarian justice?" he does suggest that if the process of social capital will help us, wherever we are, then we should use it (1999:433).

In May 2002, I attended a workshop for people working within the Aboriginal and Torres Strait Islander community controlled health sector. The workshop, held in Brisbane, was hosted by the Office of Aboriginal and Torres Strait Islander Health (OATSIH), Commonwealth Department of Health and Community Services. A paper was circulated titled *Bringing Communities Together, An Australian Stronger Communities Strategy* outlines what is termed 'capacity building'. It was delivered

at the 4th Annual National Policy Research Conference in Ottawa, Canada, (6-7 December, 2001). The author is not noted on the paper and unknown despite attempts by myself and the efforts of OATSIH staff in the Queensland Office to locate the author. The paper was addressed during a scheduled session within the workshop that was conducted over several hours. It appears that this is the new 'buzz word'. Capacity building relies on a community's capacity to draw on its own assets, resources and skills which that community can draw on to grasp opportunities and address local problems (author unknown, 2001:2). Responsibility rests with the community's commitment, resources, knowledge and skills thus the social capital, human capital, economic capital and environmental capital of that community. Kerr et. al define social capital as

The contribution to community well being that is generated and provided by community enhancing activities of citizens in providing mutual support to one another – the “glue that binds society”. This term has been coined to capture the value added contribution of community development activities and to indicate that whilst such community building contributions are not economically measured (eg in GDP of National budgets) there is a real dividend to society from civic participation and community contribution (2001:5).

Bourdieu defines social capital as

The aggregate of the actual or potential resources which are linked to ... membership in a group which provides each of its members with the backing of collectively owned capital ... it is the product of investment strategies, individual or collective, consciously or unconsciously aimed at establishing or reproducing social relationships that are directly useable in the short or long term (1993:249).

The concept ideologically has some merits for communities however, there are many issues with the concept that also make it problematic particularly for Aboriginal communities. My experience tells me that Aboriginal communities are stretched to the limits dealing with ill health across the community, participation in education,

housing shortages, high death rates, many funerals, just survival in some instances. There is also much work being carried out in the process of Native Title, health issues, and being involved in and being accountable in organisations, which all have time lines and which keep communities going. Then communities, it seems, are asked, to do even more. Kerr et al. state that research suggests that “Aboriginal Australians engaged in voluntary work more than non-Indigenous Australians (participation rates of 26.9% and 19% respectively for those aged 15 and over engaged in voluntary work” (2001:6). They suggest that the gap may even be wider between the contributions to community of Indigenous and non-Indigenous people as there is a wealth of Indigenous activity and community effort which has been largely unreported as much of it falls outside the standard parameters of the data collection (Kerr et. al, 2001:9). Therefore it can be said that the data “underestimates or fails to recognise the depth and breadth ... of Indigenous community contributions to social life” (ibid., 2001:9).

Within the Rockhampton community as in other communities Aboriginal people provide “contributions to government economic, cultural and social development as sources of consultative and advisory support” (Kerr et. al, 2001:9). Kerr et al. suggests that Aboriginal people are

already meeting their obligation to community by participating in community building, cultural maintenance and family support activities, including: volunteer roles in community organisations; the CEDP⁴³; caring for sick and elderly people; and reinforcing tradition and culture (2001:9).

Furthermore, that Indigenous “concepts of reciprocity or informal kinship and community support – equivalent to strong demonstrations of non-Indigenous

⁴³ Community Employment Development Program, under this program, Aboriginal people voluntarily forgo their entitlement to certain social security payments to work on community improvement and development projects.

nomenclature of *social capital* and mutual obligation – are often the only means for maintaining community functioning” (ibid., 2001:20). There is an obligation to contribute for the benefit of the community as a whole as this builds strength for the whole Indigenous community. Lynn, Thorpe and Miles identified that “for both Aboriginal and Torres Strait Islanders, the family and community are of central significance and group interests and needs are fundamental part of an individuals sense of identity and self fulfilment”(1998:65). This argues Kerr et. al is in “sharp contrast to the individualised notions of the wider communities ways of helping” (2001:25).

Kerr et. al put forward that “Indigenous people have developed ways of working that could be applied across the Australian community” (2001:20). Yet as reported by Kerr et. al “the significant contribution and accumulation of social capital in Indigenous communities ... is not well supported publicly and is largely undervalued and unrecognised” (2001:13). Yet within the writings on social capital and community capacity ideology there is little or no recognition within the social capital literature of the centrality of reciprocity and community interdependence that has existed for thousands of years within Aboriginal communities. They should be of great interest to contemporary societies in terms of their desire to extend social and community relationships. Within the literature I also found limited information on power relations, or of writers addressing the issues of powerlessness, racism and racial inequalities, cultural differences, dysfunctional behaviours as a result of life circumstances, Indigenous rights or balancing the power more equitably between the powerless and those who benefit and are privileged by power. Largely the discourses of social capital and volunteering are culturally constructed and based within the social norms and values of a liberal capitalist society. The concepts embodied with social capital and volunteering for Aboriginal people of cultural survival, self-determination, economic need, social activism and mutual responsibility are based within the discourses of colonisation and resistance, social exclusion and social

struggle. It can be argued that the work of others such as Black and Mooney (2002) and Henry, Houston and Mooney (2004) begin to address these issues when they talk of communitarian ways of workings.

Time will tell whether 'social capital' will just become another term for academics and researchers to study the impacts of, produce more papers and attend more conferences. Or whether it is just another term for the Government to squeeze Aboriginal and Torres Strait Islander peoples further to get 'value for money'. I will be participating in the on-going dialogue on this issue in the future. I have learnt as other Aboriginal people have, not to embrace every new concept, term and ideology as the 'new', 'best', 'must do' activity and will take the same approach of wait and see, to learn more and critically reflect upon capacity building as I have with all the others. I know that we as Indigenous people must look at how it sits within our lives, communities and within the greater political context of our lives and communities. My initial understandings tell me that it could be a 'good thing'. That social capital may be a way for us as Indigenous people to recognise our strengths and to regain control over some aspects of our lives. A term to use that might widely recognise and affirm the complex, social and economic practices of Aboriginal peoples and to describe and exercise greater self-determination over our 'very-being' within some communities (NAHS, 1989:ix). I am also aware as discussed by Henry, Houston and Mooney (2004:518), that Aboriginal social capital may also be put at risk as by the current Australian federal government in "its pursuit of divisive policies".

Conclusion

Puggy Hunter stated that the Government,

... must either act decisively to remove the stain of Australia's continuing neglect of Aboriginal peoples and Torres Strait Islanders and rescue international credibility, or bury the truth and rationalise their inaction. That is the inescapable choice now facing the government (1999:1).

Aboriginal peoples have been talking, speaking out and discussing health and other issues for years. Non-Aboriginal peoples also talk. The time has come for real action or do as Puggy Hunter suggested. With the international spotlight well and truly focused on Australia and other countries with poor records of health for marginalised peoples and Indigenous peoples, Australia can no longer afford to maintain the current status quo. Aboriginal peoples continue on the international scene to pull back the curtains that are hung to cover the state of Aboriginal health, and their efforts to maintain an international gaze on the issues at hand. Nationally and regionally Aboriginal peoples try to do the same thing in an attempt to get more non-Indigenous peoples on board to assist the liberation of Aboriginal peoples from ill-health.

At times one thinks you have people on board and then they walk away, just like others before them. This may sound harsh, but I will explain. I have been to some conferences and seen Aboriginal people do presentations, non-Indigenous people in the audience cry and then walk away only to come back the following year without making a single commitment to addressing the reason their eyes shed tears. Without doing a thing. Without making a stand. Perhaps it was possible to think that may be they were unable to argue for better conditions for a while as their own situation did not prevent them from doing so, but as time goes on and the years go by, they maintain their work, their promotional track. My experience and anger has led to this research. I see senior Aboriginal people who have been fighting within the health arena for twenty to forty years and I see their patience, commitment and their staying power to improve the situation for Aboriginal peoples. I then see them and many others in our communities die of what was said to be 'preventable' conditions, of early heart disease, circulatory conditions and diabetes. I know why the decision was made to increasingly place Australia on the international agenda. I know about the cultural process of 'shame' and 'shaming'. If shaming and disgracing Australia is the only way to make Australia listen then that will happen. Politicians will continue in their attempts to discredit those that go to the United Nations, present at international meetings and the 'back arm band' issue will be raised again, the 'look at all the

progress made' statements will rear up and statements made that make out that Aboriginal peoples are ungrateful and unappreciative of what has been done. The international work will still go on and as one of my colleagues has said many times "my mob were shot, poisoned, rode over with horses, raped, beaten and we as a people have survived, do you think I care about a few nasty words". (Mob meaning, my people, my group, my community). Another woman colleague said to me "What is the worst thing they can do to me? Kill me? I am going to die anyway and as a black woman I am going to die early anyway". The words of these two colleagues have been with me for a long time and serve to remind me in times when I feel a little bit fearful, of the pain, suffering and strength of others, including my ancestors. Thus people continue to work hard within their states and territories, within Australia and within the international scene.

The Australian, State and Territory governments must talk to Aboriginal women and Aboriginal peoples who have the mandate to talk on Aboriginal business and who are voted representatives to speak on Aboriginal business in regards to health. They can not simply speak to individuals who will agree with what they say, do and think or support the governments due to agreement or conflict with the interest issues. We need Aboriginal peoples who we know can advocate for better outcomes for Aboriginal peoples and we know who will not agree with governments some times. The governments need to be aware of this and work with it if they truly wish to see improved health policy outcomes for Aboriginal peoples and Aboriginal women.

Governments need to understand that if they undertook a serious and committed effort to address the health of issues of Aboriginal peoples and Aboriginal women in Australia, it would be a benchmark for all of Australian society. Mereana Taki sees that "the quality of life for the Indigenous peoples will need to become the benchmark for the quality of life for all who dwell in the ancestral home of the Aboriginal" (Ellis, 2001:181). In this and her other writings she implied that if

Aboriginal peoples health and quality of life is addressed then the rest of Australia's quality of life and health would additionally be good since we Aboriginal Australians occupy the bottom rung of the ladder in terms of quality of life and health status in this continent, our ancestral home. This would involve a shift in philosophical thinking within Australian politics and within Australian colonial beliefs towards Aboriginal peoples. I am not sure that this is achievable in my lifetime or in the near future. Aboriginal women in the following chapter speak to what they see as good health and health practice, which provides some hopeful direction for the future.

Chapter 6

Talkin' Straight

“When I think about my own health issues, you’re hitting that statistic now, it could be good-bye anytime, we are all reminded of that all the time’, cause our mates are passing away, and you think, well, they were the same age as me, I am 46, and I am coming up to the time which tells us most black fellas don’t make it after this ... it is something that when you reach 40, this is, hit the hump and start heading down hill and white people hit 60 and think they hit the hump” (Kay).

Introduction

Kay’s words give us an understanding of the reality for many Aboriginal women. Her words outline how this reality becomes internalised, how as Aboriginal women we come to know ourselves and what we face within our lives. Kay’s words also outline that Aboriginal women know how we compare when we look at the health statistics of non-Aboriginal people. Moreover, she expresses an understanding of the reality of aging and health as it relates to non-Indigenous people. This reality, this knowing ourselves and knowing how our health is part of this reality, is central to life, has been explored within previous Chapters. The focus of this Chapter, is the words of Aboriginal women such as Kay who live within the Rockhampton region and who were interviewed as part of this research. These interviews present a powerful insight into the lives of Aboriginal women. The insight and information gained is valuable in contributing to a deeper understanding of the interactions between health services and Aboriginal women in Rockhampton. From this information we can gain a comprehensive understanding of how these interactions impact on Aboriginal women’s lives, health and empowerment. More importantly, we can gain a clearer idea of how health services can improve their service delivery to Aboriginal women as defined by Aboriginal women. Furthermore, we can also gain a deeper understanding of how to work in ways that are more empowering for

Aboriginal women in Rockhampton and to contribute to long-term change for the re-empowerment of Aboriginal women and Aboriginal peoples.

Although the following information was outlined in Chapter 2, I must briefly remind the reader that these interviews took place during the year 2000. All the women who were interviewed identified as Aboriginal women and all lived in Rockhampton at the time of interview. Some of the women were not born in Rockhampton but elsewhere and had moved to Rockhampton for a range of reasons. Others were born and raised in Rockhampton and are now raising their own families within the area. The women's ages vary from 18 to 55 years. There is a mixture of employment status, education levels, income, whether the women have a partner or are single and if they have birthed children or not in their backgrounds. One woman who had just turned 50 years of age at the time of interview, died within weeks of being interviewed. I have not included her information as per the family's request.

This Chapter will begin by providing you, the reader, with an introduction to the Aboriginal women. Some details have been omitted as they were for the purpose of formal introduction to me as another Aboriginal woman. Should this information have been included here it would identify who the interviewees are who participated in this research, as it would detail their Nation, family, relatives and the like. I explain this for you to understand the Aboriginal process of introduction, and what additionally was included by some of the women when the following information was provided. This was about establishing our relationship with each other as Aboriginal women and to develop a sense of placement and connection. It can be compared with working out where we both fit, where we belong in relation to one another, for example, with one of the younger women it was revealed during our introduction that I had assisted her mother when her mother was experiencing difficulty some years previously. After the interview she thanked me and referred to me as Aunty. She had within herself established placement and a relationship to me with regards to herself and her mother. This is not about genealogies or relationships based on lineage but on lived relationships. The young woman and I will continue to

operate from this basis in the years ahead, and I have no doubt that she will continue to refer to me as Aunty when in private spaces.

After an introduction to each woman the Chapter will proceed with Themes, which is a grouping of the common themes raised within the interviews. These themes include generational issues, the body, perceptions of skin colour and Aboriginality, service systems and some experiences of accessing the health system. These themes will explore what the women articulated about issues, services and themselves. Following these thematic discussions, the Chapter then presents case study examples of the open ended interviews I had with one of the women, whom I have named Kay. (It should be noted that all the women interviewed have pseudonyms to protect their identities.) The interview with Kay provides a comprehensive example of how one Aboriginal woman has experienced the health system, how she has come to understand her interactions with health services and what she understands empowerment to be about for her and other Aboriginal women. Her words are a powerful example of how one Aboriginal women views herself and contains elements of issues all the other women interviewed have articulated in some form throughout their interviews. The Chapter concludes after the case study of Kay. Chapter seven provides a presentation of additional broader themes addressing issues such as cross-cultural awareness training, ideas about empowerment and improving service provision. The problems with the services as experienced by the Aboriginal women is presented first, followed by some solutions to the problems articulated by the Aboriginal women.

Fifteen of the Aboriginal women's voices will be presented in this chapter directly from the taped interviews. Two women did not wish to be taped but preferred me to take notes, they are Andrea and Lorna. You will not find the words of the Aboriginal women italicised, as I did not wish to italicise Aboriginal women's words nor change the grammar in presenting their voices. This has occasionally been done to Aboriginal women and Aboriginal people since colonisation. Some editing has been done, as it is not possible to include everything that was said. The open ended

interview with Kay was also edited to remove sections, as this interview was broken into two parts that collectively made up approximately two hours of recording. The Chapter concludes with a brief summary of the themes identified and the key issues.

Who are the Women who were interviewed?

This section provides a profile of the Aboriginal women who were interviewed to present a picture of who they are as individual Aboriginal women. These profiles are derived from what the women revealed in their introductions of themselves to me and from the interviews.

Denise

Denise is an 18 year old Aboriginal woman from the Rockhampton region. She has lived within the Rockhampton area all her life. She has travelled to Woorabinda (two hours away), Gladstone (one hour away) and Bundaberg (four hours away). She has not visited other regions or cities in Australia. Denise has two children. She became pregnant at 15 and had her first child at 16. Denise became pregnant with her second child when she was 18 and gave birth to her second child at 18. Her mother became the primary carer of her first child at the time of her first child's birth. Denise is now the primary carer of both of her children. She gets help from her sisters, mother, aunties and some of her cousins. At the present time Denise sees her purpose as being a mother. She lives in a Department of Housing home with some other relatives. The number of people in the house changes from time to time.

Andrea

Andrea is an 18 year old Aboriginal woman and says she was "born and bred in Rocky". She described herself as having no full-time partner. She has had several short relationships and enjoys casual sex. Andrea disclosed that she takes pills and drinks alcohol. She is presently not working. She said she doesn't want to get involved in community because she "doesn't like what she sees". For the past two years Andrea has been moving between relatives and friends for accommodation.

Lorna

Lorna is a 21 year old Aboriginal woman. She is “from Rocky”. She was pregnant at the time of interview. Lorna stated that she had no partner as “he [had] shot through”. She has never been employed despite her efforts. She has undertaken several courses in an effort to gain employment. Lorna is uncertain about motherhood. Lorna has moved back into her family’s home to gain support during her pregnancy. At the time of writing this thesis, Lorna had given birth to a daughter and was still living with her family in a home they rented.

Grace

Grace is a 27 year old Aboriginal woman. She is single and has no children. She works full-time and has lived in the Central Queensland area most of her life. She went to university and has a degree. She says she is a “sister, daughter, friend, family counsellor” and that with her family there is an “expectation to take on [a] counselling role”. She has been on a personal journey trying to “find who I am” which has “affected my health in a negative manner”. Grace shares accommodation with a non-Indigenous woman around the same age who is also single.

Mary

Mary is a 30 year old Aboriginal woman. She has a partner. She has no children. Mary is working, however, she is looking for other employment. She was born and raised in Central Queensland. Mary and her partner are buying their first home.

Charlotte

Charlotte is a 31 year old Aboriginal woman. In 1997 she moved to Rockhampton from western Queensland. Charlotte has one daughter who just started high school in 2000. She works full-time in Rockhampton. She doesn’t have a car but has the use of a vehicle at work. Charlotte is currently looking for rental accommodation so “my daughter and I have our own privacy, we live with family”. She was looking for a two bedroom flat for them both.

Lisa

Lisa is a 31 year old Aboriginal woman. She describes herself as a wife and mother. She has one son who is ten years old. She works casually in administration work. She was raised in Rockhampton. She and her partner moved away for a short time for employment reasons and then moved back to Rockhampton to be with family. Lisa, her husband and son live in a Department of Housing home with Lisa's mother.

Alice

Alice is a 32 year old Aboriginal woman. She grew up in western Queensland and moved to Rockhampton in 1995. She gained full-time employment in Rockhampton in 1996. Alice is married and they have two children, a boy and a girl who are 13 and 8 years old.

Sally

Sally is a 33 year old Aboriginal woman. She was raised away from Rockhampton and moved to Rockhampton to live some years ago. She said that she had "returned" to Rockhampton. She has family and strong connections in the Rockhampton area. Sally works full-time as an administration worker. She explained that she was in a defacto relationship and that they have one child who was 2 and a half years old. Sally said they "will live here the rest of our lives". Sally and her partner recently began to purchase their first home.

Julie

Julie is a 36 year old Aboriginal woman born north of Rockhampton. She is married and is a mother of two joint families comprised of 6 children. She works full-time and has just started a new job. Julie and her partner rent accommodation for the family in Rockhampton.

Sarah

Sarah is a 43 year old Aboriginal woman. She has four children, three girls and a boy. The oldest is 21 and the youngest is 15 years of age. Sarah has lived within the Rockhampton area all her life. She is a full-time student and is presently looking for part-time work. Sarah is single and was sharing accommodation with another Aboriginal woman around the same age at the time of the interview.

Linda

Linda is a 43 year old Aboriginal woman who has two children and a partner. She has lived in Rockhampton most of her life. She stated that she was a “family person, homemaker and heavily involved in community”. She works in numerous capacities within the community sector. Linda, her partner and one child rent a house from the Aboriginal Housing Cooperative.

Sharon

Sharon is a 46 year old Aboriginal woman who has grown up and lived within the Rockhampton area all her life. She has worked full-time in the same field of work for 17 years. She has a long term partner and is a mother of four children and a grandmother of 6. She and her partner are buying their first home in Rockhampton.

Kay

Kay is a 46 year old Aboriginal woman. She moved to the Rockhampton area in 1995. She has two sons. She has been married and divorced. She has a partner. Kay has lived in a range of places during her lifetime. As a child she was removed from her Aboriginal mother and raised by non-Indigenous people. Kay wasn't always able to name who she belongs to in terms of placement, she now can and talks about her journey to others. She has studied at university and works part-time. Kay and her partner have been buying their home for the past 6 years.

Helen

Helen is a 55 year old Aboriginal woman. She was born two hours away from the Rockhampton area. She married and raised her four children in the same town.

Helen has 9 grandchildren and the youngest one is 21 months old. Helen came to Rockhampton only a couple of years ago to “help with family” and to work “in Aboriginal issues”. Helen works part-time in Aboriginal affairs. She lives with her daughter and one of her grandchildren in the home her daughter rents in the commercial rental market.

Themes, What is happening now?

The section will present ideas articulated by the women, which presented as themes throughout the interviews. The themes addressed in this section include General Issues and Experiences, Generational Issues, The Body, Skin Colour and Aboriginality, Woman specific services. I then briefly detail what the women interviewed articulated and expressed about a range of health services.

General Issues and Experiences

This section concentrates on general issues and experiences. I am attempting to show that Aboriginal women’s experiences are both diverse and similar. A number of Aboriginal women interviewed revealed a level of understanding about the Australian health system and what services were available in Rockhampton.

Sally revealed she had a knowledge of the Australian health system when she discussed issues such as “not everyone can afford to see a doctor” in Rockhampton due to the lack of availability of “bulk billing” and the “gap fee”. She explained that because she was working she thought she was “a lot better off than other people”. Further to this that “ a lot of women would just not go if we [Indigenous community] didn’t have this [Bidgerdii] bulk billing service they just wouldn’t be able to afford it”. Sally expresses an ownership of the Bidgerdii Community Health Service as several women participants did. It is clearly identified as being an Aboriginal and Torres Strait Islander specific health service. Sally, in referring to Bidgerdii and to the fact that she had a job where she earned a wage, outlined that she could choose to go to Bidgerdii or to go somewhere else to meet her needs and that “for some people

there is no choice”. Some people just had to go where they could afford or that offered bulk billing due to the costs.

Sally was not the only one who showed insight into the health system. Charlotte demonstrated that she had a broad knowledge of what was available in the Rockhampton area and made choices according to her needs and her daughter’s needs, either Aboriginal specific or broader community health services. Denise made choices to utilise Aboriginal specific services where possible. Mary mentioned that she was aware of what services were available within Rockhampton and with the Aboriginal specific services she accessed staff outside working hours when the opportunity arose within the community. She said she felt comfortable accessing them in this way, and has “used that as an opportunity to question and get information, with the mainstream services, with the doctor I use, it has taken me years to find a service that I am comfortable with”. What the women all revealed was that they all had some knowledge and understanding of what was available, some had more knowledge and a greater understanding of this than others. They further demonstrated that at times access was difficult due to monetary issues, such as the gap fee and bulk billing provisions, and at other times access was primarily based on issues of comfort as Aboriginal women accessing health services. The issue of comfort repeatedly surfaced in many shapes and forms during the course of the interviews.

One of the significant factors in accessing health services was how Aboriginal women felt. The women interviewed discussed past experiences, which left them feeling good or not so good and perhaps making them angry or even feeling worse. The issue of shame, was raised on several occasions by women. Shame is more than feeling embarrassed. The process and concept of ‘shame’ involves the whole person, the person’s sense of self worth and self-identity. Added to the personal aspects of ‘shame’, are periods when a person is ‘shamed’ for their actions and behaviour. Aspects of shame are explored in the works of Kirk et al. Sharon described when they had a clinic for pap smears at Aboriginal Health how “everyone’s coming in

now, it made you feel better yourself and you forgot about that shame about having a pap smear, that's what makes you feel good about it". In this Sharon explores the issue of shame together with the issue of revealing one's self as an Aboriginal woman in a very private way during the process of undertaking a pap smear. In the past this was done in front of non-Indigenous people. Now that the pap smears take place within Aboriginal Health, there would be Aboriginal people present and non-Indigenous people whom are considered to have some degree of trust by the Aboriginal community. Mary additionally raises the issue of shame when she states that "As a Murri person you are too shame 95% of the time to ask a question and I mean for me to get to a doctor I got to be in a hell of a lot of pain, it's got to be urgent, I feel validated in doing that, just basically Murries don't use doctors, Murries don't go unless they are dead". Mary is articulating several issues here, one is the concept of shame when having to reveal one's self by asking a question, revealing that you don't know something to a non-Indigenous person. She additionally raises a widely documented issue that many Aboriginal people do not present to doctors or hospitals until the reason for the visit has become accentuated. Complications have often set in due to the time delays of accessing medical treatment or the problem with which they are presenting has become serious due to the time delay. She also states that she felt validated when she went to a doctor for the level of her pain. This brought up issues as to whether she thought it wasn't a valid enough reason to go to the hospital unless she was in a lot of pain, or if it was about accessing a doctor, or whether she felt validated because she had the strength to access a doctor about her pain.

In reflecting on the many experiences the women shared and their descriptions of how the health system had treated them, I am not surprised that some Aboriginal women chose not to engage the health system for themselves until they were very ill. This was not true for their children as all the women interviewed articulated that they sought medical attention for their children when ill, even if they felt uncomfortable and uneasy accessing that health care for their children. This is discussed further in a later section. It was shown through the interviews that some of

the women personally challenged themselves and stretched beyond their comfort zone in an effort to gain appropriate health care. At times they did this even when they knew that the health care providers or the system itself was going to disempower them in the process. Kay sums up with the following statement that “many of those things within the health system, disempowered me and kept me ill” when referring to the way in which health systems and health providers operated their services.

Generational issues

When asked ‘what makes you want to take control of your health?’ there were mixed responses from the women, although there were some common issues, which could be termed ‘generational issues’. A number of the women stated that they wished to be healthy and have a good quality of life in and for the future. There were numerous statements made by women with children about ‘being around’, in other words living long enough to be able to see their children grow and their grandchildren be born and grow. They wished to experience the full aspects of motherhood and grandmotherhood. They wanted to be what Aboriginal women call ‘grannies’ and to have ‘grannies’. There was an expression that being a mother, grandmother and partner were important roles, ones that they wanted to perform in their lifetimes. Some of the women expressed that they wanted to be healthy in performing these roles and that they were concerned about the health of their children and their partners. There were those women who had children and who had partners. Some of the following statements express their concerns and feelings held by the women.

Sally: “... son, that’s the main thing ... the long term plan ... I want to be there for his 21st birthday”.

Alice: “... making sure kids eat well, that’s important ... the kids health”.

Lisa: “... for the sake of my husband and my son .. I’d like to see him grow old and may be I can grow old ... see grandchildren”.

Denise: “for me I know, I gotta stay healthy now, cause I got two babies. I might even have another baby when these two are a bit older, I gotta wait a while” and “I gotta stay healthy for my babies they are going have their kids, I wantta be a grannie, that’s what us black women, some of us, wantta do”.

Julie: “I know that even though I am 36 I want to live a long time ... I had my children young... lots of things I want to do and if I have poor health...”.

Linda: “... look at the statistics and what people present with ... all the symptoms that I present with is what my mother has ... I remind my own daughter about health so she doesn’t have what her mother and grandmother has”. We “all want to have a good life and long life ... prolong your own life ... be a role model for your own children”.

Sarah: “... live longer ... maintain a good quality of life...continue to do, there are a lot of things I’d still like to do..” Sarah: “daughter, nieces, share these things with them, give them options, not just the same thing all the time”. In further reference to her daughters and nieces Sarah stated that they “...have more than one option going, they need to think about themselves as an individual, if they are in a relationship or not”.

Kay: “I am real proud of myself that I make sure my sons visit the doctors to have a check up, I try not to show them any of my fear”. “I don’t want to be sick. I don’t have grandchildren yet ... I want to be around to see a couple of grandchildren at least ... I ask the ancestors all the time to gift me that I can live”.

Lisa: “... can’t afford to be sick or get cancer with a young family...up to me to take responsibility for me ... it is up to me”.

Helen: "... live as long as you can and enjoy good health ... see my grannies get a bit of age on them before I die ... work for Murri issues, there is a lot of things, try and hang in there and have good health to carry out some of the things".

Some of the women were additionally specific in their words stressing that they still have things that they want to do. Whether it was working in 'Murri issues' as Helen (remember she is 55 years of age) stated, or just saying they still had things to do, things they wanted to do or would like to do (these were from women who were in their early 30s). There is the element of choice expressed in their words. The women themselves were stating from the 'I' position of wanting to do and would like to do. Sarah outlined that she wanted her daughters and nieces to have the knowledge that they had options. She spoke of this at length and reflected on her own life during the interview. Sarah stated that she wanted the younger women to know they were individuals even if they were in relationships. She spoke to me about making them aware of their own selves and their rights. This ties in with them growing up to be what is referred to as strong Aboriginal women, knowing who they are, what they are and proud of being this. Linda spoke of the importance of her daughter knowing about her mother's health and her grandmother's health so she doesn't have to have the health issues that they had as she matures. This is about teaching her daughter about making choices for herself and about being responsible for herself. Other women demonstrated that they are on the path of being strong Aboriginal women in the statements made around being responsible for themselves. Grace, who does not have children at this time, discussed what makes her take control with regards to her health, "I am the one who is responsible for any decisions I make, and I am in control of what happens to me". She very clearly articulated words to this effect several times during the interview. Grace would be perceived as a strong, younger Aboriginal woman in the Rockhampton Aboriginal community by other Aboriginal women, perhaps, also, by non-Indigenous women. Another woman Lisa, said it was "... up to me to take responsibility for me ... it is up to me". There were other such statements of taking control made during the course of the interviews.

These women, while all making some statements either about being responsible for themselves and/or seeing children and grandchildren, also expressed a sense of their own realities and their realities in terms of life expectancy too. Sally offers one example of this expression. She is 33 years old and has a son who is 2 and a half years old. She outlined in her interview of her long-term plan to be around for her son's 21st birthday. She will be 51, nearly 52, when he turns 21 years of age. As discussed earlier in this thesis, the average age of death for Indigenous females in Australia is 57.4 years. In the course of her interview Sally did not consider her age nor did she reflect on her age. I believe this is the reality Sally lives. In other words, her self-knowledge of the reality of early death permeated her expectations for the future.

Alternatively, Kay who is 46 years of age and who doesn't have grandchildren, outlined that she wanted to be around to see a couple of grandchildren and she said she asks "the ancestors all the time to gift me that I can live". In her interview Kay revealed that she is very much aware of her life span issues and her past health problems. She also demonstrated that she was very much aware of her reality in terms of the health status statistics for Aboriginal women, Aboriginal peoples and non-Indigenous people. The quote I used from Kay at the commencement of this Chapter is evidence of her awareness and her sense of reality. I am not suggesting here that Kay or any of the other Aboriginal women interviewed as part of or outside this research are living self-fulfilling prophecies; rather this reality is demonstrated through what the Aboriginal women have shared. The women I interviewed all have a sense of the realities of their lives in relation to other Aboriginal women, Aboriginal people and the broader population. When I asked each one of them if they thought other Aboriginal women had similar issues or different issues, they articulated that some women had similar issues. They additionally had a sense collectively of the issues of the Aboriginal people that were in the generation/s before them and the generations of Aboriginal people that are following their lives. The Aboriginal women were very much in tune with their positioning and their lives at the time the interviews were conducted. For example, Kay's quote at the

beginning of this Chapter in which she compares herself to that of non-Indigenous people and how a number of women state their aspirations of being grannies and watching their children and grandchildren grow. Linda makes connections between herself, her mother and her daughter.

Body

Some of the Aboriginal women made some very strong statements about their physical bodies. I refer to them as strong statements as at the time the statements were made their speech became more intense and firmer. The statements supported ownership of their bodies and knowing their bodies because they were their own bodies rather than being 'owned' by the medical profession or the medical profession having more knowledge about their bodies. For example Denise, one of the youngest women interviewed, said,

“... this is my body, I know I am young and have two babies, they come outta here (touches her lower torso) ... I know this body, no one gunna tell me what to do with my body. I know when I feel sick, I know I gotta take care. I don't smoke cigarettes, I don't smoke yandi (Marijuana). I am taking some control of my body for my body”. Further to this Denise explains “I look after me ... I got no diabetes, I got no other stuff, I got on the pill ... I know that other sexual stuff”. In Denise's words you can sense her responsibility for the Self. She knows about sexual health practices and is taking the contraceptive pill, she doesn't smoke and when she is not well she looks after herself. Denise expresses an ownership of her body and her health.

Mary: “I'm not a fuckwit and I'm not a nurse but I do have an understanding about my own body”. Mary stated several times that she did know her own body. “I know when I'm sick, I don't need a test, instrument, doctor to tell me that. I tell them what's wrong and what I want. I ask what do I need to do? This is what I think it is may be, please clarify. I know medical science isn't exact but there are answers”. Mary was very clear that when she went to seek help it was because she knew something wasn't right, she wasn't well.

Lisa says "... it's my body I know when it's not well and I know it's up to me to make it well ... it's no one else's fault, it's up to me". Lisa in reflecting on Aboriginal women and feelings about the body stated "I know that I am just as embarrassed with my body as other Murri women ... our body is our body, it is not something to show everybody ... whether they are skinny or fat they still hide their body". When I asked Lisa about the word she used of being embarrassed she said it wasn't so much "not embarrassed of the body but is in the public sense".

Grace: "I am the one who is responsible for any decisions I make, I am in control of what happens to me, I certainly wouldn't want to do something without knowing...I would want to know if there was something there that was a problem then they would need to be telling me what that was". "I feel you need to be in control particularly in relation to your health because it's a part of who you are ... I don't think you should allow someone to do something to you without knowing what ...". Grace was specifically talking about what could be called medical procedures or processes in a clinical environment.

When discussing when she had a health issue in the area of her uterus, Kay talked to me about being "the owner of the womb". Kay was expressing ownership of her body. While during the process of the interview, Kay did address a range of health issues with a variety of different parts of her body, however she always maintained her ownership to her body. More importantly, Kay always discussed how the health issues impacted on her as a woman, on her Aboriginality, skin colour, mental state, spirituality, her role as she sees it as a mother and other areas of her life. She was focused on more than just the physical body including the other aspects that make her a person, and more important to Kay, an Aboriginal woman.

The women interviewed drew particular reference to body ownership, that our bodies are our bodies. They are not for everyone and that our bodies are our responsibilities. Furthermore, we know when we are unwell and we know when we

are well. This sense of knowing one's body and the responsibility of ownership could be a concept health services draw upon in conceptualising programs and health services for Aboriginal women.

Some of the other women who made statements about their body also made specific statements around generational issues, what services they access and don't access, skin colour and Aboriginality. These are the links that thread between many of the themes, bringing the concept of the body into the broader domain of the person, not separate from the person and not separate from what it means to be an Aboriginal woman.

Skin Colour and Aboriginality

There was a diverse range of experiences that centred around how Aboriginal women were treated in accessing health services that were based on skin colour and perceptions of Aboriginality. There were also experiences of observing how other Aboriginal women were treated based on skin colour and perceptions of Aboriginality. A number of the women demonstrated at the time of interview a personal in-depth analysis of the issues surrounding skin colour and Aboriginality, which were important to them, and observed the same issues with other Aboriginal women. A number of the women voiced anger at how they were treated as a result of these perceptions held by health service personnel. The women provided some examples, which are included below.

Mary's experience, based on the public health system operated by the Queensland State Government, is outlined. Mary described a situation at the Rockhampton Hospital where she had gone into the Accident and Emergency area and was asked a series of questions by the Registered Nurse at the reception desk. The Nurse was filling out the form as to why Mary had presented at that point in time as Mary spoke to her. Mary then said that she wanted to look at the form and noticed that the Nurse had not ticked that she was Aboriginal. Mary said to the Nurse that she "might like to tick that I was Aboriginal". Mary explained to me that the Nurse had "made an

assumption based on the colour of my skin, and “ ’cause I wasn’t half past midnight, I wasn’t black. It really pissed me off, no white person has the right to judge my Aboriginality, skin colour has got nothing to do with it”. The Nurse had perceived Mary was not an Aboriginal woman based on the colour of her skin. Mary was not asked whether she was Aboriginal or not.

Helen, an older woman, also reflected on her experiences, she stated, “I have always felt good about being Aboriginal”. “I feel good as an Aboriginal ... from the time I was around 14 or 15 and vowed and declared that I wasn’t a half caste or anything else, I was an Aboriginal”. On reflecting on her experiences before moving into Rockhampton a couple of years ago, Helen explained that the “nurses still maintaining that we weren’t real Aboriginals that they lived up in the centre, see now, stupid things like that you can’t get through their heads, we are Murri people, it doesn’t matter how black, or how brown, or how fair we are, you know, they just don’t understand that”. She then said that, “they might have fitted us into another category like us, them and they”. On the topic of health care services she explained that health services need to understand that “past the skin everything else inside is the same” and that “it is ok to touch us, our colour doesn’t wear off”.

As another mature woman, Kay also reflected on these experiences, “looking back ... as a pregnant woman I was treated in a way that white women weren’t, you knew you were part of something a little bit different but you don’t know why ... now I recognise ...”. And elsewhere in her interview “things are set up for white skinned people...white race privilege is so institutionalised”. Kay demonstrates insight and knowledge of white race privilege based on her own reflections of her experiences.

Sharon, who is the same age as Kay, also gave an example how she presented to a doctor’s clinic and was asked ‘how much alcohol I drank?’ She said, “they assumed because I was black that I was a drinker”. She wasn’t asked ‘was she a drinker?’ In her interview Helen additionally raised the issues about being asked how much does

she drink before she was asked does she drink. Neither Helen nor Sharon consume any alcohol and both took the question as an insult.

Grace has a different experience of being an Aboriginal woman based on other peoples' responses to her, her identity and her colouring. "I don't look like an Aboriginal woman or what one would expect an Aboriginal person to look like, having blonde hair and green eyes, but I feel very strong about my identity and that's coming through as I get older, I am really starting to enjoy being a young Indigenous woman". She explains that "I know who I am, and I know that I am an Indigenous woman, I shouldn't have to tell everybody that, it is strange though when I do and get 'you can't be Aboriginal you've got blonde hair'". What Grace additionally understands are the broader societal issues because of the way she looks. In the city people assumed that she was a "white Australian" (She was reflecting on her experiences in Rockhampton and in Brisbane). Grace's Aboriginality went unrecognised, as she did not embody the physical aspects of being Aboriginal. Grace said she has come to realise "how easy I do have it, in like visiting services like that (referring to health services), walking into shopping centres, walking into bars, it is much easier for me to mingle, be anonymous the way I look, than to stand out in the crowd if I had dark skin". She clearly identifies what privileges accompany people who are light skinned. Holland additionally has an understanding of this when she explains "growing up blonde, blue-eyed, and fair skinned, I certainly can't deny my English and Irish heritages. Nor can I deny the opportunities I have been afforded as a result of my whiteness and being mis/taken as white in this racist society" (Holland, 1996:97). She gives an example of stopping her care when seeing that a dark skinned Aboriginal youth being detained on the street by police, and watching what was happening. She makes that statement that "[l]ooking white was to my advantage in this particular situation" (Holland, 1996:110). Whiteness and light skin can work as social capital in many contexts (Hunter, 2001) and in this way works against darker skinned Aboriginal people.

Grace can and is seen as ‘normal’ and as invisible as she states that she can be anonymous, she doesn’t stand out. Most white people would have no idea about how skin colour hierarchies operate and the degree they are privileged in Australian society. Further to this, that white race privilege and colour judgements appear with such regularity in Australia that they generally escape notice. They do not however, escape the notice or understanding of what it means to Aboriginal people or Aboriginal women as Grace has demonstrated. Moreton-Robinson states that for “Indigenous people, whiteness is visible and imbued with power; it confers dominance and privilege” (1998:39). Kincheloe states that whiteness and skin colour is “intimately involved with issues of power and power differences” (1999:42).

Grace has a further understanding of the privilege when she said, “it would be worse if I looked more Indigenous because I know from my experiences they (darker skinned Aboriginal women) haven’t received the respect they deserve from these services ... that has really impacted on their own health because they haven’t wanted to go back, I can really understand that”. Grace had an understanding and empathy for other Aboriginal women who were darker in skin colour. She believes they haven’t been given the same level of respect as she has been shown. Grace has an understanding of “colour as code” and how this “permeates popular conceptions and perceptions” and thus the way people behave (Ruiz, 2000:24). Kay earlier touched on this when she said was treated in a way that white women weren’t and that things were set up for white skinned people. Grace demonstrates insight and knowledge of white race privilege based on her own reflections of her experiences, just as Kay does.

Grace is still subject to racism, she was aware however, that she wasn’t subject to racism based on her skin colour in the same way that darker skinned Aboriginal women were subject to racism. Holland relates that living “in a white body and identifying as a murri⁴⁴ means that my experience of racism has always been

⁴⁴ Holland states that where her mother’s Aboriginal family are from in south-western Queensland, Aboriginal people name themselves as Murris (1996:190).

different to that of a murri living in a black body” (1996:97). Grace identified that Aboriginal women with darker skins were immediately recognisable as Aboriginal women. She is conscious that her colouring means that she is perceived to be a ‘white woman’ and not an Aboriginal woman. We discussed the different judgements made by people, when they don’t realise that Grace is Aboriginal, and assume she is white, as opposed to when they know she is Aboriginal. Holland suggests that, “oppression of those of us who did not embody the physical aspects of being black was ignored” (1996:102) and that when “our [A]boriginality went unrecognised; this reinforced racism in the silencing of what we had to contribute”. At no stage during the interview did Grace question her Aboriginality based on her colouring. The questioning she said came from non-Aboriginal people. While Holland explains that she is

Constantly aware of the way that others gaze at me, both literally and metaphorically speaking, when I identify with my blackness as much as my whiteness. I often find myself being aware of the literal gaze and my constant internalising of that gaze and how it translates in an internal sense according to the shifting positions I find myself in. I am constantly gazing outwards in an attempt to make sense of the cultural systems that surround me (1996:110-111).

Grace’s understandings of skin colour and Aboriginality substantiate the understandings that some of the other women have arrived at in the course of their lifetimes.

Woman Specific Health Services

When I asked the women about visiting places that assist Aboriginal women in health, all the Aboriginal women except one began their discussion around the services provided around Rockhampton or seeing a female doctor. The woman who did not begin the discussion with this was Kay. She began by stating that “I haven’t been to any woman’s sites here”. She was referring to Aboriginal women’s cultural sites or Women’s Business sites that are for women only, places and spaces where Aboriginal men do not go. She continued stating that, “.... there is nothing really

here for Aboriginal women, just for us”. Kay discussed that there was a program in Rockhampton for Aboriginal women that was connected to “baby business”, but stated that “I’ve done all that business so I’m just not going to go there, so there is nothing here for women, not even an ethnic or migrant space. I’ve been to ethnic or migrant spaces and I have felt comfortable ... they include us”. She was referring to other places where she had lived and explained that she had used spaces that were specifically for ethnic women or migrant women because she felt included. On asking her later about who she was referring to when she spoke of ethnic or migrant women, she indicated that she meant some groups of women of colour. From here Kay went on to discuss specific services and agencies that she had utilised or not utilised as the other women had discussed. Other women did not make comments on this issue.

Charlotte: “[I] haven’t used women’s services. Have no need at this stage ... Haven’t used Aboriginal specific. Know of them”.

Denise: “I call them White women’s places”.

Lisa: “[I] use a range of services for different things”.

There were also statements made about most of the women’s specific health services in Rockhampton and a couple of other services. No mention was made of the Rockhampton Women’s Shelter or other forms of temporary accommodation available to women or younger women.

What became very clear during the course of the interviews and in developing the themes was the number of Aboriginal women who use a range of services for a variety of purposes. All the Aboriginal women interviewed used more than one service for their health issues as Aboriginal women and access to those services was by choice. This was not specifically stated in this way but rather in the way women detailed which services they used and for what purpose. Even if one service could

offer a number of options which many of them did, for example, pap smears, birth control advice, general practitioner services, referrals and consultations for other family members, their health issues as Aboriginal women were dealt with separately according to the level of knowledge required by the health service and the level of intimacy required for the health issue. For example, varying levels of physical and personal intimacy and knowledge are required between an examination for a common cold in comparison to a pap smear or breast examination. Similarly varying levels of intimacy and knowledge are required for issues such as episodes of domestic violence, death within the family and cultural protocols along with problems in relationships. Even if their individual choices were extremely limited there was still an element of choice played out. The effectiveness and culturally sensitive and empowering nature of these services is another issue which comes up in later sections. (What the interviews revealed to me is that these Aboriginal women will not use a 'one-stop shop' in regards to their health needs as Aboriginal women). The sections that follow detail some of the services the Aboriginal women utilise and their experiences and feelings about those services. The first one to be discussed is woman doctors or female doctors.

Woman Doctors, Do They Make A Difference?

A number of Aboriginal women stated the importance for them of having a woman or women doctors. It assisted them in comfort in regards to female needs such as pap smears, breast examinations, discussing menstruation and so on. A number of the women who used other services in Rockhampton only used the female doctor for their women's needs as is evident from Alice's story: I "like to see women doctors ... not a lot in Rocky, Murri ones especially". She liked "having a female doctor". She also described how she used a range of health services in Rockhampton for different health concerns. Alice used the private hospital, Bidgerdii Community Health Service and a female doctor. Helen, who lived two hours outside of Rockhampton until a couple of years ago, had different experiences as where she resided she only had access to male doctors. Helen said that with "pap smears, I'd wait until there was a female doctor around". Even though she is now living in Rockhampton she

waits until a female doctor is available at the clinic she normally accesses for other health needs. Sally, in discussing how she accesses a number of health services explained that she has her “own family doctor and female doctor”. Sally sees the female doctor “for things that are more private and personal ... use Bidgerdii for colds and flu’s and those kind of things”. In referring to her female doctor who did not work at Bidgerdii, she stated, “... she is quite nice, I am happy with her”.

Not all the women had similar experiences with women doctors. Kay, in reflecting back to a number of different places and past experiences, stated that “I feel some of those white women doctors were still disempowering ... there were times when I saw the white female doctors disempower us as women”. Kay didn’t give any specific examples of what she meant other than how she had seen women doctors work with Aboriginal women in remote and rural communities and an example of where she had felt disempowered as an Aboriginal woman by a white female doctor within Rockhampton. Lisa also commented that she had tried a health service which had all female staff including a female doctor and that “... they were rough, haven’t used them for 10 years”. While these women weren’t specific in their comments, assumptions can be drawn that just because a doctor is female does not mean that the service will be any better or more understanding of Aboriginal women’s needs. Just because a doctor is female does not guarantee empowering practices for women generally or empowering practices for Aboriginal women. Neither does it mean that a woman doctor will not be racist or work in an anti-racist manner. Links can be drawn here to the work of Moreton-Robinson.⁴⁵ From the interviews with Aboriginal women what can be ascertained is that Aboriginal women will seek out female doctors for physically intimate procedures and discussions involving “women’s business”. It is therefore imperative that female doctors understand the health and sensitivity needs of Aboriginal women and enhance their understanding of Aboriginal culture and history. Moreover, that they come to understand their privilege, power and positioning in relation to Aboriginal women.

⁴⁵ Aileen Moreton-Robinson’s arguments of the standpoint or subject position of whiteness in general and white feminism (2000).

Family Planning Queensland

Family Planning Queensland offers a health and information referral service for women and provides a limited general practice service with female GPs. All of the Aboriginal women interviewed had heard of Family Planning Queensland, several had accessed the service. “Yep I go there, I get my pill and had my first pap smear there” (Lorna). I have “used family planning for usual women’s business, pap smears” (Alice). As Lorna, Alice and other women demonstrated, they access Family Planning for specific purposes identified by the women as part of ‘Women’s Business’. Mary who does have a female doctor as her general practitioner still attends “Family planning for pap smears, don’t go to doctor for that ...”. The Family Planning Association offers a “lot of respect for privacy” stated Mary and they “... respect my needs for physical privacy”. Mary’s statements above and others clearly demonstrate the separation of access points for specific purposes, outlined earlier. She split the privacy issue between personal privacy of information and physical privacy with the body.

Denise stated that “I never been to Family Planning, I know some Murri girls been there, I never been there. I know there is all white people there. I get my pill from Bidgerdii doctor ... There at Aboriginal health, I can get my pap smear there”. Denise again separated her access points but chose not to go to Family Planning for her contraceptive pill or her pap smears. She utilised other choices based on what she knew and what she has been comfortable with in the past.

Kay also utilises Family Planning for pap smears and said she felt OK about Family Planning “they were all women, welcomed me, called me (Kay), made you feel comfortable, this doctor explained what she was doing, she warmed the apparatus ...”. Kay said she only goes there for her pap smear, that is the only contact she has with that service, and that while she is there that is her focus. She explained that she was disappointed with one aspect, she “wanted Bidgerdii to be sent my paperwork, I

was told I'd have to go and get it". Kay is referring to the results of her pap smear. She wanted to discuss the results with her normal general practitioner at Bidgerdii but did not want him or other staff at Bidgerdii to perform the pap smear. There were no Aboriginal staff at Family Planning nor was there anyone there that she would see at Aboriginal community events. This additionally reflects Mary's need for privacy. There are very specific relationship issues being singled out by Kay. She accesses a woman specific place where there are all women staff for one aspect of her 'Women's Business', but with women whom she need not have any other relationship after the pap smear takes place. This raises an issue not just about sending results from Family Planning, which means that the contact with the service is increased as is the level of dialogue that may take place, but also understanding an Aboriginal woman's health needs in total. There is protection of privacy in one sense by the Family Planning Association having limited contact with other services around individual Aboriginal women's information. It does not preclude the Family Planning Association from having contact with Aboriginal women or Aboriginal Associations in health forums.

Other women beside Denise did not access Family Planning such as Sally, Sharon, Charlotte, Helen, Julie, Grace and Linda. A couple of these women indicated that they had never been to Family Planning, had no need to go to Family Planning or accessed other services for their needs. Grace had a different response. As a single 27 year old, Aboriginal woman, she said that she hadn't been to Family Planning and she didn't "really know what their service was but I have this impression that they are religious oriented". She didn't know where she had gained this idea. This is where I was able to provide Grace with some information regarding Family Planning and what they offered to women. Sarah explained that while she hadn't used Family Planning that "I do tell other women about the service, give them a number, that's about it". There is additionally an element of knowing held by Sarah that Family Planning will provide a confidential and OK service to Aboriginal women, otherwise Sarah would be recommending other options and not Family Planning. However, this does not imply that they cannot improve their practices.

Mammography Unit

Mammography screening is a Queensland State service and free to women over the age of 40. I got a range of responses when raising access to the Mammography Unit. There were some straight out yes's and some straight out no's. With the no's some of the women added that they hadn't used the Mammography Unit due to their age such as Alice, I "haven't used mammography unit, am too young". Mary stated that I "haven't had to go to mammography" and Lisa stated, "... mammography haven't had to use". Lorna and Denise both stated they were too young which indicated that they were aware that there was an age at which screening was recommended. Helen and two others had used the Mammography Unit either at the Rockhampton Base Hospital or the mobile clinic, a bus, which moves between locations. One of the women discussed how she had only attended mammography screening in the mobile clinic away from the Rockhampton Base Hospital.

In making reference to the Mammography Clinic Sharon stated "that's a scary place, a lot of our women don't have mammograms, cause it's going up there and having it done ... health workers go with them ... one time a month it's just our women that go". Even though Sharon was aware that Aboriginal women have a set day one day a month at the Mammography Unit at which time the Aboriginal Health Workers accompany the women, she still stated in reference to the Mammography Clinic "I don't like using them, they gave us a service for NAIDOC⁴⁶ otherwise I wouldn't had it". Sharon is referring to when the Mammography mobile clinic was set up to operate from the premises of Aboriginal Health during NAIDOC Week celebrations. A number of the Aboriginal specific services that provide health and human services programs choose to do major promotions at this time. Non-Indigenous programs, departments and agencies who additionally service the Aboriginal population sometimes additionally choose to participate in NAIDOC in collaboration with Aboriginal groups. This is how the Mammography mobile clinic came to be at

⁴⁶ NAIDOC stands for National Aboriginal and Islander Observance Day Committee. NAIDOC is now regarded as National Aborigines and Torres Strait Islanders Week. It is held in July each year.

Aboriginal health during NAIDOC Week. The conclusion I draw from what Sharon outlined, is that the environment in which the Clinic operates in that week, is more inclusive and therefore makes her feel welcome and less stressed. For that one week a year, it is physically offered within what is recognised as largely an Aboriginal environment in which Sharon feels more comfortable. Kirk et al. who undertook vital work exploring breast cancer among Indigenous women asserts that

Community members and local health workers should also be consulted about where to situate mobile and relocatable services, to ensure that the services operate from the most accessible and appropriate site ... In rural communities where screening already occurs at Aboriginal Community Health Services, it has been an effective way of encouraging women to attend screening. Women said they feel culturally safe and at ease in Aboriginal Health Services
(Kirk et al. , 2000:6)

In reflecting on Sharon words, it is clear that the Mammography Unit in Rockhampton and the Aboriginal and Islander Health Team discussed with one another a particular preventative screening strategy.

Kay, who is the same age as Sharon, expressed a different experience about the Mammography Unit. "I really liked them there, they talked to me, the same way that they talked to other women who came in, never made me feel like I don't need to know the same information like the white women, or more information, like I was stupid. I felt good, the women smiled at me. When you are a black woman amongst seven white women, they were talking, because you got no one to talk to in that room, you read the magazines to look occupied, if there are no magazines, I look at the paintings". Kay outlines a number of issues in her statements such as comparing how she is treated to how the white women are treated, the need to look occupied and that the white women were talking with one another. We discussed this last point. She explained that sometimes she goes into places and some of the 'white women' know each other because they went to school together, their children went to school together, they played tennis, belonged to certain organisations or just because they feel comfortable talking to one another. In a sense the other women connect with one another as they reflect one another. Kay added that sometimes they

just don't talk to her or other black women and that sometimes she doesn't know how to enter the conversation because she doesn't have knowledge about what they are talking about. For Kay, it is not an issue with having the screening or the staff being rude or insensitive. This supports the findings by Kirk et. al. (2000a,b), which outlines that "Women who have been screened by BreastScreen Queensland for breast cancer are generally content with the service. Women described staff as pleasant and said that radiographers explain the screening process clearly" (2000a:6).

I thought about Sharon's statements about Aboriginal women thinking that the Mammography Unit was a scary place. Was it because the procedure was scary, or was it because of the issues that Kay had raised? It may have been that she feared the screening itself in case it identified that cancer was present in her breasts and that she might die. These thoughts and others are expressed by numerous Aboriginal women in the works of Kirk et al. (2000a,b).

The Aboriginal women at the mobile clinic during NAIDOC were able to talk with one another, their children knew each other, they belonged to similar groups and were generally comfortable talking with one another in that space, which was not the case at the Mammography Unit at other times. Through this research and my own past knowledge of Aboriginal women, I have come to understand that Aboriginal women are at different comfort stages within themselves in placing themselves within situations where they may be the only Aboriginal person amongst non-Indigenous people. There is an element of discomfort, and at times an element of fear. Most white people according to Moreton-Robinson, "give little thought or no thought to the way in which Whiteness makes its presence felt, or how stressful it can be for Indigenous women, men and children living in their country controlled by white people" (1998:39). Some of this is revealed further in the interviews and is discussed in the next chapter.

A much younger woman, Denise, who is 18 years of age and too young to have mammograms said that “I never been to that breast clinic there in North street, my mother’s been there, she had a lump in her breast, she’s been there. I have not yet been there. I’m not scared to go there because my mother’s been there and some of my Aunties, they just go there they never really say much about that”. Denise is basing what she may do in the future on what her mother and Aunties are presently doing. They go and have their screenings, and an assumption could be drawn that she will probably go off and have her screenings when the time comes too. Lisa, on the other hand, stated “for my mum who is an older lady, when I took her to have her mammography, she felt intimidated and I did because of the way she did”. Sarah, who is at the age to access mammography screening, she is 43, said “I know I need to go and have a breast examination”. She did not say whether she was apprehensive or not. Sarah did say after her statement about having to go and have the examination that “I am pretty conscious of being healthy”.

What can be ascertained is that the Aboriginal women who were of age to have screening were having their screening or planning to have their screening. There were no issues raised around whether they shouldn’t have it done. There was an indication that some of the younger women would undertake screenings in the future when they became of age. This could be a demonstration of the effectiveness of broader Public Health initiatives, that breast screening was now considered a routine part of women’s business. I believe it can also be attributed Aboriginal women who have worked over the years to make it part of Women’s Business within Rockhampton. This includes Aboriginal women from within Rockhampton and who have travelled from Brisbane over the years. What is apparent is that some Aboriginal women do prefer and will have their screenings in Aboriginal settings, such as Sharon and may delay having a screening if they cannot access an Aboriginal setting. Remember Sharon outlined that she was aware that Aboriginal women can access the Mammography Unit one day a month as a collective, but still she waited until the one time in the year when it was at an Aboriginal setting in Rockhampton. Other Aboriginal women such as Kay will access the non-Indigenous

setting to undertake a screening. I believe that this all relates to levels of comfort with the setting in which the mammography screening is offered. It is not necessarily the screening itself. What needs to be explored further by the Mammography Unit is more mobile screenings within the Aboriginal community to ensure that more Aboriginal women who prefer the comfort of being screened in an Aboriginal space (like Sharon) have greater access to the screening. Other Aboriginal women will utilise the designated one day a month specifically for Aboriginal women to visit the Unit and other Aboriginal women (such as Kay) will visit when ever there is a need for a screening. This would increase the choices available for Aboriginal women of where to undertake the screenings.

Rockhampton Women's Health Centre (WHC)

Some of the women had not visited the WHC and explained why they had not during their interviews. One of the reasons centred on what they perceived the WHC had to offer. For example, Alice and Sally who are 32 and 33, both began talking about the Women's Health Centre from the medical point of view. Alice stated "Women's Health Centre ... what I needed to have done was done at family planning" and Sally "No I guess, anything to do with women's health side of things, I leave to doctor" (she was referring to the female doctor she uses). There is an assumption by Alice and Sally that what is available at the Centre is in fact clinical services for women. This is not accurate. The WHC does not provide clinical services to women in Rockhampton. Lorna and Denise, both younger women, had different perceptions based on who they see as the client group. Lorna simply said that it was for "older white women". Denise said "never been there, mmm, think that's more for umm white women, white women's place, I don't know. I don't know any Murri woman, any black woman been there. I don't think any black women go there, I don't think, I don't know any staff there, I don't know anything about that place, except that white women go there".

A number of the Aboriginal women I interviewed had visited the Women's Health Centre (WHC) for a range of reasons, but focused during the interview not on

talking about the reasons for their visits, but on the experiences of their visits. This was also in keeping within the realm of this research of empowering practices, what makes Aboriginal women feel good about accessing health services and what affirms Aboriginal women as Aboriginal women in accessing health services. A number of the women's experiences are outlined below.

Kay: "I go there but I never feel comfortable there, I don't go there as a client. I really do like women's spaces but this space doesn't make me feel like it is for me, it is a woman's space I feel that, it's not an Aboriginal woman's space, the design of the space, it is a totally white designed space. There is nothing that identifies me to that place ... I just won't go there as a client because I don't feel they cater for me as a black woman". She came back to the point later in her interview when she was discussing notions of place, in reference to the WHC that "there was no Aboriginality around the place, I didn't see black people, I didn't see black workers, I didn't see any posters either ... that kind of says its not a place for me, maybe that's an assumption but all of the things ...that's how I gauge whether it wants me to be part of its centre or if I'm just going to be sitting on the fringes as I have done all my life". Kay's expression of whether she feels included or not as part of the core is evident. She feels she is not.

Lisa: "The Women's Health Centre ... walked up front and walked out. It's not a nice place, doesn't welcome you in anyway at all, you walk through front door and see all the sour faces, you say 'see ya later' ... have some Murri faces, something on the wall, not be so, how do you say, so, strict, sour I suppose, more friendly, don't assume all Murri people are the same, we have different wants, needs, I'm different to (name), different to you, different ... will never go back because I felt intimidated". Lisa is additionally the woman who stated she would not go back to Family Planning.

Mary: "... haven't used the Women's Health Centre, I feel really uncomfortable from a culturally perspective, I feel really uncomfortable going there, it's the small

things from the minute you walk up there, you don't know whether you are supposed to stand in the hallway, should you go through the front door, who do you speak to first, yeah, if I don't see someone straight away you turn around and walk out again, so I find that a really intimidating experience so I choose not to go there".

Grace: "I got turned away from the Women's Health Centre ... I was working with them ... they wouldn't accept that women do have other influences on their life, one of those influences could include a male partner and they didn't respect that relationship that some women have with men. Whenever I went up there to women's health it was kind of like rigid, it just felt uncomfortable being there, so I didn't use women's health". Grace had visited the Centre on a regular basis but never utilised the service as a client.

Linda: "... haven't used that too much, haven't thought why I haven't, more for information service rather than health service ... have used the library ... haven't taken up any programs".

Sharon stated she hadn't used the WHC but she did have some knowledge of the WHC. Sharon explained that the counsellor from the Women's Health Centre goes to the Ngua Gundi, Aboriginal Health Building in North Rockhampton. She said the reason for this was that "They (Aboriginal women) just don't like entering into another place where it's not Indigenous, it hasn't got that feeling of you know what I mean ...". She was referring to Aboriginal women not entering into the WHC building and the sense of place of the WHC and that the WHC was not an Indigenous place. This was raised several times by other Aboriginal women in terms of the design of the place, things that identify Aboriginal women to the place, Aboriginal staff, pictures and so on. Sharon is additionally making reference to Aboriginal women's comfort in accessing places that are predominantly accessed by non-Indigenous women. Ngua Gundi is a specific Aboriginal health service, and it is also a building in the grounds where the Mammography mobile clinic sets up during NAIDOC Week. When I discussed the Mammography Unit earlier, Kay accessed

that Unit without stating she was uncomfortable despite being the only Aboriginal woman there when she did visit, yet, with the WHC she clearly states she goes there but never feels comfortable there. She attributes this to the space being a “totally white designed space” which she feels does not identify her to that place.

What can be ascertained is that the nature a place, what happens there, who is present and how they work, and how the place looks, feels, is interpreted and experienced impacts on whether Aboriginal and Torres Strait Islander women physically access that place. The women interviewed who knew of the WHC, did not feel comfortable in accessing the Centre. They did not identify the WHC as being a place that was for Aboriginal women. They did not use the services that are offered by the Women’s Health Centre. Kay and Grace both went to the WHC but both self-identified that they did not go there as a client.

Sharon explained that the WHC is trying to make an effort to provide a service to Aboriginal women in the form of outreach within Rockhampton via the use of an Aboriginal agency. This addresses some of the service provision issues but it does not address the Centre-based issues such as workers, the sense of place or long term change and empowerment for Aboriginal women in the future. Outreach is not about changing the Centre. It is only about the Centre making some alterations to accommodate Aboriginal women within the service provision. The way the service model is working as explained by Sharon, is also totally dependent on a particular worker being there at this point in time. “The Women’s Health Centre hasn’t got an Indigenous person to deal with any of our women either...” (Sharon). This type of service provision does, however, address the needs of a small number of Aboriginal women. Another interviewee, Mary said that the WHC were trying, “they had learning circles for eight weeks around reconciliation”. I make reference to this in general terms in Chapter 7, as while reconciliation may address issues about the need for reconciliation and may increase understanding and awareness, it does not specifically address service access issues nor does it have to. The WHC is in a position where they can choose whether or not they wish to address any of their

service access issues or not. The WHC is in the position of holding the power. None of the other Aboriginal women made any reference to efforts made by the WHC to understand Aboriginal women and/or Aboriginal cultures.

Ngua Gundi, Aboriginal Health, Queensland Health

Ngua Gundi operates as a parenting program for Aboriginal and Torres Strait Islander peoples and is funded through Queensland Health. The Ngua Gundi Program is also generally referred to as the young mother's program and has in the past few years become a place where Aboriginal women can go to have their pap smears. The workers employed are predominantly Aboriginal and Torres Strait Islander peoples. Some of the women referred to the Program specifically as 'Aboriginal Health'. Kay referred to it as the place of "Baby Business". All the women knew that the Program existed and mentioned it in some way. There were some extremely positive responses from the women about the Program. Sally for example, explained that when she was pregnant she used Aboriginal Health, Queensland Health. She enjoyed attending the program, "there was one on one, worker being friendly, felt really relaxed, the environment was great, the phones weren't running off the hook, the worker could devote that time with you ... I really got a lot out of there".

Denise was reflecting on when she became pregnant at 15 years of age and accessed the Ngua Gundi Program. "I wasn't shamed to be pregnant, I felt I was going to have a purpose to be a mother ... was going to be my purpose to be a good mother, anyway, I got hooked into the Aboriginal Health mother's program and I'd go over there when I was pregnant and then when I had my babe I took her over there". "[M]um and Aboriginal health they told me what was going to happen... I knew I was going to be a mother, that was going to be my purpose". Denise talked about how she accesses the Program with her two children. "I get a bit mixed up with changes of staff over there sometimes ... I love going there, and seeing them other mums, and some of them are young too". Denise identified with the other young women who accessed the Program and had a sense of sharing commonalities, including age. Lisa

went there not for the parenting program but “started using Aboriginal Health for my pap smears”. She was able to meet another health need while within the same environment. Some of the other Aboriginal women in the interviews stated that they had their pap smears at Aboriginal Health too.

Girls Time Out

Girls Time Out is a specific service funded by the Queensland Government to work with young girls and women from the ages of 14 to 25 years of age. Denise explained to me about some workshops she wanted to attend at Girls Time Out. “That other girls place, was near Target there, what’s that called, Girls Time Out. I been there with these other black girls, us black girls went there, that was alright, there were white girls there too, they was alright, that was when they were organising some art workshops and ... it was going to go there for a few weeks, I wanted to go there, I wasn’t slack. I would have to organise childcare for a few weeks, and umm, I kind of think, it was hard to ask my people to baby sit when I went off to art. They would look after my kids if I was going shopping, doctor, or you know needed to go to the laundromat or hospital, cause I am always asking them to look after my kids, and they didn’t explain it properly or, they didn’t kind of give me that information about that workshop, like, you know, what it was going do for me, just that it was an art workshop, but I wanted to work with that Murri one now them Murri ones said she was deadly heah, they reckon’ she was deadly them girls, them other black girls, yeah anyway, that was how it turned out”.

Denise is quite specific about the service, what was on offer in terms of it being an art workshop for a few weeks, where it was going to be and who was going to facilitate the workshop. She felt she was unable to explain to her “people”, her family members who care for her children when she undertakes a range of activities, what the workshop was about. Denise’s words said she didn’t know “what it was going to do for me”. She made a decision that she already asks her children’s carers to baby sit for a range of reasons that could be seen as being of priority and importance such as laundry, shopping, doctors and hospital, and that based on what

she knew about the workshop, “just that it was an artwork”, she couldn’t ask them to baby sit for her to be a participant, although she really wanted to be a participant. The reason she didn’t participate wasn’t because of money, transport or as she stated being “slack”. The reason was asking for childcare from her family. If the Program had provided childcare I am unsure whether she would have participated. She may have had concerns about who was providing the care, but this is hard to ascertain, and I did not ask.

Another young woman, Lorna had visited Girls Time Out on what she called the “odd occasion”, mainly looking for some of her friends when she was feeling lonely and sometimes didn’t want to go to the Darumbal Youth Service because of “some of the boys”. She explained the need for there just to be a ‘girls only’ place. None of the other Aboriginal women interviewed stated they had accessed Girls Time out. Sally explained that she had made contact with Girls Time Out when she was pregnant. She said they told her that she “could come along to the program they were offering even though I was over their target group”. She appreciated the offer. It was Sally’s choice not to attend the Program.

Bidgerdii Community Health Service

Bidgerdii Aboriginal and Torres Strait Islanders Corporation Community Health Service Central Queensland Region was established as an organisation in 1995 and gained funding later that year to provide a mini medical service to Rockhampton and Central Queensland. It is now in its seventh year of operation and moved premises three times to accommodate growth. It is a non-government community based organisation that elects a Governing Board of Directors from its Aboriginal and Torres Strait Islander membership. Its main source of funding is through Commonwealth via government grants and through generating income via Medicare.

Most of the women interviewed raised the name ‘Bidgerdii’ or made reference to ‘our health service’ or the ‘Aboriginal health service’. A number of the women I interviewed did know I was on the board of Bidgerdii, and while I thought this may

hinder the process, it helped. I will explain. A number of women raised issues with me, for example about Bidgerdii providing a transport service and a dental service or how they could become a member of the organisation. At the conclusion of the interview we were able to discuss these issues and I was able to provide information and suggest a contact person for future concerns. None of the women appeared apprehensive in discussing the services provided by Bidgerdii. The younger women were not aware that I was on the Board of Bidgerdii. I did disclose this to them later in the interview.

Generally the views expressed were very positive. Helen outlined that when she is in Rockhampton she accesses Bidgerdii, “they really do look after your health if you are not there for an appointment they will remind you. The doctors have all been good”. When being given referrals for an x-ray or to visit specialists, Helen outlined that what is important for her, was no time being wasted. An “appointment was made and I was in and out ... half an hour from when I left Bidgerdii to when I was back again”. Linda stated that there are times when she has had to “use the public system on referral from the Aboriginal medical service” but made no comment on the time it took or the follow up service.

Linda stated that in “Aboriginal medical services there is a philosophy there of recognising you as an Aboriginal person and things that may be contentious are dealt with”. She outlined that, “Bidgerdii is continuity, the doctors take time to refer back through the chart, remind you about check ups, on your back too if you haven’t done what they told you to do they’ll be on your back”. What Linda detailed in her interview was aspects of continuity, she said that you “tend to feel that you’re going there to seeing somebody, they know about you and your medical condition ... they see you as a person, holistic approach to your health as well, which I really appreciate, with a private doctor for example, it is how you present on the day”. While the issue of holistic care may conflict with the concepts of separate, impersonal care articulated by some of the Aboriginal women interviewed, it can additionally support this requirement. For example, Kay explained that while she

doesn't undertake her pap smear test at Bidgerdii, she takes her results back to Bidgerdii. She additionally takes a copy of her mammography screening and all other tests back to Bidgerdii too. Thus even though Kay's Women's Business did not take place at Bidgerdii, the results are still within a file at Bidgerdii presenting a holistic picture of Kay.

Sally additionally raised the same concept of more holistic health care and the aspect of seeing somebody. She stated you "can notice programs up and running at Bidgerdii, they really do try to serve and address the problems of Aboriginal people". For example she said "... you'll get the full assessment, you won't just sort of, you know, um, may be only get part of it ... they check for diabetes, and your high blood pressure, things that are more prevalent in the community". She said "I know people and that ... you do feel more welcome and it's friendly ... feel at ease ... someone you can talk to about things". This does not mean that Sally additionally used Bidgerdii for her Women's Business needs as she too went elsewhere for her pap smears. Sally emphasised that at Bidgerdii she knew that the "same service is given to me as everyone else". None of the women who discussed Bidgerdii raised the issues of discrimination, racism or skin colour being an issue, nor did they raise the issue of feeling intimidated based on their Aboriginality.

Denise, who was 18 at the time of interview with two children, is perhaps the most descriptive and expressive in her dialogue of Bidgerdii. Denise is disempowered in the broader community and is vulnerable in many areas of her life. She states, "I like going there you know ... the sister explains everything there for me, I don't feel stupid, I don't feel dumb, and even though they are white people there ... I don't feel stupid. They got Aboriginal staff there, they are you know, talk to me real nice, always say, you know, how are you ... they don't talk like I talk, they good, good them Aboriginal people there, you know they get me what I need, one time my new baby, just borned baby she was real sick and I needed to get to the doctor real quick and see doctor and they got me there to see him, and that was real good, they even said did I have a problem getting there to Bidgerdii ... They came and take me there

to Bidgerdii. I just thought that was really good... They always respect me that mob there, always make me feel good, they respect me as a black woman, they treat my kids good, like black kids. I teach my other one now, the 2 year old, she gunna call them Aunty them health workers. I know that, gunna teach her properly like they respect me like a black woman cause they are a black place". Denise raises numerous issues around her skin colour linked with who she is as a 'black woman', an Aboriginal woman and her comfort with Bidgerdii in its sense of place as a 'black place', an Aboriginal identified place. She further identifies that her children are additionally considered like 'black kids', Aboriginal kids. She shows that she feels valued and respected as an Aboriginal woman in Bidgerdii. Her needs as an Aboriginal woman and the needs of her children have been considered and made worthy by what she described when her young baby was ill. Denise is doing more than just indicating how happy she is with the service provided at Bidgerdii with her comments around how she is teaching her child that they will call the health workers 'Aunty'. This is a cultural issue around respect for how she and they are treated, about the services that they provide and the environment that it is provided within. The term Aunty is a given term from other people to someone. It is not just a term we take for ourselves. It has to be earned.

The issue of being comfortable at Bidgerdii was raised numerous times, comfort with the people there, whether they are staff, or other people accessing the service, and with the place itself. Some of the women raised the issue of comfort in relation with being an Aboriginal person with darker skin within the space. Lisa simply said "I feel more at ease there, safer there, people are friendly everywhere, you know you are in a Murri environment". Lisa compared this to where she takes her son to a non-Indigenous environment, where "everyone is staring at you, the black face in a white surgery".

Other women were not as verbose in their discussions of Bidgerdii, Julie simply said "their services are good". She uses a range of services in Rockhampton. Sharon was brief and stated, "a lot of people do like going to Bidgerdii ... it employs Indigenous

peoples”. Helen identified a “personal problem with one of the sisters (RN) but that’s all been sorted out”. Sarah, in discussing very briefly the troubles Bidgerdii had in its establishment, stated “Bidgerdii’s come along from that ... you hear in the community from other people ... there is always going to be a negative side”.

Kay’s Story

I have selected parts of Kay’s story to feature in more of a case study approach to demonstrate a range of issues that were discussed in earlier chapters. Initially I thought to provide only a snap shot of what Kay revealed during her interview, but on listening to her tapes and reviewing her transcript several times, I decided to include some lengthy sections. Her story contains many of the themes discussed in the previous sections and highlights the complexity of some Aboriginal women’s lives and how they may try to deal with issues, and how they might choose to move to a position of empowerment. Kay tells me she is still continuing this journey. During her interview Kay offered many answers, solutions and a high level of analysis of her own life that will be apparent to the reader. She provided me with some insights that began me thinking of some of the issues from other angles. This will be evident to the reader. After reading the following section it becomes very obvious that Kay was open and generous with her sharing of herself during the interview. On a personal level, Kay’s interview offered me, as researcher and as another Aboriginal woman, a powerful learning experience that also complemented the interviews I had with the other Aboriginal women. In several ways as Kay shared her knowledge as an Aboriginal woman of wisdom, she was in relationship to me of older sister. This is very much how we ended the interview.

Kay experienced a lot of sickness as a child and has experienced a lot of sickness as an adult. When Kay was reflecting on her past health experiences she recalled two very significant events that occurred, both while in her twenties. The first occurred when she was in her mid-twenties, as she was experiencing a lot of pain and found it very difficult to get medical treatment for the pain at the time. She said that

“everyone thought I was imagining it, [but] I had gall-stones ... 201 stones, they were amazed that I made it as long as I did”. She ended up being admitted and having the stones and her gallbladder removed. She recounts the process, “I was the youngest one in the hospital, I thought I would have a tiny mark, I didn’t know what questions to ask. I got big dog stitches. I was in my mid-twenties. I got the dog clips. I was the only one who got the apprentices (possibly interns/new registrars). I was really upset, just because I hadn’t asked about the scar didn’t mean I wanted to be the ugliest. Aboriginal people we mark when we scar, that kind of scarring [shows me], if I hadn’t been so sick...I felt it was discrimination. How come all those old [white] women got the clamping situation and I got the old dog stitches. I felt really ashamed then ... I felt it was because of the colour of my skin”.

The second significant event was when she was pregnant with her first child and went up to the hospital. “That doctor said, good, she’s right, she is obviously having her second or third child ... ”. The doctor made an assumption about Kay that became a barrier to her asking questions about her birthing process. How Aboriginal women present to doctors, doesn’t always reveal what is happening with them as Kay explains “...on the exterior I’ve got it together and on the inside I am so scared. I am so ashamed how fearful I am, how I am ignorant, never touched a baby in my life, never had any one who had a baby in my life. I didn’t know what was happening with the baby, like, I didn’t know that we even bleed after you have a baby ... it’s hard to believe now, but that’s how it was ... another assumption that people make about us”. Not knowing what to do and what happens is a barrier in addressing health issues and carrying out healthy practices. As Kay identified she was frightened and she wasn’t really in a position to ask. She felt the staff made assumptions that she knew what to do because on the outside she had ‘it together’, may be she showed outward signs that she was confident, but she wasn’t.

Kay shared a few more examples and stated that “It has never made any sense to me that people could treat me different because of the colour of my skin ... now I look

back I recognise it was racism that I didn't want to face ... I wasn't given equal treatment". It is when Kay looks back on the events that she can analyse them more thoroughly and interrogate what happened or the treatment she received. She talked about this reflection back and the importance of this reflection in self-growth and becoming stronger as an Aboriginal woman. The two experiences of Kay's that I have outlined above were only twenty years ago. Some may say they were twenty years ago and things have changed. Anyone who says this needs to be sure before making that kind of statement, as some of the more recent experiences shared with me by Kay and other Aboriginal women and what I have read through the literature leads me to the understanding that there are still issues of discrimination based on skin colour and issues around Aboriginality.

Further to this, the experiences that Kay has had still impact on her life. She said, "because the trauma of my life is connected with the medical system and government, I fear both government as much as I do the medical system". Kay has what could be described as "soul wounds" (Duran et al., 1998:341-354). What was additionally revealed during the interview was that it was a doctor who was responsible for "stealing me from my mum". Aboriginal people and non-Indigenous Australian people are aware that in a range of different situations police, government officials, welfare workers, religious congregations and others including doctors and nurses, were responsible for orchestrating child removals and adoption of Aboriginal children. Many younger health professionals may not even be aware that older members of their professions were engaged in these practices. The removal of children and other historical processes have impacted on the health of Aboriginal peoples. The policies of the past, including child removals have impacted on the health and well-being of Aboriginal peoples. For Kay her long term illnesses, the many sicknesses she has experienced and her removal from her mother as a child have all impacted on her overall health and well-being for most of her life, and still impact on her life as demonstrated from the following statements. "Even though, as a dynamic woman, who is very motivated and empowered in most areas, I feel like I'm a little girl when I'm, when it comes about health but I haven't let that put me

off, I go off and have my pap smear tests, and now my mammograms”. Earlier in this chapter Kay’s experiences of accessing the Mammography Unit were shared. In accessing services Kay says “I still put myself there even though ...”, “I still get really scared when I have to go to other doctors (referring to doctors outside of the Aboriginal community health service she presently uses), the blood people, non-Indigenous female doctors. I felt totally disempowered, I felt really angry”. Kay discussed how she presents to people including the health system can often lead to misinterpretations of her and her needs at the time. “I know that I present, I try to present to the community as a woman whose got it together. I try not to come from a place of victim”. She stated several times during the interview that she doesn’t want to be a victim or be seen as a victim, this was important to her. Kay explained that she wants people to understand that “even on the outside if we look like we have got it together, that mightn’t be what’s happening underneath and that we as Aboriginal peoples can be disempowered in different ways, when that has happened continually, you work up strategies”. Health services that Kay presents to, may perceive that Kay is ok, she is strong enough to handle the reason why she presented, when in fact it may be at that point in time she is not ok. This may additionally be happening with other Aboriginal people too. It may create situations where extra attention or care is given to those Aboriginal people that present as more vulnerable and in the place of ‘victim’ to use Kay’s words.

Kay and I had a discussion in the process of the interview about how she believed that no one ever thought she was traumatised through all her illnesses and diseases or her removal from her mother. They only ever looked at the physical sickness that she presented with at the time. She accessed counselling through the Aboriginal community health service for two years and felt comfortable doing that stating that “I never hear anything about my life” in the community. Concerns of confidentiality were stressed by Kay, and also the other women interviewed. For Kay it was important, as she was conscious of not being a victim, and also of her privacy. The counselling Kay undertook assisted her to work through many of her issues including her health issues. Through counselling she was able to draw links between

incidences in her life and her health issues. It was this counselling and support which has lead her to a deeper analysis of her own situation and of the situation of other Aboriginal women. Kay was able to tease out situations and to look at the ways she had experienced trauma and re-traumatisation.

Kay raised some powerful concepts and a high level of analysis when discussing the issue of women's spaces and women who are employed as workers within women's spaces or health environments. She said "I always like female workers in the health area, but then again they don't always make me feel comfortable, a lot of them are kind of cultural voyeurs, it's like they take anything from anybody's culture, but they kind of put it on the exterior ... cultural tourist ... too many cultural tourists in women's spaces". I asked Kay when she meant by the term 'cultural tourist'. "Cultural tourist, it's where everything is on the external". She outlined that they, the cultural tourists, have bits and pieces of clothing or jewellery that they may wear and even sometimes may have a number of cultures reflected on the exterior of their bodies. She said it was also about them talking about concepts that might be drawn from a range of cultures. She told me that she asks them a question about something they have on or something they are talking about and that "that question can locate for you" whether that person is a cultural tourist or not. From her question/s she determines whether that person takes the culture from the exterior of their body to the interior, if that happens "then that person is not a cultural tourist". They take the "culture from the exterior into the interior ... building it as part of them" as part of their ideology. Kay saw how it could become part of how they live, where they are able to be reflective of other people's cultures from within. She said "someone who has all the gear on the outside I just automatically say cultural tourist!". When Kay explained this to me I could understand the concept and even visually picture some people as cultural tourists.

Kay talked further about the concept of cultural tourists and whether she believed they could empower Aboriginal women. Kay stated that "they are like leeches and suck people dry, they need to keep taking they don't give ... it is the same way they

become a cultural tourist...its not just one culture on their sleeve. They con me up quite quickly, they are nice and friendly on the top surface, exchange, locate where you are from, then it's like they have known you forever, and then they put it out there ... it's totally disempowering ... sometimes in the first instance you can think that you'd like to get to know this person, they have some deep and meaningful that you can exchange but you soon learn that you are the only one giving ... they work in health a lot, comes into this thing where it is just you and them when it is client, and they, get on to the one on one now, outside the room they wanted all this from you, and all of a sudden you realise you don't have any rights to ask questions anymore, they don't freely give you the information ... even those people in the women's health places ... even when you feel you have had a good relationship ... friendships go out the door and that person gives you the energy that they have your power and that you have to bend and stretch". She describes how she sees power and control being maintained. The staff in health services need to be adequately trained so that they can create Aboriginal friendly environments, that will enable Aboriginal women to gain and feel a sense of control in person to person interactions and other forms of communication. Further to this, they need to reflect on how the dominant culture maintains its strong hold over all aspects of health communication processes.

Roger's study is useful to draw on at this point. She interviewed white women in helping professions in Canada (psychotherapists) and discovered that historically they have been inscribed into representation and discourses of respectability, and as social subjects within imperialism (1998). Throughout the narratives of the women interviewed by Roger were identifications that marked the presence of whiteness. In this she showed that the white female helping professionals managed and incorporated whiteness within their practice as a social service provider.⁴⁷ What can be understood is that there is a need of an historical analysis of racism and

⁴⁷ Links can be made here to numerous health and human service professions.

colonisation in order to provide a greater sense of how women helping professionals might be better able to work with Aboriginal women. This would enable the narratives of white women helping professionals to be pulled apart in terms of how race, gender and class are constructed and expose the subject positionality of white women. This may assist in addressing the issues Kay raises of ‘cultural tourists’ working in women’s services.

Kay was also able to stand back and look at how Aboriginal people can be cultural tourists too. She gave a women’s example, that of belly dancing “I like different cultural dancing, how come no one ever looks to doing Aboriginal women’s dance? How come (name) is doing belly dancing? Why are we cultural tourists and taking up the pretty business, the belly dancing? From the outside there is sexuality, all these connotations from belly dancing and not the knowledge behind belly dancing, the religious, cultural knowledge behind the belly dancing ... I have queries about it. Why are the Aboriginal women choosing to do belly dancing instead of our dancing, with the earth and the dust?”. Our dancing is not evil, sorcery or inferior, but is treated in ways which has often seen our dancing belittled or given less emphasis.

In her discussion around accessing health services, she described how she accesses some of the Aboriginal specific services, in particular Bidgerdii. She outlined how she identifies a place as to whether “I’m just going to be sitting on the fringes as I have all my life, I don’t want to be, I want to find places where I can be part of the centre ... that why it’s important at Bidgerdii”. She identified that Bidgerdii was a place where Aboriginality is part of the centre, part of the thinking of the place and where she wasn’t going to be left on the fringe as an Aboriginal woman. Kay argued that part of the difficulty with the health system and broader systems was the centre that it operated from as its base. She means the ideology and foundation when she refers to the centre. She articulated that, “I want the white system to understand that we are not part of the white centre, we are on the fringe, we have not been included into that centre, and we won’t until the white system sees that”.

Kay also discussed other examples of what happens with interactions between Aboriginal and non-Indigenous people talking about colonising processes. She additionally gave examples where she said “we colonise ourselves in a way too ...”. This can happen through the way we think about ourselves and the way we think and treat other Aboriginal peoples. We can oppress each other as we strive for liberation (Freire, 1973:22). In her discussions Kay outlined how we as Aboriginal peoples internalise oppression and keep ourselves as Indigenous peoples locked into positions of powerlessness. Kay suggested a number of ways that she and other Aboriginal women could work towards changing this along with ways the health system can work towards changing the present situation. Kay’s and other women’s voiced suggestions are to be presented in the following chapter, integrated with information from the literature.

Conclusion

I have presented one of the in-depth interviews in a case study format (Kay), which provides an example of how one Aboriginal woman has experienced the health system. Kay’s words resonate some of the experiences of the other Aboriginal women. From Kay’s words and the words of the other Aboriginal women we are able to develop an analysis of how to work in ways that are more empowering for Aboriginal women. Some of the lessons gained in the words of these Aboriginal women with regards to the health arena have implications for broader human services. Furthermore, of how we can work towards longer term change for the re-empowerment of Aboriginal women and Aboriginal peoples. The following Chapter provides a presentation of broader themes addressing issues such as cross-cultural awareness training, recruitment of Aboriginal staff, empowerment, the physical environments of health services and other ways to improve health services. While I present what Aboriginal women have said are the problems within these themes, I additionally present what Aboriginal women and I (through the literature and analysis) see as some of the solutions to these problems articulated by Aboriginal women.

Chapter 7

Which Way?

Introduction

In parts of Queensland, 'Which Way' is used in general Aboriginal conversation to imply where to now, which way do we go, where are you going or we going, how is that person connected or how does that work? In this Chapter, I address what needs to be done to move health services to a point of incorporating more empowering structures and processes for Aboriginal women within the Rockhampton area. Many of these suggestions are applicable to other domains and that many are economically cost neutral. I explore what the Aboriginal women interviewed saw as important in building rapport between services and themselves as well as with other Aboriginal women as clients. I outline how services can improve their practices for Aboriginal women. The Chapter is underpinned by the voices of the women and my own personal experiences as well as data gathered from the literature.

I begin with a discussion as to the basic elements of what can be done. I then discuss Cross-Cultural Awareness Training within the Health sector, particularly the public sector, which is designed to enhance service provision to Aboriginal peoples, in doing so I incorporate a number of issues that the women raised during their interviews. Another strategy currently in place within health systems is to increase the number of Aboriginal people working in the health arena, a strategy which comes with its own issues that were raised by the women. These measures and others are contextualised within the spaces of health services and health systems. The issues that are being dealt with within this Chapter are what Aboriginal women identified as being central to what made them feel good about themselves as Aboriginal women, which would assist them make decisions and which would empower them.

What can be done?

A number of factors are constantly present when addressing the health needs of Aboriginal women. There are also factors, which should be present and be brought to the interaction to better meet the health needs of Aboriginal women. These ‘moving’ or changing factors are dependent on the interaction between health services and Aboriginal women. This section addresses what some of these factors are for individual workers and their individual interactions with Aboriginal women. It additionally addresses how health services made up of a varying number of workers, can address these issues as an organisation or agency.

Privacy and Confidentiality

Before any face to face interaction takes place, some basic understandings need to be explored by workers in health services before Aboriginal women even enter a building where a service is to be provided. Health service personnel need to be aware that there will be varying levels of intimacy allowed by Aboriginal women according to their particular health need at the time. The Aboriginal women I interviewed do not want to have the same doctor or service for all their health issues, they ‘shop around’ for services to meet their needs. In all of this, privacy and confidentiality was a major issue. Collectively, there was expression that their privacy be protected. Sarah wanted to know that “all information is going to be kept confidential” and Lorna wanted “no one knowing my business, even that I went there”. Grace visits a mainstream health service in Gladstone (one hour away) to avoid people in Rockhampton knowing she attends such a service. Visiting a mainstream service does not necessarily guarantee anonymity for some Aboriginal people, as even access to the building is often problematic. There may be issues with the workers in a service and this may also be confronting or raise issues around confidentiality. For example, in the past a couple of non-Indigenous workers openly indicated to me which Aboriginal person or persons uses their service/s. This is not isolated to the health arena. I have received emails from one young female teacher asking me for advice on behaviour management for a number of Aboriginal students,

who she named. At times Aboriginal people are placed in situations where workers may be seeking advice on how best they can 'assist' Aboriginal people. I make the statement here that these workers do so with the assumption that I or any other Aboriginal person they approach can assist them and that we will maintain a level of confidentiality around the request. I place the reflection back that I would not discuss which 'white' people, clients or students were within their work environments. To me this is inappropriate and reeks of a time in Australian history when Aboriginal people were under surveillance. There are issues around control, accessibility and confidentiality. Some of this was explored in the works of Kirk et al. (2000).

The Aboriginal women interviewed collectively expressed their need for privacy and confidentiality. They did not wish to hear stories about themselves or their information discussed with others. This is an openly expressed issue and fear within the Rockhampton Aboriginal Community and in many other communities across Australia. When confidentiality is broken, it can have varied consequences including loss of clients and mistrust by community members. In Kay's story we read that she accessed counselling through the Bidjerdii Aboriginal Community Health Service for two years and felt comfortable doing that, stating that I "never hear anything about my life" in the community. In this instance Kay is expressing confidence that what she discloses within the counselling sessions stays within the service as she doesn't hear any thing back about her life via community networks.

Positive Communication

A number of the Aboriginal women discussed the importance of one on one interactions, the importance of spending time with workers and the dialogue that occurs between them as an Aboriginal woman and health service personnel. Alice explained that health personnel should, "take that little bit of extra time with a client rather than rushing them in quickly ... introduce yourself, not like a far out conversation, just talk to the client ... don't take their file and then ask their name ...

friendly smile and nature and things like that”. While Julie said what was important to her was,

... a smiling face, a good greeting ... some kind of respect I know that respect is earned as well, but respect, just consideration for my feelings ... I don't like sharing myself with everyone, I allow people to know what they need to know, there is a lot of us who don't like to share with people we feel uncomfortable with.

Mary said a lot of services could improve their “simple meet and greet”. Sally said she preferred “one on one, the worker being friendly” and that it is good when “the worker could devote time with you”. Helen offered the following simple advice, “just sit and listen to people”. Grace outlined that generally health service personnel needed to,

... be nicer to people for a start, more sensitive to people's needs, not just Indigenous women but everybody because they are in a position of power and respect and authority and yes sometimes they make you feel like an idiot and that shouldn't be happening ... people have a need, they are looking for help they don't need to be made fools of to get that help.

Health service personnel “are in the people business and yet some of these people don't even know how to deal with people” she added. Mary said she did not want health personnel to “use big words” or to “talk in front of me like I'm a dickhead”. Charlotte provided an overall comment for Aboriginal women accessing health services, when she stated “communication is a big breakdown” and that when health service personnel give explanations, they need to keep terminology “easy and simple ...otherwise they'll [Aboriginal women] walk away none the wiser”. ‘Simple’ should not be interpreted that ‘Aboriginal women are simple women’. At times the attempts to make health literature ‘simple’, has made the information very inaccurate (Trudgen, 2000:65). Sometimes health concepts are complex and thus require complex and comprehensive information to understand them - it is not the inability to understand that is the issue, it is the way in which the information is conveyed that is the problem (ibid). When information is conveyed from the dominant culture in

ways that see Aboriginal women as 'simple' it further compounds rather than alleviates the crisis (ibid.). Thus simple should be interpreted here as working towards solutions for presenting, delivering and developing health information and programs in ways that encapsulate Aboriginal women's ways of learning and knowing.

Lisa and Linda both referred to Aboriginal women being individuals and having different needs. Linda stated that health service personnel need to deal with people on an individual basis, "showing people that you care, not standing over, empathy and understanding" are also what is important. Most of what has been stated in this paragraph is in fact about treating people with respect, having time to give to people, not being interrupted during discussion and valuing of Aboriginal women who are accessing the health service. It could be argued that most of this is common courtesy that should be given to all people, that it is part of good client or customer service for Indigenous and non-Indigenous and yet here, as this research shows, it became apparent that at times Aboriginal women are not given this common courtesy. What could not be ascertained at this time and what is out of the scope of this research, is whether in some instances this lack of 'common courtesy' is just because the women are Aboriginal women or whether it is a problem with the services and the personnel within the services more generally.

Knowledge of Culture

In looking specifically at the health issues for Aboriginal women, my research found that there was an expressed need for health personnel and services to have an "understanding that cultural stuff about shame, why people don't want to talk about, show people, bring people in, with them" and that health services needed to "bring some training to understand the social side, the emotional side of Aboriginal life"(Linda). Services need to increase their level of knowledge and understanding of Aboriginal culture and ways of doing things along with developing skills in working with Aboriginal people. In regards to health services and personnel Sarah said "they need to expose themselves to more Aboriginal groups, actually attend group

meetings that they know of ...”. It would help, said Linda, if they looked at the “Murri ways of doing things, looking from holistic point of view, remember what health is like, track and plot a bit of their history of health, things that they do, things that prevent them, from engaging them ... complete picture of where they’re at”.

Mary said that at times, she wished for “a bit of bloody cultural sensitivity”. Here, Linda, Sarah and Mary all articulate that health service personnel need to be aware of what happens within the Aboriginal community, what are the common issues for the Aboriginal community in which they are based and what it means to live life as an Aboriginal woman. Linda in particular is expressive in her dialogue that they need to “understand the social side, the emotional side of Aboriginal life”. Attending a Cross-Cultural Awareness Training session may give some people a glimpse of this, as may reading a book or a journal article, but the only way to really develop an understanding of what it means to live an Aboriginal woman’s life is by talking with Aboriginal women and spending time within the Aboriginal community. I add here that it is time and talking without the hidden agenda of furthering careers, or using the information for personal gain. It must be open, honest and based on respect. I state this due to the past experiences of Aboriginal women being used and exploited by non-Indigenous peoples, as I have outlined in previous chapters. I will also point out that this is only one part of the equation, the other fundamental issue is that non-Indigenous people have to come to terms with the way they occupy their positioning in Australia. This is as vital as coming to know who we are as Indigenous peoples.

Accessibility

Lorna, Denise, Julie and Linda were all very clear and articulate in their desire to see Aboriginal people within the services they use, even in mainstream services. Julie stated she’d like,

... to see Aboriginal faces around, to know its a service that employs Aboriginal people around, to see Aboriginal people around in the waiting room accessing the service ... women’s things that are displayed like pamphlets ... they are taking

consideration of women's issues, sometimes it's easier to pick up something than ask.

If any promotional material is going to be placed in the waiting rooms, Kirk et. al. identified that "any promotional material should be developed with community involvement, be culturally appropriate, easily understood, and deliver a clear message" (2000:41). As identified in the Kirk et. al. breast cancer study, women in all of the study sites felt that "generic mainstream materials were not always appropriate, did not catch the attention of women, or were not seen as relevant to them" (2000b:35). One Urban Indigenous Health Worker is quoted as saying that "I think they (pamphlets) are just taken out of the envelope and chucked in the bin. If there was an Indigenous design, that is going to make people open it up for a start" (Kirk et. al., 2000b:35). The issue is one of Aboriginal identification and perceived relevance to Aboriginal women.

Linda expressed her wish to be "amongst other Murri people" when she accesses services. This again raises the issue of where Aboriginal women locate themselves according to their comfort levels in being with other Aboriginal women, Aboriginal people or amongst non-Indigenous people accessing services. The additional concern is whom do Aboriginal women feel most comfortable with in disclosing private information and health problems. In regards to women specific services, Linda stated that they need to be,

... looking at where Murri women gather, not coming in with a big fan fare, making links first and then coming in to work with Murri people...working across daughters, mothers, grandmothers ... [There is a] need for women specific program still, lot of women (Aboriginal women) don't want to talk about.

Sarah wanted to know she "can go to more places for services or advice" and that there would be "other women there for support". Helen, who is 55 years of age and has a long history of accessing health services, said when talking about improving health services for Murri women that they should "treat them as human beings". She also commented that "it's OK to touch us, our colour doesn't wear off". These

statements relate to what Helen has experienced over the years. They reflect the way Helen feels she has been treated by some non-Indigenous people working within the health arena in the past. I do not wish to appear to generalise too much when I state that Helen's experience would not be isolated and that the reality of her experiences would additionally be the reality of some other Aboriginal people. It can I think be safely assumed that the health personnel she interacted with to gain these experiences and thoughts, would have additionally behaved in the same way with other Aboriginal people at that time.

In terms of non-specific health services, Sally outlined the need to be looking at "making accessible" services and that there were "not enough female doctors in Rocky, bulk billing, not everyone can afford to see a doctor with the gap fee". She also stated that such services should promote themselves. Some of the women, including Sally, were not clear about the programs some of the services had on offer to women. It was also raised that the way services are used might change if the services themselves changed their approach and the way they promote themselves. Lisa said from her point of view that the "only time Murries go to hospital is to die, my son saw his grandfather go in and never came out again". We discussed how this impacts on some Aboriginal people's health because of their decision around delaying access to treatment, which often causes other health problems. Julie raised the topic of leadership when addressing some of these issues,

... we need to have strong people at the top who are willing to say 'no you can't do that, you can't treat people like that' ... look at services that are going to meet everyone in the community not just the majority, if there is a gap then do something to fill the gap ... even though they are there for everybody I'd like to see more Indigenous services in the mainstream ... [I'd] feel more comfortable.

The next topic that will be discussed is that of Cross-Cultural Awareness Training which is what many of the women expressed as an area that could assist to bring about change. Cross-Cultural Awareness Training is one strategy that encompasses

many facets, as will become evident. The Training is one of a number of strategies utilised to increase the level of awareness, knowledge and understanding of Aboriginal culture in services, government departments, institutions and other agencies. As was demonstrated in Chapter 6 and this Chapter so far, there is a need for such organisations to gain this knowledge and skills if it wishes to better service the needs of Aboriginal women.

Cross-Cultural Awareness Training

When I, and the Aboriginal women who were interviewed, refer to Cross-Cultural Awareness Training, we are referring to those courses conducted through employers or through another agency which workers access outside their organisation. There are a number of Cross-Cultural Awareness Training programs on offer within the greater Rockhampton region.

The past decade has seen substantial growth and emphasise on cross-cultural awareness training programs. I was first engaged in cross-cultural awareness training in 1992 while with the Department of Commonwealth Department of Community Services and Health/ Commonwealth Department of Health and Human Services. The Department's Queensland State Manager supported that all staff within Queensland undertake cross-cultural awareness training in an attempt to better service and address the needs of Aboriginal and Torres Strait Islander peoples in Queensland. In 1995 there was a specific cross-cultural awareness training package developed for people within the Disability Services Program. The training took place at a Torres Strait Islander organisation's premises in the Fortitude Valley, Brisbane. The organisers wished to engage people within a community setting and invited Aboriginal peoples and Torres Strait Islands people from the community to the training as active participants and as active co-facilitators of sessions. The community members who were invited had knowledge on disability issues. The setting took into consideration what was comfortable to the guest speakers and placed departmental staff in an Indigenous space. Cross-cultural awareness programs tend to be based within workplaces of the participants or within training institutions,

they tend to be general in nature and not work place specific or issue specific. Angela Barney Leitch in her time within the same Commonwealth Department (1991-1995) was instrumental in developing and delivering cross-cultural awareness training programs. I make mention of the Disability Services Program and Angela Barney Leitch's work as the cross-cultural awareness training programs could not have been developed nor delivered if the leadership of the State Manager or the Disability Services Program Manager had not been present on this issue nor if some of the Aboriginal staff had not been pushing the issue or chosen not to participate in the delivery of the training. A withdrawal on either side can have consequences of no training being delivered or unsupported training. There can be mixed reasons whether either can occur. Puggy Hunter refers to cross cultural training courses as "hug a blackie courses" (Hunter, 2001:12). Some Aboriginal peoples look on such courses as a positive move towards non-Indigenous peoples coming to understand how to work more effectively with Aboriginal peoples, others are more cynical of some of the cross-cultural awareness training programs.

Since the early 1990s Queensland Health has employed Aboriginal workers across Queensland to deliver Aboriginal and Torres Strait Islander cross-cultural awareness training to all employees within Queensland Health. This includes clinical staff, administration, executive members and auxiliary staff of Queensland Health. There is one employee currently employed specifically to coordinate the delivery of Aboriginal and Torres Strait Islander Cross-Cultural Awareness Training with other workers in Queensland Health workplaces across the Central Queensland region. Other workplaces within the health sector contract private consultants or independent training providers to deliver Cross-Cultural Awareness Training as needed or as identified. These training programs vary in quality, presentation style and length. The presenters may be Aboriginal people, Torres Strait Islander people or a mixture of Aboriginal people and non-Indigenous people including individuals who identify as belonging to another minority culture within Australia.

Essentially Aboriginal and Torres Strait Islander Cross-Cultural Awareness Training, Cross-Cultural Training or Working with Aboriginal People (all names used for these type of training programs) has been employed as a strategy by workplaces in an attempt to create work environments which are more appropriate to the Aboriginal cultures and/or Torres Strait Islander cultures that may be found within those workplaces, and the clients that those workplaces serve within their designated region or area. These days targets are now measured by funding bodies and some services are funded based on numbers of people accessing them from specific 'target groups'; ensuring access by Aboriginal peoples comes down to money for those workplaces, too. Put simply, if the services do not have the numbers coming through their doors then they don't get the money. What needs to be identified additionally is that services need to offer more appropriate program initiatives to better meet the needs of Aboriginal peoples and not just become more sensitive or aware of Aboriginal peoples. One such strategy for making services more appropriate is Cross-Cultural Awareness Training, another is employing more Aboriginal and Torres Strait Islander staff, through workforce strategies or recruitment strategies.

Susan Young has undertaken research during the 1990s into the domain of Cross-Cultural Training programs in Western Australia (1999). Her work is the first in-depth interpretative analysis of Cross-Cultural Training programs and the role they play in Australia. Young explains an expectation underpinning Cross-Cultural Training programs is that if workers know more, they will be more tolerant of people from other cultures and make the appropriate adjustments to their behaviour at work (Young, 1999:205). She interviewed numerous Aboriginal people in her research process and some of her findings complement what a number of the women I interviewed stated and reflect a number of my own thoughts on the programs. The issue of diversity has been given considerable coverage in Cross-Cultural Training manuals, for example has tended to focus on *valuing* cultures, in particular, *valuing* the cultural needs of migrants within the host country. We as Aboriginal Australian peoples, have not been given the same value-added status as immigrants by the host

country. Non-Indigenous workers receive *awareness* of Aboriginal issues in order to primarily service Aboriginal people as clients and secondly to work with Aboriginal peoples as co-workers. One is valuing, the other is sensitising (Young, 1999:213). We are therefore not valued in the same way. Young asserts that this “characterises the inadequacy of a ‘rights’ focus which can position people hierarchically according to societal attitudes” (Young, 1999:213). It again adds to the litany of the occurrences that continues to attempt to erode us of who we are and what we represent as Australia’s Indigenous people and the issues associated with racism and white race privilege are left not faced head on.

One of the major contributions in the area of cross-cultural awareness training was a manual, a training package and a book titled *Binan Goonj Bridging Cultures in Aboriginal Health* by Eckerman, Dowd, Martin, Nixon, Gray and Chong (1992). While there have been comments over the years that the book is now ‘outdated’, ‘needs revising’ and that ‘we need a new text’, the comments have come from university based academic staff. I have found no other book that contains the material within the Binan Goonj book. I do accept that it does need a revision to include the ten years of what has occurred within the Aboriginal health movement and it does need some reworking in terms of language. In particular the language around our rights needs strengthening and the thread of our inherent rights and our human rights needs to be woven throughout the text. Binan Goonj is from the Bidjara people language in South Western Queensland. The phrase means, “they listen but they don’t listen” (Eckerman, Dowd, Martin, Nixon, Gray and Chong, 1992: Foreword). It has been adapted by a number of Aboriginal peoples across Queensland. It is often used to refer to non-Indigenous people who are told the issues but still don’t seem to alter, change their behaviour or bring about action because they haven’t really heard what is being said. It is utilised for cross-cultural awareness training in an attempt to “sensitise non-Aboriginals[es] to the needs and aspirations of Aboriginal people[s]” (Eckerman, et. al.,1992: Foreword). This cross-cultural awareness package was the first major cross-cultural training package written collectively by Indigenous and non-Indigenous people. The program was

funded by the Commonwealth Department of Community Services and Health through its Rural Health Support Education and Training Program, also known as RHSET. The package has been used by a range of institutions, agencies and organisations and was used by Queensland Health as their training package for several years. It specifically addresses issues within the health sector and highlights that non-Indigenous people need to listen to what Aboriginal people are saying in regards to health, really listen. In order to be funded under RHSET it needed to be recognised as an issue with health training and to be a priority. Unless Aboriginal health and understanding Aboriginal health in order to address the issues, including Aboriginal women's health is seen as a priority, important and worth knowing about, then the health status of Aboriginal women will remain poor.

Sophie Couzos and Richard Murray's (1999) text forms a companion text for Binan Goonj. Couzos' has worked for sometime with Aboriginal community controlled and based organisations and Aboriginal peoples. The text has emerged from this work in where Aboriginal peoples are in the lead, providing direction and management. This is a reverse situation of what happens with many other authors of papers, journal articles and chapters in texts where non-Indigenous peoples are observers or employees of governments, research institutes, universities and so forth. I am not stating that their work is of lesser value, rather, I am stating there is a difference when writing from a lived experience. This is very evident in Couzos' work (Couzos and Murray, 1999).

The Yunggorendi First Nations Centre for Higher Education and Research at Flinders University of South Australia produced a training package specifically for medical practitioners, students and other health professionals (Hollinsworth with Cunningham, 1998). This package is an excellent resource containing a manual and video. I have utilised the package numerous times with some adaptations for training in the health field within Central Queensland. The project managers of the training package, Aboriginal academics Jenny Baker and Daryle Rigney from the

Yunggoendi First Nations Centre were successful in “highlighting the central, common principles and issues in Aboriginal health, while also presenting the views of Aboriginal people from diverse backgrounds and interests” (McKendrick, 1998:737). There are a range of views presented from the Chairperson of NACCHO, to Aboriginal health workers, policy makers - both Indigenous and non-Indigenous- along with educators, academics and students. McKendrick, a psychiatrist with many years of experience working in Aboriginal health and mental health states, that “it is intended to equip doctors to work in Aboriginal communities” (1998:737). She outlines the project managers have concentrated on “bringing out the key issues, an understanding of which is required to enable students and health professionals to develop and use their skills to assist Aboriginal communities” (1998:727). She makes it very clear that it is an “indictment on the Australian medical system that, despite the appalling state of health of Aboriginal people, Aboriginal health is not an integral part of the curriculum in most medical schools” and that this “inadequate treatment of Aboriginal health by medical schools reinforces the marginalised status of Aboriginal peoples and renders health services relatively ineffective in meeting their needs” (1998:737). This situation has changed with medical schools now teaching modules in Aboriginal health issues within medical education programs.

Why would such training packages need to be developed some people might ask? The NAHS 10 years earlier outlined that in a survey conducted amongst medical undergraduates at the University of Queensland this year showed that ninety percent of them believed Aborigines were to blame for their own problems” (NAHS, 1989:iv). The Yunggoendi training package offers one way for health professionals to become better educated and to de-mystify what has been created within Australia in an attempt to deny, diminish, and to depreciate and dispossess Aboriginal peoples. It is a package that involved Aboriginal and non-Indigenous participation in working towards improving Aboriginal health, including Aboriginal women’s health by increasing greater understanding and knowledge around Aboriginal women and Aboriginal health issues. It is evident from the examples of

where cross-cultural training packages are being developed and working well is that it requires leadership of those with some form of power and influence and Aboriginal and non-Indigenous people working together on the issue and extending further than basic awareness to incorporate change strategies and personal reflections and attitudinal shifts. It also meant working from the lived experience. In order for this to happen knowing about Aboriginal people, including Aboriginal women and understanding Aboriginal women's health and issues needs to be seen as important and of value.

In the past decade there has been a shift from a 'top down' to a more 'bottom up' approach to cross-cultural training with some of the health professions themselves beginning to explore how they themselves can take some responsibility for their own education on issues. There is evidence that some training modules are being taught through processes that involve Aboriginal peoples in the development, teaching and evaluation. However, there is a need for more work to be done and the thread of inclusivity needs to be through *all* programs taught within the health domains. While it may be possible to have one module that may heighten awareness and develop some knowledge and skills in working with Aboriginal peoples, it does not necessarily alter the way an individual perceives the remainder of the curriculum taught. I am advocating that it is not enough to just have one module. There is a need (based on my experiences and discussions with others) for curricula to be widened to move away from viewing health merely within a western framework and worldview. For example, the "development through the lifespan" or similar focus modules, which are offered in most universities and in most health programs, often include aspects of psychological, cognitive, sexual and psychical development throughout a range of life cycles. For example, conception, baby, toddler, child, teenager, young adult, adult, mid-life, retirement, aging, cultural aspects should be included. Why couldn't students explore in such modules, how fifty-two percent of the Indigenous Australian population is under twenty years of age and the impact this has; how few Aboriginal peoples get to 'retirement' or 'old age' as determined by these texts of

development through the lifespan that are used in most parts of the continent at universities? Why couldn't students explore how non-English speaking background and cultures other than white people experience the development stages in life? My argument is that we need greater inclusivity across health curricula. Just as health policies put people into 'body parts' in a process of dissection, cultural training segments and dissects people. In the dissections what remains a constant is the dominant western worldview and in Australia's situation it is a colonising worldview. We need to get people thinking out of this narrow worldview and away from the idea that they can do an Aboriginal module from anything between four hours to four months that I've 'done' Aboriginal health. My experience has been that if they choose not to relate such learning within their own paradigms on health they will find it hard to incorporate within their existing knowledge base. (I believe this to be true about *all* curricula regardless of discipline, but here I am limiting my very brief discussion to the health domain).

McKendrick states that if health professionals and students are to, "learn how to work with Aboriginal people, to treat Aboriginal people, they must be able to listen to what they have to say. If we are serious about improving the teaching of Aboriginal health we must listen to what Aboriginal experts say" (1998:737). Listening is the first step, from listening comes dialogue with Aboriginal people. Once there is dialogue learning can occur around what is important to Aboriginal people in terms of health and well-being making it easier for a western trained health professional to work out the best way to work with Aboriginal peoples. This is easier said than done. Aboriginal people have been saying for a long time what is health and well-being, what could happen, what needs to happen and what are some of the best ways to make that happen. Despite this many non-Indigenous health professionals, academics, researchers, government officials and policy makers continue to seek answers from within their own worldviews and knowledge bases. There seems to be always some new response, some new words and some new approach to 'fixing' the Aboriginal health 'problem'.

Aboriginal Women's Voices

There were mixed responses to the question of Cross-Cultural Awareness Training from the Aboriginal women I interviewed. Some women were apprehensive about the outcomes while others had thought about Cross-Cultural Awareness Training for some time and had experience in the area. The women also demonstrated that they had quite an understanding of some of the complex issues around Cross-Cultural Awareness Training. As a group they repeated many of the findings from Young. Linda provides good example of the apprehension:

... sometimes I wonder about those programs. I mean it's good that people do training first of all that they have an open mind to want to go and learn something different, but I think a lot of that stuff happens if you are committed and you make a resolution to practice those things everyday of your life and not just go off for a two day course and have a piece of paper to say I know everything there is to know about Murri stuff now ... it's more how you operate on a day to day basis ... what you do know about Aboriginal lifestyles ... comes down to the individual perspective, putting yourself out as an individual ... sometimes people don't want to get that close, it's still keeping Murri people at an arm's length.

What Linda is raising, is the fact that some people are happy to do the training, provided they do not have to change their practice or adopt the training or the reflection on their ideas within their normal modes of operation. This can be seen as non-Indigenous people coming to know Aboriginal people provided their personal level of comfort isn't challenged. Moreover, this means they must have a willingness to let go of old misguided stereotypes and to accept what Aboriginal peoples lives actually do encompass. What the response appears to suggest is that it may be enough to know what to do in some circumstances but not to do it all the time. If there is no long-term commitment from individuals to making some real changes then such changes will not happen. It additionally means people can be aware and not do anything about their awareness.

The majority of Aboriginal women I interviewed had concerns around the length of time of the training and made comment about how long it may take to change some people's ideas. For example Julie explained that "in the long run the person has to change the attitude ... [they] could go to 10 classes and still not change...". Grace stated it "should be [a] core component of their training before they get out into the services, [it] should be done continuously, one day or three days, [is] not enough..." and Sarah asserted that "I don't agree with two days, [it] needs to be done on a reasonable time frame ... it's gotta be treated pretty serious ... putting ideas into action is another thing".

Julie added a very important point to discussing the time frame and with the training that it "might be fixing up what's there but it mighten' be catering to our people ...". She is expressing a real concern that the service model itself might not even be right or the type of service may not be appropriate. The answer may not be the actual Cross-Cultural Awareness Training, as the service workers may provide Aboriginal peoples with inappropriate services and then apply the training which will have minimal impact. In this, the blame can be shifted from the service, service model and workers back on to Aboriginal peoples. Occasionally, this has happened in the past and later excuses are made that they tried and it didn't work or Aboriginal people rejected their efforts or that it was Aboriginal people who didn't want the particular health or human service program. In terms of my research, several of the women interviewed acknowledged that staff in a number of services in Rockhampton had undertaken Cross-Cultural Awareness Training. There were no specific comments made as to whether the women had noticed a change in the service delivery models.

The content of Cross-Cultural Awareness Training differs depending on who delivers the training. Sometimes the training can be geared to a specific work place. The program delivered within Queensland Health was written specifically for a broader health audience whether they were employed as cleaners, managers, doctors or nurses. Even though the Queensland Health Cross-Cultural Awareness Training

program is written for health personnel and directed at Queensland Health employees, some workers still do not wish to undertake the program. The program is not mandatory and workers cannot be forced to undertake the training. Alice stated that she knew that the Queensland Health course had some problems and that some health personnel were not prepared to do the course,

... to be really honest, I, if, while it's a good program, I think, I have heard it has it's ups and downs ... nursing staff and doctors and that not willing to participate in the program ... generally I think it's a good idea ... In time I reckon' it would you know break down that, that wall there.

There are many reasons workers may choose to do the training and many reasons why they feel they should not. These reasons then impact on how people participate within the training. Mary identified that there was a difference between those people undertaking the training because they “want to improve” or because “this is a directive”. This was raised during general discussion with a number of the Aboriginal women. Aboriginal people have a general awareness that in some workplaces people are directed to do the training. This could be because they work specifically with Aboriginal peoples or because there have been some issues identified with that person/s behaviour in relation to Aboriginal people.

There are varied reasons why non-Indigenous people and Aboriginal peoples may choose to undertake Aboriginal and Torres Strait Islander Cross-Cultural Awareness Training, just as there are reasons why people choose not to undertake training. Others might hold back from participating in the training because they question the presenters of the training, the content and the reasons for the training. Helen stated that she “would like to choose and pick the people delivering that service ... may be I'm too critical, when I see people up there saying what they shouldn't be saying”. Helen explained that she would like to be involved in such training, for example helping or assisting for change if she was asked, that it is “hard to be diplomatic with people who use ignorance as an excuse for not wanting to know”. Helen was referring to the participants in training in this statement.

The women I interviewed all suggested ideas on how to improve the curriculum of Cross-Cultural Awareness Training packages. Sally discussed that people who undertake training should gain an idea of the lives behind the statistics and not just the statistics. She wanted them to have “more an idea of what Aboriginal people go through or more appreciation ...”. Sharon and Denise both suggested training that would complement the more formalised training done in a classroom or lecture setting. Sharon knew that all the new medical interns in the Rockhampton Base Hospital needed to do the Cross-Cultural Awareness Training. In referring to them and other people within the health arena she said, “... those people in other places they need to come and work with us (Aboriginal people) and see how it operates and how to service our people ... they’ll get an understanding of our culture and what it’s all about it’ll make their service a lot better too”. Denise looked to the community-controlled health service as a place where health personnel could gain training to work along side Aboriginal people and within an Aboriginal environment.

Denise additionally thought through some of the processes and suggested that it “can’t be that hard for that mob to go from their work place to some other work place”. That is, it is her belief that it cannot be difficult for health personnel to work in other areas of their work place or in other work places. She then explained that when she was at the Rockhampton Base Hospital she saw the same nurse in Maternity and then in Ward 5B some months later. Denise suggested that training go beyond the classroom. She is implying that health professionals need to get out and about and that they can’t do anything just sitting in their offices, work desks or work stations. Opportunities could be created for work place exchanges, placements in other work environments or situations where workers work along side other workers.

Charlotte saw that Cross-Cultural Awareness Training was a useful option to a workplace that did not have any Aboriginal workers. “I think it would be really good at least if they can’t get Aboriginal workers at least they have some knowledge and understanding of someone with an Aboriginal culture...”. However, as the next

section discusses, sometimes it does not matter if there is an Aboriginal worker as part of the team within that workplace. Sometimes having an Aboriginal worker provides an excuse for non-Indigenous workers not to service Aboriginal clients or not to learn about Aboriginal cultures within the service model in which they work.

Can it bring about change?

Aboriginal and Torres Strait Islander Cross-cultural Awareness Training may only be awareness raising and showing people how to better communicate with Aboriginal peoples, in some cases it may not have any impact on the individual participants of the training at all. In other cases it may be influential in changing long held beliefs and attitudes about Aboriginal peoples and assist in better communication with Aboriginal peoples. Jan Pettman put the position in discussing Aboriginal Studies that such programs are,

... frequently taught within education, social work or health departments, which tend to encourage (with notable exceptions) a social problem, social welfare, and culturalist approach. A concentration on trying to understand 'them' better so that 'we' can do our job better both underlines their otherness, and detaches their decision making from wider highly political, structures and processes (1988:36).

In this research, a few of the programs do not support Pettman's findings. Discussion with the participants of past Aboriginal and Torres Strait Islander Cross-Cultural Training Awareness Training available through the Yungalla Rural Health Training Unit, Queensland Health and other State Departments reveals that this is what is on offer to government employees. That is, training is aimed at how they can understand Aboriginal peoples better and how they can better service Aboriginal peoples. I gained an understanding through my discussions, of the training challenging the societal inequities or structural constraints that maintain Aboriginal disadvantage. I believe it does create some awareness of the inequities and constraints. I am unsure whether it gives an understanding to participants that Aboriginal disadvantage also means that others are advantaged, or whether the

participants see connections between themselves and Aboriginal people and processes required to assist in bringing about change. Young asserts that,

... CCT (Cross-Cultural Training) is an individual change strategy which relies on learning interpersonal interaction processes which, at the very best, might start a collective conscientisation process leading to change at an organisational level for the betterment of the social position of people of different cultures and backgrounds (1999:212).

Note that Young uses the words 'at very best' and 'might start'; she does not say 'will start' or that it does or if the programs were at their very worst or average. She additionally states that it is about interpersonal interaction, and not necessarily about attitudes or beliefs unless the individual participants choose to follow this path. In terms of the short cross-cultural training programs she comes to the same important but common conclusion that I and numerous other Aboriginal women and Aboriginal people hold, that "cross-cultural training is never going to produce, of itself, structural change"(1999:212). What needs to be explored is what will produce the changes and what type of education or training might support these changes or assist in making change.

Educating for Cross-Cultural Knowledge

Public health policy has attempted to introduce other forms of training and education that may result in some future changes. For example, the House of Representatives Standing Committee on Family and Community Affairs' recent report, *Health is Life: Report on the Inquiry into Indigenous Health* (May 2000), contains the following recommendation (p.107):

Within two years, all undergraduate and post-graduate health science courses should include an effective cross-cultural awareness component, as well as dealing in detail with the current health status of Indigenous Australians and the factors which have contributed to their ongoing social and cultural disadvantage.

All continuing medical education courses should also expand on these matters and continue to expose health professionals to cross-cultural learning. (Recommendation No. 29).

Some three years after the recommendations came out, however, little has changed in health sciences programs offered at Rockhampton's Central Queensland University. Four designated hours of Indigenous content designated as *core* content in the entire three year nursing undergraduate degree. Further to this, it is in a module of teaching titled "Health Care Across Cultures" which subjugates knowledge from the main curriculum knowledge. Any other Indigenous content is governed by the content choices of lecturers with other modules. There are no Indigenous lecturers employed on a standard contract or tenured basis that teach any health science modules; only Indigenous 'guests' brought in to share their knowledge during the 'Indigenous four hours'. Few universities have less Indigenous content and many more who have highly developed Indigenous health modules and sections within other modules. Others have developed full degree programs, for example, The University of Queensland offers a Primary Health Care in Indigenous Health degree program. The present inequity privileges the Western knowledge systems of health and marginalises Aboriginal women and Aboriginal people's health concerns despite the appalling situation of Aboriginal health in Australia. The CQU nursing curriculum is due for review in 2004, it is anticipated that some changes will be made, however I do not anticipate any changes in the curriculum that would see Indigenous knowledges and content throughout the degree rather than being compartmentalised.

In some education environments and workplaces, learners and workers might be lucky to get a few hours of training, or one or two days of training or a highly developed training or education program. There may be justification that workers cannot afford the time, or that the employer cannot afford the time or the training. There may be unresolved questions within TAFEs and universities where in the curriculum Aboriginal content might be included, when they 'are already stretched'. The questions that still remain include: how important is such training and how

important is it to address Aboriginal health issues in Australia? How much further can Aboriginal health be stretched? If Aboriginal health issues were of major concern and we were considered of worth, training would be provided and curricula would be changed to reflect content that is seriously attempting to address Aboriginal health issues, not just nursing and health professional curricula, but in other areas too.

There are numerous Aboriginal people who have the capacity to bring their experiences, knowledge and skills into the education system in ways that can contribute to the ways of seeing the discipline. We can see the disciplines as they are being taught with from our Aboriginal perspective. In this way we can provide a valuable contribution to the knowledge base as can people from a range of backgrounds, who may view the discipline from other perspectives. In order for this to happen, we need to move beyond the dominant cultures stronghold on what is valued as knowledge and what is perceived of lesser value. I am calling for a redistribution of power in what is 'knowledge' and who controls knowledge within education settings. It is more than just making education environments culturally appropriate, teaching segmented Aboriginal Studies programs and employing a few Aboriginal people. I am in essence calling for a "reversal of the traditional cultural dominance of Westernism" (McTaggart, 1989:40) and for racism to be addressed.

From Cultural Awareness and Cultural Sensitivity Training to Anti-Racism Action

Swendson and Windsor argue that, in nursing, in trying to understand cultures,

... nurse education would be better directed towards the development of critical understanding of the complex political and economic relations that have perpetuated racial divisions and the fundamental structural reforms required to address this situation (1996:9).

According to Swendon and Windsor, “cultural sensitivity” means that people generally remain neutral and avoid dealing with political judgements in dealing with human difference (1996:9). They argue “cultural awareness does not equate with equality” (1996:9). Cultural safety is another concept that is being used within health care settings in Australia. It was originally developed by New Zealand Maori nurses attempting to overcome what they saw as the failure by the general health care services to recognise Maori culture and service Maori people.⁴⁸ The principles and practices that underpin cultural safety, have been adopted by Queensland Health (Queensland, 2004). I would argue that while cultural awareness, cultural safety and trans-cultural nursing may answer problems and dilemmas at the point of service access and delivery, it often does little in terms of long term change *unless* the health professionals take some action within themselves, their work environment, the system in which they work and within the broader society in which they move. If this does not happen we, Aboriginal women and Aboriginal people, can become yet again the ‘problem’ that needs to be overcome by health professionals through greater education and understanding. It leaves the present health system and health personnel in the position of domination and nurtures dependence.

The mere creation of awareness does not bring about the structural changes needed and the recognition of our inherent Indigenous rights, nor the reflection in the positioning of non-Indigenous people by non-Indigenous people. It focuses the lens on Aboriginal people, as being under-serviced, needy and problematic to non-Indigenous people to some degree in that their efforts to service us have failed. If more people become more cross-culturally aware, what will it bring for Aboriginal peoples aside services and programs that we are entitled to and that fit within Australian society’s bureaucratic structures? It does not mean that we as Aboriginal peoples will be any healthier as Aboriginal people as defined by Aboriginal people. It does not mean that we will be exercising our rights, roles and responsibilities as Aboriginal peoples or that non-Indigenous people will be exploring how they

⁴⁸ See Ramsden 1990, 1992, 1996, 1997, 2000 and 2001.

acquired their privileged positioning within Australia and move to re-dress their positioning. Cross-cultural awareness training needs to acquire more depth, begin to explore what has come to be termed 'white race privilege' and incorporate anti-racism strategies. More focus is needed on the role of non-Indigenous people in their societal positioning and our positioning as Indigenous peoples and structural change.

Anti-racism training incorporates more than cross-cultural training. The models of anti-racism training and anti-racism workshops currently being conducted in the United States challenge racism, sexism, class exploitation and oppression, homophobia, environmental degradation, and support multi-faceted struggles for social justice in the United States and internationally (Ashmore, 1999, The People's Institute, 2002, The Anti-Racism Training Institute of the Southwest, 2002). They incorporate and challenge the notions of racism and unearned white race privilege, training identified that is needed within cultural training programs in Australia. Ashmore states that "Racism is a systematic form of oppression by the dominant culture in power in which people are oppressed economically, socially and politically solely based on skin colour" (1999:1). Racism in Australia towards Aboriginal women is based on the developed historical stereotypes of Aboriginal women and skin colour. Aboriginal women in this research describe their experience of varying degrees of racism from remarks, to overt discrimination when attempting to access services. What is important for health professionals to learn is how they both consciously and unconsciously participate in a racist health system and in a racist society. Ashmore (1999) put forward some useful suggestions which could be utilised to push the boundaries of cultural training within Australia.

- Be honest about racism
- Acknowledge white privilege
- Start to heal
- Learn the history of another culture
- Learn about another culture
- Keep up with media aimed at people of color [Aboriginal people]
- Question yourself
- Try to learn from your mistakes
- Acknowledge the skills and experience of people of color [Aboriginal people]

Never be afraid to ask questions
Join another organisation oriented towards another culture
Learn to share power
Realize the enemy is not people of color [Aboriginal people]
Expand your spiritual horizons
Support minority owned businesses
Support non-profit organisations that empower minority populations
Make a commitment to broaden your perspectives beyond your narrow euro-
centric world (Ashmore, 1999:1-6).

Under each of these headings and more, Ashmore provides an explanation and practical advice for undertaking the suggestions she has offered. She places questions for the reader around each suggestion (1999:1-6).

The People's Institute for Survival and Beyond is a multi-racial and anti-racist network of organisers and educators dedicated to building a movement for justice by ending racism and other forms of institutional oppression (2002). It works from the premise that racism is a barrier to building effective conditions for change. Furthermore, that "racism has been consciously and systematically erected and can be undone only if people understand what it is, where it comes from, how it functions and why it is perpetuated" (The People's Institute, 2002). In Australia as with the United States, white privilege acts as a major barrier to building the kind of social movements that could bring fundamental change. Social justice activists have a real stake in tearing down this barrier if they wish to bring about change. In the United States, institutions and culture gives preferential treatment to peoples whose ancestors came from Europe over peoples who came from elsewhere and that Euro-Americans are exempt from racial and national oppression inflicted upon peoples from elsewhere. We see parallels in Australia with preferential treatment being given to Anglo-Australians, or people from Europe and the United Kingdom over peoples who are Aboriginal Australians, or those people who originate from Asia, Arabia, Africa and the Pacific Islands.

The Anti-Racism Training Institute of the Southwest (2002) is based in the state of New Mexico, United States of America and has one of the highest populations of

what the United States terms “people of color” (The Anti-Racism Training Institute, 2002). New Mexico is additionally one of the poorest states in the United States where “people of color have less access to health care, less access to credit and capital, higher poverty rates, poorer educational outcomes and higher incarceration rates” and “there is compelling evidence that racism drives these statistics” (ibid.). New Mexico has high and diverse populations of Latino, Mexican and Native American peoples. The Anti-Racism Training Institute states that they initiate “the hard conversations about race, with the goal of building racial, ethnic and cultural groups” and that this form of multi-racial and inclusive cooperation will assist in uprooting racism and challenging “institutionalised and thereby legitimised” racial inequality (ibid.).

The work of The People’s Institute for Survival and Beyond, Ashmore and The Anti-Racism Training Institute of the Southwest has connections with the writings of Moreton-Robinson (1999, 2000) and Tannoch-Bland (1997) centered on white race privilege and racism in Australia. Racism is embedded in Australia’s colonial history, within Australia’s institutions, policies, way of life and within the psyches of Australian peoples. It commenced, as I have outlined in this thesis, with the arrival of the British, which began the theft of land, murder, massacres, poisoning, torture, dispossession, internment, enslavement and genocide. These acts committed against Aboriginal peoples were all based on race. It continues today often in more subtle and less overt forms. What racism does within the health system is maintain the marginalisation and disempowerment of Aboriginal women. Disapproving of racism and simply changing language is not enough to change the situation. Jenny Tannoch-Bland speaking as a non-Indigenous Australian suggests that,

Race privilege works to over empower us - conferring dominance
- permission to control on the basis of race. It gives licence to one
group of oppressors ...White Race Privilege still gives us a licence
- we can be ignorant, oblivious, arrogant, destructive, insensitive,
patronising, paternalistic ... Our arrogance is damaging us.

She adds, that, “it is through exposing our White Privilege that we can begin to unpack and unlearn racism” (1997:10).

Thus I believe one of the answers in addressing Aboriginal women’s health is for health professionals and those working within the health system to first become cross-culturally aware of Aboriginal women, history, culture and statistics. Second, I believe they need to move beyond this to an anti-racism framework in which they develop an understanding that racism is fundamental to Australian society and not just about Aboriginal disadvantage; it is also about unearned white advantage, or white race privilege. Non-Indigenous white health professionals and those within the health system need to address how they benefit from the invisible and unearned elements of white race privilege and how these are continually enacted to maintain Aboriginal women’s disadvantage. By not addressing their own positioning they assist in maintaining the status quo. Third, move towards establishing Aboriginal friendly environments with Aboriginal women.

The health interactions explored by some of the women of accessing services explain some instances of where services maintain their white race privilege, where the staff and the other clients maintain the white race privilege. Kay addressed this at length in her interview and how she builds strategies in order to access specific women’s services, while Grace (who is much fairer in complexion) discusses how she can remain ‘hidden’ within a group of non-Indigenous people due to the colour of her skin. However, white race privilege is not just about skin colour, it comes with a whole range of other assumptions, attitudes, beliefs and expectations which fairer complexion Aboriginal people do not meet and thus become excluded from white race privilege based on Aboriginality. This was evident from Grace’s experience when she discussed feeling culturally uncomfortable accessing the Women’s Health Centre.

Anti-racism training in which participants develop an understanding of white race privilege needs to be part of all cross-cultural training programs. This will cause

some discomfort as racism in Australia has generally focused on those who are oppressed and on race hatred. Racism has been seen as a problem for Aboriginal peoples and not for white Australians. Racism needs to be seen as a problem owned by all Australians, black and white, if it is going to change current practices. The conversation needs to additionally include the reality that some Anglo-Australians who are non-ruling class are both oppressed and privileged. They are oppressed based on the basis of their class, gender and sexuality and may be on the basis of religion, culture and ethnicity, age, disability and politics, while being privileged based on the colour of their skin and their connection, and affirmation, of with white race privilege. The difficulty is when oppressed Anglo-Australians, Celtic-Australians or European Australians protest against their own oppressions, while remaining silent about racial oppression and white privilege, they become oppressors of Aboriginal people and other groups. Their silence acts as a form of consent.

Throughout Australian history, non-Indigenous people have joined in the common cause with Aboriginal people to fight colonialism, racism, imperialism and the ongoing impacts of these on Aboriginal people's lives. There have been non-Indigenous people who wanted to be part of the struggle and to make changes. Today, the scope of the battle has widened with more non-Indigenous people joining in the Indigenous struggle and expressing doubt not only the racist institutions and agencies, but also the racist narratives of Australian society and the purported superiority of all things British, European, American and 'Australian'. Sometimes however, the support against racism and for equity is flawed, as there may be best intentions that contain the coloniser's and non-Indigenous white privilege of what is right, just, anti-racist, and culturally valuable and viable. These individuals must be open to seeing how their own histories and experiences of white race privilege have distorted their best intentions and be prepared to challenge themselves just as they are willing to challenge others. This can cause real frustration and a crisis in terms of what it means to be an 'Australian'. I have witnessed this within some non-Indigenous people as they come to terms with themselves as white Australians who have benefited from privilege while others have been disadvantaged, it can bruise a

positive self-image and make someone depressed with the reality of others lives in relation to one's life. This can be a painful surprise. Aboriginal people may also be challenged, only from another lens. The real obstacles are recognised, that is the 'Australian' conceptions of who Aboriginal peoples and non-Aboriginal people are and what we are supposed to be and the picture becomes clearer as to who we really are as human beings.

Aboriginal people employed in health

In this section, I will focus on another strategy to address the needs of Aboriginal people, of employing more Aboriginal people within workplaces that service Aboriginal people. This was identified as a strategy by both Aboriginal and non-Indigenous peoples within the health sector in the 1970s and identified through policies implemented by governments and institutions such as Affirmative Action and Equal Employment and Opportunity. Over time this has led to specialised Aboriginal positions also termed 'identified' or 'Aboriginal specific' or 'Indigenous designated' positions. Identified positions can be found in most government departments and agencies, and in some non-profit community-based organisations. There are additionally positions such as Aboriginal liaison officers, Aboriginal program co-ordinators or field workers, and Aboriginal health workers, which generally imply that these positions are for Indigenous peoples. This is not necessarily the case. There are instances, where these positions are occupied by non-Indigenous people who meet the position selection criteria and who are deemed the most suitable individuals. This is not necessarily an issue where there are no suitable or qualified Aboriginal people available to undertake the position. It becomes an issue in communities or workplaces when there are deemed to be (by Aboriginal people), a number of Aboriginal people who are suitable for the position. There may be incidences where what is deemed as suitable by management may be different to what is deemed as suitable by Aboriginal people and vice versa. For example an Aboriginal person who knows nothing about working in the Indigenous community may be employed by a non-Indigenous employer as a project officer to work with Indigenous communities. When this occurs, the NHMRC (1996b) suggests that these

employees “can do more damage than good, by ‘rubber stamping’ an idea that belongs to somebody else – often a non-Indigenous employer (1996b:38). While Trudgen stresses in relation to health workers, that the “more a health worker’s authority comes from the dominant culture and the less it comes from the people, the less functional he/she becomes” (2000:153).

Within Aboriginal community-based organisations, an effort will be made to recruit Aboriginal peoples with the necessary skills, abilities and qualifications or the ability to gain these within a short period of time. This is to increase the number of Aboriginal people employed in those designated Aboriginal services and is about the affiliation of the organisation and services provided with the Aboriginal community. This is at times referred to as capacity building as discussed in Chapter 5. It concerns itself with ownership, comfort, cultural understanding and Aboriginal peoples being part of the self-determining and self-management of ‘Aboriginal business’. There is a demonstrated commitment by some government agencies to the employment of Aboriginal peoples within Aboriginal designated programs or programs with a high number of Aboriginal clients, for example the Queensland Department of Family and Community Services and Abstudy, Centrelink. There are other broader workplaces, with a stated commitment to employing Aboriginal peoples within the health domain such as Queensland Health.

There are benefits of employing Aboriginal people within broader services such as ‘having a black face’ within the organisation, increased visibility to the Aboriginal community of an Aboriginal person whom they can contact, and of teaching the non-Indigenous people within that workplace more about servicing Aboriginal peoples if those workers are open to such learning. Sharon outlined the benefits of having Aboriginal people employed in broader health services. She argues that there needs to be employment of,

Aboriginal people to be in those, to work in those mainstreams ...
we got no Aboriginal people that they can go to and to ask them
for their support and that’s why they don’t go. If we had more

Indigenous people employed in those positions it would make it a lot better for our people to access because they won't do it ...

A number of the women wanted to see more training to 'train up' Indigenous people so that Aboriginal people could have more contact and access options and possibly have more Indigenous services, doctors, nurses and "more Indigenous people all over the place" (Sharon). She in fact named a strategy that Tsey (1997) put forward, that of education and training. There are increasingly more Aboriginal people being trained, educated and employed. In some worksites, this has had an impact in the number of Aboriginal people accessing those services, and in other cases little difference has been noted within the community. If more Aboriginal workers are being employed this does not mean that the sole responsibility for servicing Aboriginal clients should shift from all workers within a workplace to only the Aboriginal workers. The situation should not arise where Aboriginal people are not served if the Aboriginal worker is not available. An Aboriginal person may choose to wait for the Aboriginal worker but that is their choice. Other workers should still offer assistance and should utilise the knowledge and skills of the Aboriginal worker to improve their communication with Aboriginal peoples.

Aboriginal workers can face the risk of becoming 'ghettoised' within the larger programs in which they work or within the department or institution in which they work. These employees may work in situations where they are marginalised and become easily over loaded by the increasing workload within the Aboriginal community. Workers can be left unsupported or with co-workers not knowing how best to support them. The designated positions in most instances have extremely limited career path opportunities and these tend to be in administration and up to middle management. They may be health workers, liaison officers, dental assistants, program coordinators, education workers and support workers. Those occupying the designated positions tend to become known as Aboriginal specific workers by both the Indigenous arena and the broader arena. This further limits Aboriginal workers.

Trudgen suggests that Aboriginal health workers are told that it is they “who should be leading the way in health interventions in their communities” (by both Aboriginal people and non-Indigenous people)(2000:153). He asserts that the system sometimes sets them up to fail “as the meat in the sandwich between their people and the dominant culture medical system”(ibid.). Parallels can be drawn between health workers, liaison officers, project workers, assistants etc in many other arenas. Thus Aboriginal people can be left to feel a failure in the job and also a failure to their own communities.

I recognise that in order for Aboriginal people to further develop their careers it may be necessary to improve their knowledge, level of skills and undertake further training and formal education (Tsey, 1997). Some Aboriginal people are undertaking this process to gain career advancement and others are given employment opportunities at higher levels *without* the necessary skills, abilities and training. This can result in having the positions on the ground and being told this by departments or agencies, and the workers having difficulty in operating at the capacity to which the position was designed. These workers spend their whole time just trying to keep their ‘head above water’ in the job and casting off the assumptions by non-Aboriginal and Aboriginal people around their skills, abilities and qualifications and about how they gained employment.

There may be another reason why at times particular Aboriginal people might not be employed or employed. Kay provides the following insight,

... the white world sometimes wants us to be puppets in a way, [it wants] Aboriginal people who don't have as much experience, knowledge, and competition. White race privilege doesn't take empowered people, they don't want empowered people, they encompass you because they can do everything for you ...

What Kay is articulating is that being an empowered Aboriginal woman can place you in a position of disadvantage. She raises the dialogue around the comfortability of white race privilege and around the desires of others to encompass or do things

for Aboriginal people. Further to this, they want people who can just fit in to the white world, the 'mainstream' to be "puppets in a way", or to be told what to do. Basically, if you are an empowered Aboriginal women who can articulate what you want and need, you may not get the same assistance or be asked to participate because the workers don't necessarily know how to relate to you as you don't fit within their white way of seeing Aboriginal women. How do they "encompass" and "do everything for you" as an empowered Aboriginal woman? I believe this is an historical phenomena and connected to past colonial practices and the belief that the dominant society was trying to 'rescue' and 'save' Aboriginal women. It is about nurturing dependence and paternalism. It is also about measuring Aboriginal women up to a standard that is not our own and one that is based on a society that believes itself to be better than us. The behaviour of how to work with Aboriginal people who have a sense of their own personal empowerment is one that is still being worked through by both non-Indigenous people and Aboriginal people. I believe that there is personal discomfort at times for some people in facing Aboriginal people who have a sense of their own personal empowerment.

Keoner's honours thesis (2001) on the topic of reconciliation includes a discussion on Aboriginal people and employment, which could be referring to the same issues with a twist regarding skin colour and adds to this discussion. The research involved interviewing a woman named Grace, who implies that at times it is those Aboriginal people who fit into the frameworks of whiteness who may more easily gain employment (2001:90), that is Aboriginal people who the white system identifies with either because of appearance and/or because they work comfortably within the framework of whiteness. Trudgen (2000) explains that sometimes Aboriginal people who are "hand-picked by the dominant culture rather than chosen by their own people, can become oppressors". Furthermore,

... where the dominant culture works through a few chosen ...
Aboriginal people instead of working with the whole community,
the seeds of cronyism easily germinate. These chosen leaders,
irrespective of their original intentions, can easily become corrupted

because their position is supported and nurtured by the dominant culture ... this leads these dominant culture agents ... to unconsciously build their own leadership base (2000:197).

Trudgen states that this too is how Aboriginal people can also become “agents of trauma” (2000:197). He explains using the context of the Yolnu⁴⁹ people of the Northern Territory, that when the “dominant culture tries to answer a problem from the dominant culture perspective, inevitably a short-hand solution is decided upon. Normally this involves getting a few Yolnu or other Aboriginal people who speak English to meet together and design the answers for ‘their people’” (2000:196). This process Trudgen argues can result in these people also becoming “agents of the dominant culture and therefore of re-traumatisation” (2000:196).

When the processes described are in place it doesn't matter how many Aboriginal people are employed, nothing really changes within the system as the Aboriginal people working within it are maintaining the same systemic marginalisation of Aboriginal people. Phillips argues that sometimes the workers “try to make health programs culturally appropriate by merely placing Indigenous workers in programs without concurrently decolonising non-Indigenous theoretical frameworks and methodologies and reconstructing specific locally appropriate ones” (2003:129). I understand that it can be hard not to become embroiled in this process with the Aboriginal worker's kids needing to be fed and schooled, and rent and bills needing to be paid. This can feed white race privilege and perpetuate the dominant system that maintains our marginalisation. To change this requires hard work, constant critical reflexive practice within the workplace and within policy development and service delivery. It requires a challenge to ‘learned hopelessness’⁵⁰ and dependency⁵¹ and a broader view of where we sit within the political struggle and within organisations in which we as workers are engaged. In order for this to happen workers must be given space to be reflective and to contemplate the nature of their

⁴⁹ The peoples of north-east Arnhem Land, Northern Territory.

⁵⁰ See Trudgen, 2000:169-175

work and their actions. To think that a job is only about increasing participation in a program or access to a service may be purely acting out the philosophy of assimilation. It requires our non-Indigenous and Indigenous co-workers to be open to working towards decolonisation of the existing theoretical frameworks and to reconstruct new ones (Phillips, 2003:129). It requires healing of traumatised behaviours and the prevention of re-traumatisation. When we think of the broader political angles we can also think of the consequences and possible alternatives if required.

In order to make real differences for Aboriginal people, I am arguing that more Aboriginal people should be employed to participate in making organisational structural changes, to challenge the status quo and for addressing where ideological and theoretical differences can be developed and implemented. Real change will not happen if Aboriginal people are employed merely as an adjunct to maintaining the status quo or to make slight adaptations that continue to perpetuate white race privilege, domination, re-traumatisation and continued colonisation of Aboriginal peoples. If the health services and systems only ever employ Aboriginal people who fit into the frameworks of whiteness and never challenge or question, then some cosmetic changes will occur and some minor improvements but the entrenched situation will remain. Aboriginal people will continue to be re-traumatised, disempowered and our health status will remain poor.

Aboriginal people all come with a mixed bag of skills, abilities and knowledge whilst still being Aboriginal people. Employers need to be aware whether they want someone who will 'fit in' within their work environment who will organise a NAIDOC display once a year and canvass Aboriginal clients, or whether they want to challenge the way they operate and function, their philosophies and even the core values of their organisation, institution or agency or whether they want to do both.

⁵¹ Dependency according to Trudgen "is poison to the people's dignity, destroying their very soul and in the end, life itself. It is the direct cost of non-recognition by the dominant culture of Yolnu as human beings with human needs, rather than children of some 'lost' culture" (2000:175).

Employers need to question their work and recruitment practices in light of the connections between Aboriginal health improvements, healing, re-traumatisation, self-determination and empowerment and their articulations of wanting to work towards improvements in Aboriginal health or the socio-economic status, housing or employment or some other area.

Sense of Place and Space

What I propose with the use of the words *space* and *place* in this context, is that a site itself could be a place, and an allocated area within a place I have called a space. Areas where a program may do outreach work, create an area within their space for an activity could also be called spaces and all the things that are within that space are important to acceptance of that space. For example, the Women's Health Centre and Bidgerdii Community Health Service and the Mammography Unit are all places. The Accident and Emergency section at the hospital would be a space within the place called the Rockhampton Base Hospital. How I have defined *space* and *place* for the purpose of this thesis may not be reflective of how cultural geographers would utilise the terms. I have encompassed how the women interviewed interpreted *space* and *place*.

It is important to note that space and place are not passive, they act according to Kitchin (1999) as a social text that conveys messages of belonging and exclusion and reproduce power relations within society. There is as MacGregor outlines "complex interrelations between who women are (identities) and the environments in which women live (spaces and places) (2001:342). Miranne and Young (2000) add that it is the aspects of women's identities such as class, race, ethnicity, culture and sexual orientation that add complexity to the interrelationships between women and space and place. Women don't just physically use spaces and places, they interpret, represent, and produce and reproduce space (MacGregor, 2001; McDowell, 1999). The sense of place and space within health services operates within this complex context. Dyck (1995) and Dyck, Lewis and McLafferty (2003)

explore how women manage their physical, social and economic consequences of their illness along with the complex layering of social, economic and political relations that frame women's health.

It is essential to ensure that Aboriginal women feel welcomed, comfortable, secure and culturally safe if Aboriginal women are going to access and utilise health services openly, freely and happily, and in an informed and empowered manner. This is also outlined in Kirk et al. (1998:20) in the research they did focusing on Aboriginal and Torres Strait Islander Women and cervical cancer in Queensland and in research undertaken focusing on breast cancer screening, diagnosis, treatment and care for Aboriginal and Torres Strait Islander women in Queensland, Kirk et. al. (2000:32). If Aboriginal women do not have a connection to a place as a site or a space within a place, then they will not utilise that health service or they may do so only with a great deal of effort, angst and energy.

Aboriginal women want to see evidence that they are part of the space and places that are called health services. Planners and designers of health spaces and health places need to give consideration to how people access spaces and places culturally. Weisman explains that, "design is a reflection of prevailing social, political and economic values and is often symbolic of the place that each individual holds in society" (1992:10). If Aboriginal women are not part of the design process they are reflected within the social, political and economic values by their absence. There is a symbolic representation of the place that Aboriginal women hold within that community. Aboriginal women are represented as voiceless, marginalised and powerless. The buildings may end up looking beautiful, have all the latest equipment and room for staff and clients but are in fact unsuitable for certain groups, including Aboriginal women. Sharon gave one example. She explained that when Queensland Health developed their new Community and Public Health complex in Bolsover Street, Rockhampton and opened it in 1998, they placed the Aboriginal Health Program "in the back room". Aboriginal people entering the building had to generally ask a non-Indigenous person at the new complex's large reception desk

where to go to get to Aboriginal Health or where they wanted to go, if they needed help. In addition as it was in a highly public area, people could see who was going in and out. Aboriginal people had to walk into and through the building out the back to access the Aboriginal Health Program. As Sharon said, “Murries ... they’d rather just come to somewhere where they can walk straight up into you”. What happened as a result of the move into the new building was a large reduction in the number of Aboriginal people accessing the Aboriginal Health Program. A decision was then made by District Health Service management that the old Aboriginal Health Program premises would be renovated and that the Aboriginal Health Program would move back where it became ‘business as usual’. I acknowledge the work of the District Health Service in addressing the problem. I would argue that it was not about what people were used to, or even a flat refusal to accept change, rather it was issues associated with place and space. Helen emphasises this when she is referring to the new buildings being built in the hospital grounds, the new Community and Public Health Building along with other new health services being built. It’s “no good putting up big buildings, I’d rather go to Amy’s tin shed”. Amy’s tin shed was in fact the site of the Bidgerdii Community Health Service’s premises prior to September, 2000, when Bidgerdii operated from a modified and renovated shed at the rear of another business in Bolsover Street, Rockhampton. Amy is Amy Lester, the Chief Executive Officer of Bidgerdii.

In discussing her sense of place and space, Kay was quite particular about her needs. In Chapter 6, I discussed her views on the Mammography Unit and the Women’s Health Centre. Kay was uncomfortable about accessing the Women’s Health Centre due to the feelings within the place and the spaces within the centre. Her feelings of discomfort were around not having a connection with the place as an Aboriginal women’s space. Other women also expressed discomfort with the Women’s Health Centre. Mary commented that it was “culturally uncomfortable”. There were differing comments regarding the Mammography Unit around space and place. Some women utilised the service and others did not. There was an increased level of comfort for some, who utilised strategies for increasing comfort levels. References

were made by several women as to whether or not a health service undertakes any effort in making a place reflect Aboriginal women and Aboriginal people. It can be viewed as an attempt to recognise Aboriginal women and as valuing of aspects of Aboriginality. It fosters greater inclusion than if there were nothing pertaining to Aboriginal women or Aboriginal people in that place at all. If there is nothing within a place that reflects Aboriginal women then it can be viewed that Aboriginal women are not valued and not wanted. If the place in total creates this feeling then as the interview responses demonstrate women will not access those services.

What cannot be mistaken is that just because a women's space is for women that it is appropriate for all women. As several Aboriginal women highlighted the Women's Health Centre is obviously a place for women, but for 'white women'. There is little if anything for some that identifies Aboriginal women to the place. Kay explained that "it's not an Aboriginal woman's space, the design of the space, it is a totally white designed space. There is nothing that identifies me to that place. I just won't go there as a client because I don't feel they cater for me as a black woman". Kay does not get a sense of belonging or identification with the place. The identity, meaning and power are constructed and bounded by space and place in a way that does not create this for Kay (Olsen, 1995).

What the centre failed to do was make sure the space also caters for Aboriginal women, as they missed including Aboriginal women in the design and decoration of the building, its renovation (2000) and then the re-location (2002). What is clear is that spaces can be recognised as gender-specific spaces and as non-Aboriginal spaces. In this, non-Indigenous people can be ignorant of the way spaces can be privileging to themselves and disadvantaging to others. Spaces reflect the historical, political, social and economic values, and power relations of broader society. Women's spaces also reflect these aspects. In this way, they can continue to constrain, rather than improve the health of Aboriginal women. The only way this can be changed is if Aboriginal women are involved in designing, developing, production and operation of women's spaces and Aboriginal people are involved in

the spaces for *all* people. Furthermore, if Aboriginal people are valued as contributing to broader society, racism and power relations are challenged.

Aboriginal women interviewed talked in ways about spaces and places that implied that they felt less able, not able or intimidated. If Aboriginal women feel that that space is not for them, they will not go there. At times, it may take a lot of courage to enter a space which you know has not included you in any shape or form yet tells you through one leaflet that it wants to provide a service for you or that it has some program money that 'your community' or 'your organisation' might be able to use. Thus you end up entering the building with the feeling that you are only there in a sense to see what 'they are willing to hand out'.

In looking at what is important in a sense of space and within place, and what makes Aboriginal women feel good about space and place, some had concrete suggestions: Julie said, "I like a bright happy place, I don't like dark green or nothing on the walls ... I like to see Aboriginal paintings on the walls". Aboriginal identified spaces including government agencies that are specific to Aboriginal people, generally have a range of Aboriginal artworks and/or posters on the walls that portray Aboriginal imagery. When the choice is made available to Aboriginal organisations and their staff to paint office walls, I have noted that blues and earth tones have generally been favoured. For example, the new Queensland Health hospital at Woorabinda is painted throughout in earth, water and sky tones selected by the staff. The Woorabinda Hospital is reflective of the Aboriginal community in which it sits. It is not painted in the older often seen clinical colours of pale green, blue, grey or off-white.

Linda stated in reference to places, "make it a place that Murri women want to use it and be comfortable to use it, lay out of the place, Murri staff, not that you're the only one, liaise with Murri organisations". Other women suggested that there needed to be leaflets around, easily accessible information and posters on health issues. However, it is not that simple as laying down brochures and leaflets and any old

posters. As Kirk et al. (2000) found through their research with Aboriginal and Torres Strait Islander women in the area of breast cancer, the women “in all of the study sites (across Queensland) felt that the generic mainstream materials were not always appropriate, did not catch the attention of Indigenous women, or were not seen as relevant to them” (2000:4). The health education materials were criticised for not using plain English, which is imperative for people who speak English as a second or third language or people with who have a limited education in western systems. The women who were part of their study wanted to be involved with development of educational programs (2000:4). Kirk et al. also asserted that, a “cost-effective method of developing appropriate materials would be to develop a basic format to which communities could provide input. Local education materials, such as artwork and banners, are one way of disseminating health education messages” (2000:4). Care needs to be taken too, Trudgen explains that lots of money has been spent on posters and charts, books, leaflets and videos that at times “tell simple stories about highly complex issues. But [Aboriginal people] demand highly intellectual information for complex issues, just as ‘English’ thinking people do”. Just because people may have difficulty with English or with health terminology does not mean that people cannot understand issues if placed in an appropriate context. This allows for the appropriation of the new medical and health knowledge in ways that give Aboriginal women more control and the ability to become masters of one more aspect of their lives. It is Aboriginal women who need to be involved in the processes of working out the best way to convey messages and the contexts. In other words ‘simple English’ does not translate to Aboriginal women having ‘simple minds’.

The Women’s Health Centre and other organisations could incorporate a process of decision-making, planning and implementation that involved Aboriginal women in a leaflet and materials for Aboriginal women. Aboriginal women could utilise their own words, meanings and symbols for the services or agencies and what was available by them. This would increase visibility and meaning for Aboriginal women and also recognise that Aboriginal women’s needs are also considered important by

those agencies or services too. Aboriginal women could be involved in designing the space and adding what Aboriginal women see as a form of identification to place. This, of course, would need to be followed up with what happens inside the place and within the spaces in that place.

The physical layout of the place and the use of spaces needs to be discussed, planned and then implemented. One suggestion was that health personnel should have smaller chairs and the clients bigger chairs, making them equal, not as they are at present (health professionals have larger chairs and clients have smaller chairs). Clinical practitioners needed to look at the layouts of their clinical rooms, the positioning of furniture, equipment and information and question themselves around the power dynamics at play within the space. They need to ask what power dynamics are at play that are interfering with their communication with Aboriginal women?

Are there any examples of where women from other cultures and groups can be incorporated within a sense of a woman's place and space and being delivering culturally inclusive health programs? I found little evidence of this in their literature, photographs of the organisation or staff profiles (many available for access through the Internet). I identified one very successful organisation and service operated in Toronto, Canada, *Women's Health in Women's Hands*, which happened to be an anti-racist, pro-choice, and multilingual community health centre. The centre is committed to women of diverse needs and backgrounds and primarily services immigrant and refugee women from the Caribbean, Africa, Latin America and South Asia. The centre is also accessed by Native Canadian women and some poor white Canadians. The centre aims to readdress the "issue of accessibility to healthcare due in part to the cultural, linguistic, racial, gender and class barriers embedded within the health care system" (Johnson, 2000:1). The centre has created a unique model of service delivery for women within the greater Toronto area that recognises and incorporates the understanding that "women's health issues are personal, cultural, social, racial, political as well as medical" (Johnson, 2000:1). I was fortunate to meet several of the women from the Centre at the 2nd International Conference on

Primary Health Care held during 2000 in Melbourne, Australia (Johnson, 2000). While the women did a short presentation, I was able to spend time later discussing their centre further and to view all the materials they had bought with them. I came to understand at that time and in my continued contact with these women and centres in Vancouver and other sites that inclusive spaces and places are not only possible they are do-able and are important contextual practices to successful health care delivery.

What is established is that if thought, time and energy are placed into consideration of how spaces will be used and how places are developed then they can be a successful part of the equation in servicing Aboriginal women. This requires a commitment from management and staff of services, organisations, agencies and departments to see their services more comprehensively than they presently do. It is more than just having the service, it is also how the service is delivered and from what point the service is delivered. Ensuring Aboriginal women are comfortably going to walk through the door or telephone is one step on the pathway of servicing Aboriginal women. Ensuring that the environment is Aboriginal friendly is a step, which I believe, is most overlooked. Enabling the provision of a space or place where Aboriginal women feel confident to walk through the door is a demonstrated inclusive practice. In looking at what is Aboriginal friendly the questions that need to be asked are: What does the health service mean by Aboriginal friendly? How far will it extend? Is it Aboriginal friendly according to the dominant culture's perceptions or according to local Aboriginal women? Services should also be looking out for ways that do not constrain but rather improve and empower Aboriginal women. They are Aboriginal women friendly rather than being sites of culture shock where the dominant culture controls all within that environment.

Towards Empowerment

This section will focus on aspects of what the Aboriginal women interviewed identified to be aspects of empowerment in accessing health services. Aboriginal

women are generally considered to be disempowered within broader Australian society. The processes of colonisation since invasion and the on-going impacts have left Aboriginal women in a disempowered position and have left some with considerable fear of white governments, institutions, services and agencies. Aboriginal women continually find themselves in alien situations where the dominant culture is in control. This includes hospitals, schools, courts, work places, health services and health personnel. More importantly, every time an interaction between an Aboriginal woman and a white health service is experienced as negative this reinforces the fear within Aboriginal women and serves to re-traumatise. Further to this, it can act as a much more complex form of violence, and be like a knife twisting deep within the soul. What needs to be considered here is the amount of energy it requires for some Aboriginal women to enter into a place, which she is fearful of, to face people she is fearful of and to access a service in which she places her trust in a system of which she is fearful. Sometimes the fear can be too great. Sometimes it may not be. Kay, in talking about herself, explains this energy concept, “as an empowered Aboriginal woman accessing those spaces ... sometimes I just don’t have the energy in my spirit. I have to work up to, to have the courage to make the appointment”. Sometimes, she doesn’t have the energy when she is stressed, tired or unwell. She does not have the energy reserves to enter into dominant controlled environments that are ‘non-Aboriginal friendly’ environments. Other women too are fearful. They cannot make an appointment, their level of fear and their level of discomfort is just too great. It may be hard for some to understand this type of fear. It would be hard for most non-Indigenous Australians to comprehend and may be too easily dismissed that “they just don’t want to come in”, “they are not interested”, or “they don’t see their health as important” rather than to have an idea of the complexity that the fear itself is disempowering, debilitating and re-traumatising. The other aspects that then accompany this are the feelings of hopelessness and loss of control.⁵² Trudgen (2000:177-183) identifies that Aboriginal people can suffer from culture shock when accessing services in the

⁵² See Trudgen, 2000:180

domainant culture or offered by the dominant culture staff or health personnel within Aboriginal communities.

Incidences of where Aboriginal women have spoken up or questioned the health system and society in general may provide examples that are both positive and negative responses. Some of the negative stories have resulted in even greater forms of discrimination and racist treatment, almost I argue as a form of resistance to an Aboriginal person raising an issue. At times the penalties can be high for those Aboriginal peoples who resist and who speak up, and who become labelled as unreasonable, trouble makers, aggressors, uneducated, unacceptable, ungrateful and therefore, become excluded from the system by the controllers of the system. I will add that it is both Aboriginal and non-Aboriginal people who participate in the slurring and in the exclusion of Aboriginal people. There are also positive examples to be found where individual Aboriginal women have spoken up and taken on the system with mixed and /or positive outcomes.

Julie, in expressing what Aboriginal women were willing or not willing to accept in terms of health care, suggested that “It’s up to all of us what we’re willing to accept, what we want to change in our lives we all have different priorities”. She explained that,

... sometimes you accept that you are given by the attitudes of those people and you know you’re not going to get any better, because they are not going to treat you any better ... sometimes it’s too big to fight, there are times when that doesn’t stop me, there are times when I have a voice.

Julie indicates that she gauges when and the time she will articulate her voice, and when she will not. In this, there is empowerment in making a choice and acting from that position of choice. Some Aboriginal women do not even feel that they can make a choice or that they have a choice to voice and to act on that voice. Julie additionally makes a judgement whether she believes that she can improve the

service by voicing the issues she wishes to raise with the service. She has an understanding of what is involved in her expressing her voice and what actions the service and she may require. On some occasions she explains it is too big a fight, while at other times that does not stop her. At times she is willing to take on the challenge of the 'fight'. I suspect that it too may be tied with her energy level and her spirit in the same way that Kay discussed. Thus sometimes Aboriginal women just don't have the energy and even on some occasions needed to build up to even making an appointment with an agency, while at other times they may not have a problem. Some Aboriginal women who do have a sense of empowerment or a small sense of what personal empowerment is, work very hard at maintaining that level of empowerment and maintaining the level of energy and spiritual strength that accompanies a sense of empowerment. This is what I have come to understand as contributing to making strong Aboriginal women and strong empowered and re-empowered Aboriginal women.

Kay used the word empowered a number of times during her interview. In the later part of her interview she explained to me what empowerment was to her,

... me being proud and able to conquer no matter what it is, conquer and be proud and you look back and say yeah I did that ... I ask my ancestors to be with me, I still feel empowered to even have the courage and understanding to do that now. Other people can empower us but we ourselves are the strongest to empower ourselves that is more exciting ... you have to challenge yourselves, reflect on things, take on changes.

She articulates a sense of connection to her Aboriginality, the capacity to take on board new information, insight about oneself, the openness to being challenged and to have an understanding about what you did and be proud of what you did no matter how small. She uses the word 'conquer' in reference to dealing with an issue, winning and doing something and feeling proud that she did it. The word conquer is a word of battle, used to describe overcoming something. As we know from her interview Kay has worked to overcome her fears of the health system. She has

experienced what it is like to be the victim and she herself articulated that she doesn't want to be the victim when she enters a relationship with a health professional. She has come to an understanding within herself of what she expects from others in accessing a health service. She is an Aboriginal woman with a sense of her own individual empowerment, is aware of how she can be disempowered systemically and within a space that does not encompass her as an Aboriginal woman. This can over time be hard to live with and means that there is a constant dialogue within one's self of encouraging one's self, facing fear and empowering one's self. As we get older this process may become easier and some of the interviewees demonstrated this within their interviews. Linda in particular addresses the age question, she explains that,

... as you get older and know your way around a bit more, you then start to stand on your own two feet and ask questions ... things have changed and particularly the way women are treated ... come back to you a lot ...what you want and what you don't want ... In Aboriginal medical services there is a philosophy there of recognising you as an Aboriginal person and things that may be contentious are dealt with ... personalities in a Murri context, warriors take things on themselves ... they become frustrated pretty quickly, as there are people who are laid back about things (not warriors).

Linda addresses a number of issues when she discussed empowerment such as age, how individuals are, the philosophy of recognising and encompassing Aboriginality and that some Aboriginal people are what are called warriors. Warriors raise problems and questions that need to be addressed and articulate their needs and wants along with advocating for other Aboriginal people. Once again, the naming of someone a 'warrior' is about the individual. As Linda pointed out, we cannot be a warrior and be too fearful to ever use our voice or the other gifts you may have in battle, such as writing or mobilising people and organisations. Linda also identified that Aboriginal warriors become frustrated quickly due to other people who are 'laid back' about things. That is, by those people who are not warriors along with systems and society in general. I sensed some of this frustration in Linda during her

interview. A sense of frustration was present also among some of the other Aboriginal women interviewees.

I would name Linda a warrior, I would also name Kay a warrior and I have heard people, both Aboriginal and non-Indigenous people, use the term to describe these two women. Turning to Kay now, who states that,

... what has helped me is being educated, if I hadn't started that western education system when I was 30 ... I understand the intricacies of the western system ... when you understand the theories and methodologies ... you understand them, what must happen ...

As she explained, she is able to talk and act using western frameworks. She is also able to express what she needs as an Aboriginal woman. Kay knows her “own cultural needs as a black woman” and is able to identify where the western frameworks let her down or do not encompass her as an Aboriginal woman. At times she said she is able to raise these issues “for white people” as are other Aboriginal women. There is also a paradox here for it is education which Kay identifies as having given her the words and skills to talk back to systems and yet it is also education which has let Aboriginal people down in the past and which still has limits. Pamela Croft (2003) states that, “many Aboriginal people today are increasingly interested in both being empowered in terms of the western world and in retaining and rebuilding Aboriginal identity as a primary identity” (2003:72). She is advocating for a strengthening of Aboriginal identity as well as increased strength and confidence within the western world, the white world. Kay and Croft’s words offer a lived Aboriginal woman’s context to the work of Martin Nakata (1997, 1998a,b) and his research on Indigenous peoples ‘talking back’.

Kay is consciously aware of where she and Aboriginal women sit within the world as she sees it, “I want the white system to understand that we are not part of the white centre, we are on the fringe, we have not been included into that centre, and we won’t until the white system sees that”. By articulating issues around who is in

the centre and who is not, Kay was not advocating that Aboriginal people should just be accommodated and embraced without the centre changing. When Kay refers to the white centre, she included all areas of society including the health, education and employment arenas.

Kay identified that for her, being empowered meant placing “yourself anywhere and even though you still feel fears, you know immediately how you can conquer them, you can make yourself relaxed, take control, take whatever comes”. Kay said that as an Aboriginal woman “you don’t ever lose fear when you are other, and we’ll always be other, when we are the only black one in with all the white people”. In this she said it is important to have your “mind, heart, spirit and physical body open to new challenges, any of those four areas” because “asking questions, that’s how I am empowering myself”. Linda too, made a statement based on standing “on your own two feet” and “ask [ing] questions” that can be set within this context. What is described is very much a process of empowering oneself. Kay has discussed education, taking control and being very much aware of oneself with the process of what is happening around you and within you. She touched on issues around identity and explaining that even if you don’t know your Nation, know what it means to be an Aboriginal person. She describes what is very much a process.

As indicated in the interviews with Aboriginal women, we can empower ourselves as individuals, each other as Aboriginal women and other people can empower us as Aboriginal women through the processes associated with health policy development, implementation, service delivery, evaluations, organisational memberships, staff profiles within organisations and institutions, the way the organisation or institution presents itself through its sites and service environments and the anti-racist and inclusion strategies it works hard to engage.

Some Aboriginal women such as Kay and Linda have their own sense of being empowered and recognise this within themselves and within other Aboriginal women. Other Aboriginal women give inspiration and encouragement to one another

and recognise what it is to be empowered within one another. Sometimes it can be a combination of other Aboriginal women, Aboriginal men, or an Aboriginal organisation that has been instrumental in bringing about empowerment or further empowerment for Aboriginal women. What has been highlighted in the interviews is that some services made Aboriginal women feel better and more empowered about accessing them as services than others. Some services had an impact on people's lives in ways that lead to negative consequences, limiting choices while others lead to more empowering outcomes and actions for individual women and their circles. We can see this almost as ripples in a pond.

Aboriginal women cannot and will not become empowered if we keep being spoken to, being spoken for and spoken about. It is through Aboriginal women's voices being heard and being acted upon that Aboriginal women will become empowered. There must be processes in place, which foster confidence building, education and true inclusion and not tokenism. Thus for Aboriginal women to become more empowered in health services and health interactions, Aboriginal women's voices must be heard. The dominant culture's attitudes towards us need to change, it is the dominant culture who needs to adapt, cope and communicate in ways that are Aboriginal friendly and who must build change within staffing bases, structures and policies to meet this form of working. Aboriginal women's participation and inclusion must be part of any changes to health policy, development and services delivery. If we are to become the sovereign, empowered Aboriginal women that we once were, this is vital!

Conclusion

This Chapter has outlined what can be done by health services to offer more empowering structures and processes to Aboriginal women within the Rockhampton area. Aboriginal women explored within their interviews what they saw as important in building stronger and more empowering relationships between themselves and health service providers. Some of the Aboriginal women also

identified for themselves what they could do as service providers within health and other areas for Aboriginal women. It was the first time that some had ever articulated what they thought could happen. This brought about new learning and the giving of voice to their ideas offered an empowering experience for them as Aboriginal women. All women were thankful of the interview experience.

The information and suggestions provided by the Aboriginal women is underpinned by my own experiences as well as data gathered from the literature. The information and suggestions made by Aboriginal women, my personal experiences and the information from the data are grouped into themes. These themes include the basic elements of what can be done, Cross-Cultural Awareness Training within the health sector drawing particularly on the public sector and employment of Aboriginal peoples within government, institutions and organisations and environments. The Chapter concludes with a sector which I have titled 'Empowered'. This section encompasses what Aboriginal women interviewed identified as being central to making them feel good as Aboriginal women. That is, those things which assist them in making decisions and which empower them from what they described as being empowering.

I end this chapter with the following quote,

When empowering programs are implemented the people will not just create the interventions necessary to avoid or minimise contact with these diseases. They will also adopt overall healthier lifestyles and become more responsible for their own health. By adding modern knowledge to their cultural base they lay the foundation for easier appropriation of other new medical knowledge. And perhaps most significantly of all, regain a degree of control over their lives, becoming masters of one more aspect of their contemporary living environment (Trudgen, 2000:249).

Chapter 8

**“...and this is what I’ve decided to tell you after
everything I’ve already shared...”**

Introduction

This research has explored how Aboriginal women in the Rockhampton region view health services aimed at servicing women. The focus of the research came after discussions with Aboriginal women and the suggestions that were put forward. The process of the research was additionally developed in consultation with Aboriginal women and other Aboriginal researchers along with ethics documents prepared by Aboriginal peoples and literature drawn from a range of disciplines. I did not set out to do a PhD based on my own personal curiosity or question. This study has lead me on a research journey, it has additionally lead Aboriginal women whom I have networked, interviewed and discussed issues with, on a research journey. This project has been an exploration of Aboriginal women’s lived experiences when accessing health services in the Rockhampton Region. As a process, it enabled Aboriginal women to articulate what they see as empowering practices in health service provision for Aboriginal women.

In this Chapter, I draw conclusions from the information presented throughout the thesis. It also includes a postscript, which will contain some of the lessons that I have experienced in the internal and external landscapes of my research Pathway. The purpose of the postscript is to assist the many Aboriginal women and men who may follow after me in the research journey, on their own Pathways. For non-Indigenous people, I hope it may assist them to further understand some of our research dilemmas as Indigenous peoples undertaking research within higher education institutions.

Research Highlights

In exploring women's perceptions and experiences of health services, a number of issues surfaced. These included body image, white race privilege, privacy and confidentiality, identity and concepts around empowerment.

This research has:

exposed the lived experiences of some Aboriginal women living in the
Rockhampton Region when accessing health services
explored with Aboriginal women ways that these health services can be more
empowering for individual Aboriginal women
enabled Aboriginal women to individually articulate what are empowering
practices for Aboriginal women in the Rockhampton Region
enabled Aboriginal women to discuss ways of improving health
service provision through the articulation of empowering practices
demonstrated a workable research model for use with Indigenous peoples
demonstrated Indigenous processes of collaboration and consultation
demonstrated Aboriginal women's ways of working individually and
at times in small circles within a research process

Some of the research findings were:

* Aboriginal women will not utilise a specific health service or access a health worker if that health service or health worker makes her feel uncomfortable about her Aboriginality or if her Aboriginality is denied or not considered.

* If health services wish to improve their targets and outcomes for Aboriginal women they need to consider practices that affirm, acknowledge and value Aboriginality.

* If health services wish to improve health outcomes for Aboriginal women they need to work in ways that bring about empowerment for Aboriginal women as Aboriginal women which includes empowerment connected to Aboriginality.

* Aboriginality, health and empowerment are integrally linked.

* When Aboriginal women's Aboriginality is recognised, and their health issues are addressed, it assists the processes of Aboriginal women's re-empowerment as the sovereign women in this continent recently named Australia.

Aboriginal women use a variety of health services, including Aboriginal specific services, broader community health services and woman specific health services. Access is based on a decision making process where Aboriginal women consider the reason for access and where is best to access based on issues of racism and white race privilege, comfortability, their body, colour, individual staff members, familiarity, and the physical place and space of the health service. Aboriginal women vary in their experiences of health services but share some commonalities of issues around access. Several of these also appear in the literature in depth or are briefly touched upon and were revealed within this research.

Some individuals (whether they are individual health professionals, community members, bureaucrats, academics or politicians) find individual empowered, self-determining and self-managing Aboriginal peoples a threat. The 'some people' that I am referring to here is both non-Indigenous and Indigenous people articulating colonial and neo-colonial thoughts about Aboriginal peoples. The most fundamental issue which impacts on Aboriginal women's health and Aboriginal peoples is that non-Indigenous Australians need to come to terms with the way they occupy their positioning in Australia.

Suggested Strategies

I offer the following suggestions for all health services to consider when contemplating the provision of services to women and in particular Aboriginal women.

Extend beyond Aboriginal and Torres Strait Islander Cross-Cultural Awareness Training to Anti-Racism Training and addressing White Race Privilege.

Employ Aboriginal women in women's services and in health services.

Employ Aboriginal women who have the knowledge, skills and abilities or the capacity to acquire these within a short time frame.

Be conscious when employing Aboriginal women exactly why you are employing Aboriginal women and then recruit appropriately.

Encompass Aboriginal women in the design of broader health and women's spaces and places, that is, in the planning, operations and evaluation of woman centred spaces and places and health service spaces and places.

Encompass Aboriginal women's worldviews, concepts, ideas and knowledge in ways that affirm Aboriginal women as Aboriginal women.

Reflect on the ways that white privilege impacts on Aboriginal women and other women in the health arena and work to combat these impacts.

Encourage all individuals and health services to explore issues of white race privilege and how white race privilege may manifest itself within their practices and health services in ways that advantage some women and disadvantage other women.

These suggestions have arisen from the literature, research process and the articulations of Aboriginal women within the Rockhampton region. These suggestions will be workshopped with health services within the Rockhampton region as to how they can implement more empowering practices to improve the health outcomes for Aboriginal women within the region. This workshopping is still to happen and forms another phase in this research journey.

Background to the Research

To provide a comprehensive context for this research, I needed to examine the historical impacts of colonisation, explore issues of Aboriginality, and ask Who are Aboriginal women? What is this thing called empowerment?, and tie all of this in with an Aboriginal concept of health. I needed to review historical accounts, theories and ideology linked with the history of Australia, Queensland and the Rockhampton Region in relation to Aboriginal women and peoples, past social and health policies, the women's movement, social justice agendas, primary health care frameworks and public policy, together with the emerging theory base of what is termed 'whiteness'. I deliberately sought out literature written by Indigenous peoples, and in particular Aboriginal women. This literature is drawn from a range of sources including locally produced reports, papers, journal articles, copies of presentations, consultancy documents and formalised organisational and governmental reports.

This research arose from the suggestions made by a number of Aboriginal women living in Rockhampton. We discussed what was a Doctor of Philosophy, my background, skills and abilities, along with what would be the most useful project for improving Aboriginal women's health in broad terms. Consultation took place with Aboriginal women within the greater Rockhampton area, other regions and Aboriginal researchers across Australia. I spoke with a range of Aboriginal women and Aboriginal people in this research project. Discussion focused on the issues that have been presented within this thesis and on many other issues, such as, alcoholism, battery and violence, exploitation, memories of the past, worries for the future, for

their grandchildren and their great grandchildren's children. There were within it all echoes of past colonial racism and the new forms of racism. I was conscious that this was also about the world in which I live, think and dream. I became more than aware that I could not remove myself from my own world in order to be a researcher. This research process is attest to that.

I utilised the *Pathway* metaphor put forward by Gregory Cajete to frame the process and the context of this research project. He suggests that the *Path* denotes structure and the *Way* implies process (1994:55). This metaphor lent itself to an external exploration of the literature, university environment and community environments, possible methodologies and all the social, political, historical contexts in which Aboriginal women live within contemporary life in Rockhampton and Australia. After an exploration of the research context further discussion with individuals and groups took place to see whether my understandings gained from the literature were accurate in the lives of Aboriginal women. From here there was a formal process of open ended interviews, where time was spent listening and talking with Aboriginal women as they told me of their experiences of health services and how they felt these could be improved for them as Aboriginal women. In the process of the interviews there was a witnessing of the women's stories and at times the anger and pain that was bound within their stories. The research enabled Aboriginal women to honestly articulate what they see as empowering practices in health service provision for Aboriginal women.

The *Pathway* metaphor also lead to an internal exploration which engaged me in a deeper journey of the Self, understanding what it means to be an Indigenous researcher and facing some of my own issues around education and another level of my Aboriginality. I exit this PhD process different to how I entered, which is within the framework of Cajete's metaphor and within what he suggests is the nature of Indigenous education and learning.

Establishing Myself within the Research

I was more than aware that an opportunity such as this study may be considered a luxury activity, may be a privilege, particularly to Aboriginal peoples, “not as bread, rice or taro”, as I was once told when something is regarded as a privilege. Thus this research and thesis can be seen as ‘not as bread, rice or taro’, not the basics of survival, of community, of life itself. If it is ‘not as bread, rice or taro’, why then am I not ‘out working in the community’, ‘assisting my people’ and ‘working outside the privileged system of the University’. It is a privilege that very few Aboriginal women have and one that at times is not seen to be part of the real world of living. I have experienced the sense of guilt at what has been implied as my ‘selfishness’ and ‘giving in’ further to the sometimes ‘colonising forces of education’. I have also experienced incredible support from those who see the long term gains, the product and process and that I [we] get to learn about the spin offs of being part of such privilege.

I have also experienced being labelled as an aggressor, stirrer, troublemaker, agitator, unacceptable and ungrateful and excluded by both Aboriginal and non-Aboriginal people. I am aware and laugh that I and several others in Rockhampton were known for some time as ‘witches’ in relation to health and the ones with the ‘poison pens’ as a result of letters sent to government departments and Ministers of Parliament. I am conscious that when I and other Aboriginal people have resisted and maintained the stance of rights and maintained the positioning of being Aboriginal peoples, tactics have been used by non-Aboriginal people to combat the resistance. The penalties can be high for those Aboriginal peoples who resist Eurocentric thought, the colonial iron law and the false premise that prevents Aboriginal worldviews from being incorporated within the health system and broader society. It is all of this for me that is located alongside what can be considered a ‘privilege’. This is not the same for all Aboriginal people who are engaged in research or within university environments.

I placed myself within the context of this research and I explained how I came to be engaged within a PhD program with the focus on Aboriginal women and issues of empowerment within the Rockhampton region. I provided a brief background of my community engagement and outlined some of my community responsibilities. For the purpose of this research I needed to be clear and open in terms of accessing information in ways that are in accordance with what are public documents, what is not a public document, and gaining permission to use documents needed in the course of the research. I took special care not to use the privilege of any position or my community access. I recognise the trust placed in me by members of the community with the positions I hold and the years of contribution and of being gifted with knowledge. I additionally fully understand the obligations that accompany such trust. At the same time, I am aware of the knowledge I have contributed to over the years and the knowledge with which I have been gifted. I am aware that I am immersed in the field constantly. I and others are forever reading, writing, talking, presenting, speaking with government departments, with ministerial representatives, with local, State and federal government representatives, with policy personnel, with lobby groups, with professional bodies and with agencies and many others regarding the health and well-being of Aboriginal and Torres Strait Islander peoples. This is part of my life, has been and it will continue to be. It is in essence what I am about, what I have been directed to do at this time, what I am asked to do, expected to do, part of my obligations and part of reciprocity for me. This is how it was before the research began, during the research and now after the formal research process has finished. It is this too that I brought to the research.

Aboriginal Women in Rockhampton

The Aboriginal women I interviewed and the focus of this study has gone beyond the definitions and academic arguments of Aboriginality and to present the multidimensional understandings and experiences of Aboriginality. I presented the reader with facets of Aboriginality as they manifest for Aboriginal people and more specifically for Aboriginal women. This included a brief overview of how feminism

relates to Aboriginality and Aboriginal women. In addition I discussed how feminism and the Women's Movement has shaped the Women's Health Movement and where Aboriginal women rest within this Movement. Many historical aspects have impacted on Aboriginal women, including invasion, colonisation, government interventions and social movements such as the Women's Movement. I presented the argument that for any response to Aboriginal women and Aboriginal women's health needs must incorporate Aboriginal women's concepts of Aboriginality. Any response must listen to Aboriginal women.

A number of Aboriginal women interviewed from Rockhampton articulated what they thought and how they felt about women's specific health services within the Rockhampton region. There were numerous statements made by Aboriginal women that clearly indicate that some women's spaces were white women identified and not Aboriginal women identified spaces, despite being labelled as women's spaces. Furthermore, that some of the women workers who work in women's spaces and general health services have the capacity to and do disempower Aboriginal women. The information gained from the interviews supports the argument that generally women's spaces do not see themselves as raced, and in particular white-raced spaces. Chapter 6 concludes with large excerpts from the interview I undertook with an Aboriginal woman I called Kay (all women have been given pseudonyms). Sections of her interview are presented as a case study. I selected Kay's words as they best represent the words of many Aboriginal women I interviewed and because of her level of analysis of her own situation and her variety of experiences and interactions with health services. Kay articulated that the process of providing an interview as part of this project allowed her to be more knowledgeable about herself, her health and that she felt more empowered that she was able to tell her story, have someone listen to her story and have someone acknowledge her story.

I didn't focus on Aboriginal women's health status statistics in Rockhampton, they are as they are elsewhere in Australia, poor in comparison to all Australian women

and directly related to the colonising historical impacts within Australia. Aboriginal women have survived oppression, abuses, colonisation, violence, discrimination and dispossession and the health impacts of these are irrefutable. This was presented within Chapter 4 along with the broader definitions of health. I looked at what Aboriginal peoples understand to be health and well-being and how Aboriginal peoples have been involved in shaping the health agenda for themselves. Aboriginal well-health is connected to empowerment as are broader health ideals and concepts. These were discussed within the framework that Aboriginal women were once empowered, sovereign women within this continent. Aboriginal women in Rockhampton and elsewhere were once strong, healthy women who controlled all facets of their lives. Through colonisation we became disempowered and unhealthy and now have people, governments, researchers and policy writers trying to address the issues or 'fix' us or the system or services. Even this research in one way is exploring one of the ways to address or 'fix' the problem.

In attempts to address the health status of Aboriginal people there have been numerous health policies, particularly since 1989. Chapter 5 asked 'what is health policy?' and came to some conclusions about how such policy relates to Aboriginal women and Aboriginal peoples. I showed how the policies have influenced Aboriginal women's lives over the years. The health policies that have been developed over the years have been based on a historical process and systems which have seen inequity and injustice experienced by Aboriginal peoples. The Australian Constitution which denies Aboriginal women recognition and rights as Australia's Indigenous women, its accompanying laws, legislation and policies and programs have all assisted in perpetuating lies and inaccuracies about Aboriginal women and assisted in maintaining the systems in place that keep Aboriginal women in a position of unequal power. The Australian Constitution is at the heart of the matter almost as an onion, with a centre and many layers, so too is the Constitution with all its associated layers. Health policy and health legislation is tied back to the Constitution which could be said is underpinned by notions of keeping Aboriginal

people in a position of powerlessness. This thesis has argued that great shifts are needed in policy and practice if the present health policies are not to continue to maintain the positioning of Aboriginal peoples and Aboriginal women.

Chapter 7, presented information around themes such as employment of Aboriginal staff, Cross-Cultural Awareness Training, space and place and what Aboriginal women articulated being empowered meant for them. I drew from what Aboriginal women had expressed throughout their interviews along with literature, other examples and my own analysis to demonstrate the themes. This provided a greater interrogation of the information gained from the women than would have been provided if I just utilised the interviews. It is the combining of this interrogation, the information gained from the interviews, my analysis and all the data of the literature from which I can now draw my conclusions.

Women's Services

What then of general women's services? What is the nature of their services and how do they empower Aboriginal women? They fall within this story and within this journey. The sum of who we are as Aboriginal women in Australia today is also about who the health services are today. Aboriginal women have come through a colonial process of invasion, colonisation, settlement and development and are now at varying levels of entrenchment within the capitalist, sexist, classist, racist and distinctly Christian worldview that dominates contemporary Australian society. The policy makers and health services that deliver services to women, may continue to make small gains, sometimes effectively no gains, towards addressing the needs of Aboriginal women. There may continue to be a lack of understanding and at times a seemingly lack of interest in gaining and understanding about Aboriginal women's health issues, and about how the health issues of Aboriginal women relate to the health policy and improvements in Aboriginal health status.

As demonstrated in this thesis, to understand the poor health status of Aboriginal women in Rockhampton today the history of invasion, dispossession, exclusion and neglect must be recognised. The health issues of Aboriginal women must be viewed as the health issues of landless, economically, politically and socially marginalised and dispersed women, of women labelled as marginal, 'Other' and who continue to be held in this position by a range of structures and by the neo-colonialism that persists within Australian society. Any policies, solutions, programs and development in the health arena must be framed according to the overall situation of Aboriginal women and Aboriginal peoples, and take into account the diversity of Aboriginal women and the range of social and environmental situations in which Aboriginal women live. Health services including women's health services need to develop policies that impact on Aboriginal women's lives and they must involve Aboriginal women in this process in ways that empower Aboriginal women.

Health services for women need to explore and address racism within their ideology, services provision and staffing base. Racism accompanied colonialism and Aboriginal women's health status is related to colonisation. Racism still exists in Australia and is in part one of the prime causes of unequal and racially discriminatory provision of funds for health services, lack of health care, insufficient housing, high unemployment, low land ownership, poor sanitation in communities and excess morbidity and mortality, much of it this is preventable. As long as the issues around race and white race privilege remain unresolved and continue to develop in complexity, which I believe they are, then we as Aboriginal women will face difficulties accessing services, including health services for the general population and health services for women. Even if racism ended today, at the minute of you reading this thesis the effects on health for Aboriginal women would persist in part due to the social and economic situation Aboriginal women live within as a result of racism, invasion and colonisation, the on-going colonial practices, elitism, sexism and classism. This is in addition to the denial of Aboriginal rights and the maintenance of the white race privilege order of Australian society. Australia has the

capacity and ability to reduce the serious health problems of Aboriginal women. It (we) can choose to eliminate institutional racism and discrimination that has for well over two centuries been violating Aboriginal women's human rights. I believe we collectively need to be working to decolonise and to develop anti-racist and more inclusive feminist practices. These elements need to be working together to improve health services for Aboriginal women and will not work in isolation from one another.

Questions raised here include where does involvement of Aboriginal women truly happen in this process? Where are the concrete steps of action occurring that will change and are changing practice? Why is there such a heavy reliance on written guidelines, papers, policies and plans rather than on doing? Where does the issue of rights appear and where do such groups, associations and health professionals challenge the positioning of Aboriginal peoples and thus themselves? Within this, if these groups, associations, governments enacted their principles, they would see that they did not have the right to determine what is best for Aboriginal women, what Aboriginal women should do and what Aboriginal women need to have in service delivery. They would see that they should not expect Aboriginal women to accept a predatory set of assumptions and beliefs about Aboriginal health and the world. These are the same assumptions and beliefs that are historically based on an empirical reality and that are generally at times regarded as 'fact'. Groups, associations, health professionals and government officers do not have a role unless within communities they are given this role through decision making processes, determining from the community who and what the role should be, needs to be and will be. In this, the role of non-Indigenous peoples within organisations and bureaucracies is to support what Aboriginal women articulate and to work out how what is articulated can best be resourced and delivered. In other words to incorporate Aboriginal women's views into women's health policy making decisions and programs.

General Conclusions Drawn

It is the right of Aboriginal women and Aboriginal peoples to determine what the provision of a health system will look like for Aboriginal women and Aboriginal people. As such, Aboriginal women and Aboriginal organisations must have a pivotal role in consulting, designing, developing, implementing and evaluation of health services for Aboriginal women and Aboriginal peoples. Women's health services that proclaim that they are for all women in the community must espouse and enact these notions. They must involve Aboriginal women. The challenge rests with predominately non-Indigenous individuals, community organisations and government departments as to how they do this and how they ensure that Indigenous women's participation is not purely rhetorical or tokenistic. Not just featured in a newsletter around NAIDOC or asked to be a guest speaker or part of a group year after year without anything changing. How do organisations that deliver services for women which Aboriginal women may additionally access ensure that Aboriginal women are determining what type of services they receive, how they are received and how effective are they? How do government departments, particularly Queensland Health and community controlled health services which are the largest providers of health services to Aboriginal women ensure that Aboriginal women are part of a formal consultative mechanism for influencing how Aboriginal women's programs will be developed, delivered and evaluated? And that these mechanisms are not just going through the motions of consultation for ticking off that it has been done.

Within the realm of health policy, its development, implementation and evaluation, it seems to be becoming increasingly harder to challenge the language and the processes. The language and processes include words such as equity, social justice, access, participation, involvement and collectivism, cooperation, consortiums and working in partnership. Yet behind the words, under the tongues and carried on the breaths of the speakers, as my grandfather would say, is the same old story of domination and struggle. In the end it is the policy that is determined by governments which is implemented and the governments processes of how they

believe things should happen. At times Aboriginal women and peoples continue in shaping, directing and attempting to manage government responses to Aboriginal people. There is a tendency to be reactive rather than proactive and to make jumps for the monies rather than ask is it ok for us at this time?

The question I ask is will we continue to be ill as a collective of peoples, while our human and cultural rights are denied? I believe the answer is yes. Our rights are slowly being extinguished by the pats on the backs, the career moves, the Ministerial appointments and so forth. Our 'health advancement' is seen as a special effort by governments, policy makers, public servants and health professionals when it is part of a denial of rights, the non-recognition of rights and the oppression of rights. Instead it should be seen as a process of assisting us to achieve our cultural and human rights to health and wellness as Indigenous peoples in the communities in which we live. It can be argued that health policy construed in the existing framework is a form of cultural genocide. In the processes of policymaking, data collection, development, implementation and evaluation of programs, government platforms, enacting Constitutional frameworks there is systemic and institutional violations of our culturally inherent rights as Indigenous peoples. These rights include the expectation that the Aboriginal health and the broader health arena will implement policies that will enact and result in Aboriginal definitions and concepts of health and well-being. Concepts of health and well-being that encapsulate our Aboriginality and us as Aboriginal peoples. Unless the health and well-being issues of Aboriginal peoples are addressed, Aboriginal women's health may not be addressed.

I am in agreement with Aboriginal activist Peter Yu from the Kimberley Land Council when he advocates for regional self-determination (Yu, 1997). Yu proposes that we as Aboriginal peoples must be able to manage our own lives and that this will involve devolution of government. Yu brings to the fore the need for Aboriginal peoples to feel individually and collectively in control of what is happening in their

lives and what is happening in their communities. If people are given more control and more ownership, a greater sense of ‘this is for us’ and ‘this is about us’ can happen, rather than feeling like we are merely jumping through some new governmental hoops again. This change is about slow steady developmental change from the ground up, what we at times call ‘grass roots’. It is not about government policy change, new political platforms or vote winning.

Aboriginal women need to feel individually and collectively in control of health, as, it is determined by Aboriginal women, including, what it means to be an Aboriginal woman. This includes bringing in Aboriginal women at every stage, every level within a program, employing Aboriginal women, conducting Cross-Cultural Awareness Training and Anti-Racism Training for the broader health workforce and addressing white race privilege. Aboriginal women and Aboriginal people must be given greater control and power over processes, organisations and services that are about Aboriginal women and Aboriginal peoples.

There need to be further devolution and letting go of some power and control by government departments, politicians, bureaucrats and policy makers. The legislation, policies, practices and programs that we live by and by which services operate have perpetuated unequal balances of power. They have created and maintained the disempowerment of Aboriginal peoples. The only way to change this is to let some of the power go and to allow Aboriginal individuals and collectives gain a sense of power and control back. In order for policy makers, bureaucrats, managers and politicians to also incorporate the worldviews of Aboriginal peoples, there needs to be a letting go of some of the power that rests within the system. They need to understand that they *can* take a risk and allow us to determine the type of health services we need and manage these according to how we believe things should be managed. I am advocating for more autonomy than we have now within the Indigenous community controlled health sector and for more autonomy to be incorporated within Aboriginal health services delivered by the government sector. I

am advocating for more say, involvement and autonomy within the broader health sector. There has to be the belief that we can do it and not the old stereotypical belief that we need protecting and to be looked after. There needs to be a bit more faith in our abilities, capacity and our humanity as Aboriginal women and as Aboriginal peoples.

In conjunction with the letting go of power, I believe we *all* need to be developing trusting relationships built on respect for one another and responsibility to and for one another within Indigenous communities and then between Indigenous and non-Indigenous groups, organisations and agencies. In order to do this, Indigenous peoples must be allowed to use monies and programs for the healing of trauma and for re-generation (Phillips, 2003:165). Phillips states that

... support must be given in the revival of culture and spirituality for well-being and health, for the development of emotional, mental, physical and spiritual healing tools and strategies that allow people to address and resolve their personal traumas (to be able to live a balanced life in the future), and for the redevelopment of traditional economies of reciprocity for the twenty-first century (2003:166).

We need to be working in collectives where resources and information can be shared, pooled and utilised across communities. I believe that this allows for community access from the whole community. In regards to working between Aboriginal and non-Indigenous people and relationships within the health sector, I believe we need to be avoiding hierarchies and the patron/client relationships of the past and redressing and avoiding some of the power and control attributes. This means we must address the issues around white race privilege, colonisation and decolonisation and domination and control. Non-Indigenous must address their positioning within Australian contemporary society and we as Aboriginal people must address our positioning.

Postscript

This postscript contains some of the lessons, thoughts, feelings, happenings, tears, and laughter that I have experienced in the internal and external landscapes of my research Pathway. I know that there will be many Aboriginal women and men who will follow after me in the research journey, on their Pathways. I hold within my heart, mind and spirit that they will keep within their hearts, minds and spirits the academy's broad methods and approaches, and at the same time be able to construct their research in a way which is in accordance with their Aboriginal worldviews. In stating this I believe that my thesis will be able to assist them in their journey. For non-Indigenous peoples may this section of the thesis provide them with an insight and understanding of some of our research dilemmas as Indigenous peoples undertaking postgraduate studies in higher education institutions. I am hopeful that all of us will see that we can be academically rigorous yet maintain our sense of identity at the same time.

I am not saying anything new as an Indigenous person when I state that we need to ensure that Aboriginal practices, customs and beliefs are protected and safeguarded. Furthermore that we need to ensure the social integrity of Aboriginal peoples and communities at local levels are secure. I have come to even more greatly understand during this PhD research project that if this is not done, we risk further erosion of who Aboriginal peoples are and what we are and our communities. I have heard older people already express this fear. We risk this in coming generations if we do not look at ourselves, and what we need to do. Non-Indigenous people need to also look at themselves and how systems and processes continue to assimilate, integrate and almost consume Aboriginal peoples. This combined with the issue of rights presents as I see it an even greater problem, as rights are often focused on individuals. Rights are not presented as collective rights as Aboriginal peoples have also demanded in the past and what Aboriginal peoples continue to demand.

I accept what educator Martin Nakata explains that we must speak back (1998b:4, 1997). The only way we can speak back is to have the tools with which to speak back and to have the forums in which to speak within. In order to gain some of these tools we need to enter higher education institutions and learn the theories and the knowledges and in order to speak back within higher education institutions, we need to be more than just within them, being within them is not enough. We must be given the space and the opportunities to speak within them. We must be provided with the opportunities for intellectual dialogue with others within academic contexts. Non-Indigenous peoples additionally must provide these opportunities to themselves too for in not engaging with us, they continue to remain distant from the dialogues that we are having with one another as Indigenous peoples aside what they may pick up in a book or via attending a conference. Universities and people within them, including Indigenous peoples need to understand that if we do not interrogate the harmful assumptions and the myths of history, power, unexamined and hidden privilege and the way of the world seen through ethnocentric eyes, then gaining a degree becomes somewhat like a process of forced assimilation by the educational processes. While gaining the tools if we are not mindful we can later become insider traders of the multifaceted nature of oppression. These tools can also if we are not careful additionally oppress each other, and there is evidence of this. We need to also know that we must have the tools that also assist us with the elimination of persistent racist and ethnocentric educational policies, procedures, and practices. The tools can give us an understanding of what we are dealing with but we additionally need other tools for change to dismantle the order that keeps us in 'our place'. As Aboriginal researchers, we need to be more conscious of our choices within these contexts. Within the contexts that I now work, either in paid work or community work, when I am called a witch, a radical, a stirrer or a woman with a 'poison pen', I think of myself as a warrior using ink, my mouth, spirit and mind (encapsulating all that I have learnt about knowledges, theories, practices and processes) as my weapons, my waddie, woomera and spear. They are my artillery in fighting within the struggle for better health for Aboriginal peoples and for a more just society.

I found that as I moved closer to the point of having the PhD completed, I felt a distancing from some non-Indigenous people, particularly some academics. This may be a distorted perception but this is what I experienced. I did contact another Aboriginal woman who has her PhD and was told that she experienced a similar phenomenon. She put it down to the reality that there would be slight shift in power due to the PhD simply being closer to being a reality and the 'equalling up' on paper. I was told to remember that it is only on paper; what happens in reality is different and the next challenge would be to find an academic post *not* in an Indigenous education unit within a university. I will add that some people made assumptions in general discussion that I would get a position within an Indigenous unit and need not worry too much about getting a job. This came from non-Indigenous and Indigenous peoples. (I also know that due to the nature of my PhD, my activism and willingness to challenge, that there will be some Indigenous units who want me and some who will not). I ask how many non-Indigenous postgraduates are provided with these statements or expectations. I believe this is a form of racism and minimising of the skills, abilities and research undertaken by myself and by other Aboriginal postgraduates. Both non-Indigenous and Aboriginal peoples are party to this and need to reflect on what is really being said. We might have the pieces of paper and we might be within institutions but we still do not have any more power nor the capacity to bring about change if we are still marginalised within the places that speak of our marginalisation, education, health, housing, incarceration, employment and death statistics. Aboriginal people are not excluded in participating in this process of marginalisation of other Aboriginal people. Furthermore, the reality exists that I will experience what numerous other Aboriginal PhD graduates have experienced, difficulty in gaining an academic position.

For me I made the choice to go to university and to give up some of the other things that I wanted to accomplish. I feel culturally poorer than I think I should be; I am not talking about money. I know that Aboriginal people around me all talk of how there is not enough time in the day to do everything that needs to be done. There is not enough time to accomplish all that needs to be accomplished. Being within the

university system undertaking a PhD has allowed me to think, yes, it allowed me to sit for some five years struggling financially and trying to do community work, still I was able to think about issues, explore concepts, undertake research and write this thesis. I suffered with stress over the thoughts of being torn between spending time in isolation writing and doing the finalising of the research and between expectations, obligations and social relationship commitments. I became lonely at times and wanted to engage back within community with family and friends in ways that I was used to in Aboriginal process. I give a message to those that follow to be careful of allowing the desire for the PhD or Masters degree to come at the cost of your personal, family and community sense of Self. You will suffer socially and emotionally. You need to build in safeguards and develop a way that you can maintain the benefits of being connected to family and community while participating within the research world of academia. When you feel you are becoming disconnected know that this is unhealthy for us as Aboriginal people. If you continue rather than step back and re-connect, then you will become unhealthy. Be careful of giving up your sense of Self for your research. At times the institutions in which we study force us to make choices between ourselves, family and community, to attain a reward in one section of our lives. Know that this comes at a cost in other areas of our lives. Attaining the reward can come at our cultural and spiritual impoverishment and deprivation. You must ask yourself are you prepared for this? What strategies and supports should I put in place and do I need to have in place before I even begin? What am I prepared to let go of and what am I not prepared to sacrifice? Where are my boundaries? What does my supervisor need to know? What do we need to agree on? Do I want to compartmentalise my life with this research in its own discrete little box or do I want to integrate it in to my life and within the social configuration of the Aboriginal community? The social configuration that made and makes our culture viable.

Any prospective Aboriginal researcher needs to research what it means to be an Aboriginal researcher. This needs to be established because it sets the scene for the research and it entrenches for the researcher a set of premises from which to work.

As a researcher you need to consider all your resources not just the ones within the university, the scholarship or Abstudy, the library and supervisors, but also your social and spiritual resources as an Aboriginal person. Ensure you maintain and utilise these resources to sustain you in the same way you will maintain and utilise the other resources. We must take care not to walk the road to impoverishment while becoming accomplished within the university sector. We must also take care not to walk the road to impoverishment when the individualistic and materialistic elements of Australian contemporary society attempt to entice and seduce us after we graduate. We must understand this struggle and be aware that we can be a part of our own cultural genocide and oppression if we are not careful, reflective and engaged. The choice rests with each of us.

Conclusion

We have survived the most inhumane acts and violations against us as Aboriginal peoples in this country recently named Australia. This is despite others trying in every way (poisoning, murder, starvation and removing children) to make us extinct. We have survived and we aren't going anywhere else nor are the generations that follow. I have used the term warrior several times in this thesis and I know that we as Aboriginal women still need to be warriors, warriors for our health and to gain and enjoy our social, economic, and cultural and spiritual rights. I am acutely aware that we need warriors who are writers, activists, community workers, politicians, government workers, academics and health workers. We also need non-Indigenous warriors to support us, encourage us and walk along side of us in this journey. Non-Indigenous warriors can also challenge the falsehoods of Australian history and are needed to assist other non-Indigenous people to develop an understanding of how the dominant culture is ingrained with prejudices and biases against Aboriginal peoples. Furthermore, grow the understanding that the upholding of the dominant culture and its values maintains the advantage for the dominant culture and the disadvantage of others. Aboriginal women cannot do it all on our own for reasons

outlined in this thesis. I know that it is vital for all of us to be warriors to restore us as the empowered and strong sovereign Aboriginal women that we can be!

This research is one part of my journey. It is also one part of the collective journey of many who are working towards bringing about change in this country recently named Australia. This research represents a unique study set out to listen to the voices of Aboriginal women in Rockhampton and ask what Aboriginal women see as important for health service provision that is aimed at Aboriginal women for Aboriginal women. It adds to the understanding within the Rockhampton health community, and in particular how service providers can enhance their service provision to Aboriginal women, to better meet the needs of Aboriginal women, for improved health outcomes. It has been Aboriginal women who have added to this body of knowledge as to what is empowering for Aboriginal women. It has also been Aboriginal women who have guided the process and were the definers of what was empowering for them as Aboriginal women. It has not been filtered through the lenses of non-Indigenous people, which at times can alter the interpretation of the data. I argue that this research process in itself can therefore be said to have been empowering for the Aboriginal women who participated. I know that it has also been an empowering process for myself.

I conclude with a poem written by Juanita Sherwood, who was working as a Lecturer at the Koori Centre, University of Sydney at the time this thesis was written. I believe it sums up much of my research journey and the research journey of other Indigenous researchers. I additionally believe it sums up some of the feelings expressed by the Aboriginal women participants in my research and maybe the participants in the Indigenous research of Aboriginal peoples. The poem is titled My Research Journey,

I cringe at the texts that disregard and misrepresent my identity

I'm embittered by the data that confounds my notion of social justice

I weep at the reckless abuse of ignorance and power
I reject the consciousness of superiority and prejudice
I reflect on the despair of my brothers and sisters
I rejoice in the empowerment of my people's voices
I dance on the mother as she responds to our growth
I claim my inheritance of resisting oppression
I write my story to counter disbelief and encourage understanding
And I will my story to nurture a place for the safety and respect of our culture
and our
peoples

Sherwood, J. (2001:28)

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What do Aboriginal women in the Rockhampton region see as empowering practices in health service provision and how can health services implement these practices?

Age: , if you don't know for sure, what age do you think you are?

Nation/s:

Community/ies of association:

Roles:

Explain a couple of your experiences with the health system/ health workers?

Do you sense that these were positive or negative experiences?

Explain

What happened?

What were your thoughts?

What were your feelings?

How do you know?

Did they make you feel different?

Do you feel the same way now?

Can you notice a difference in how you felt afterwards?

How did this make you feel generally?

Personally?

Approach to health?

Approach to health issue?

Being an Aboriginal woman?

How did this make you think and feel about being an Aboriginal woman?

Do you think this may be experienced in the same way by other Aboriginal women?

What generally makes you want to take control of your own health as an Aboriginal woman when you use a health service?

Does this happen?

What do you think could happen to change this situation? Or

What do you think could happen to make this situation happen again?

What could health services do to improve their practices?

Do you think you would be involved in assisting them improve if given the opportunity?

What do Aboriginal women in the Rockhampton Region see as empowering practices in health service provision and how can health services implement these practices?

- 1. Your participation is voluntary.
- 2. If at any time you are concerned about my behaviour or questions please tell me straight away. If you are not satisfied with my response you are free to withdraw from the interview. You may additionally speak with Priscilla Iles who is acting as my cultural supervisor in the research process should you not want to tell me directly.
- 3. You are free to withdraw from the process of this research at any time.
- 4. I respect your right to confidentiality.
- 5. If I wish to report on your ideas or examples of good practices, I will get your permission and reference you. That is only if you agree to allow me to recognise you personally. If permission is not given to recognise your ideas I will make reference only to an interviewee.
- 6. I will provide you with a copy of you transcript (what you have said when it is typed up) before I use any of the transcript for the purposes of the research project. You will have the opportunity at this time to correct the transcript or to say "ok" to what you have said. I would like you to let me know your best mailing address for me to send you the transcript. If you wish me to mail it, let me know how I can get your transcript to you. The package with the transcript will be marked confidential.

Address: _____

7. Do you wish to be involved in on going work with the research project? Yes/ No (Like workshops, discussion circles)

8. You understand what I have outlined with regards to this research and you involvement? Yes/ No

Name: _____ Signature: _____

Date: _____

Thank you for your involvement in this research.
Bronwyn Fredericks