Australian Aboriginal women’s health: reflecting on the past and present

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Abstract
Aboriginal women collectively have the poorest health of any other group of women in Australian society. Aboriginal women live this day to day reality and understand that we are not the remnants of part of our history but the sum of our history. This article presents in a case study format one in-depth interview of an Aboriginal woman’s (Kay) experiences of the health system, past and present. Kay’s words resonate some of the experiences of the other 19 Aboriginal women who participated in a research project involving in-depth, semi-structure, face-to-face interviews in a participatory-action research process. Kay’s words offer an understanding of the sociological and psychology of the health system in the historical context and the on-going impacts on everyday life.

Introduction

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)

Kay’s words give us an understanding of the reality for many Aboriginal women. Her words outline how this reality can become 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, and is explored within this paper.
Aboriginal women such as Kay who live within the Rockhampton area of the Central Queensland region were interviewed as part of a research project exploring ‘how the relationship between health services and Aboriginal women can be more empowering from the viewpoints of Aboriginal women?’ The assumption underpinning this study was that empowering and re-empowering practices for Aboriginal women can lead to improved health outcomes. The focus of the study arose from discussions with Aboriginal women in the community as to what they wanted me, another Aboriginal woman, to investigate as part of a formal research project. The terms empowering and re-empowering were raised through these early exploratory discussions. They were later discussed during the interviews. Re-empowerment was discussed from the viewpoint that Aboriginal women were once empowered as sovereign women who had control of all aspects of their lives. Aboriginal women became disempowered as a result of colonisation and thus the term re-empowering was discussed and agreed upon.

The ethics process included presentations before an Indigenous inter-agency meeting of over 50 representatives from community organisations and Indigenous work units; an Aboriginal women’s meeting; and an individual organisation that was recognised as having specific responsibility for women’s issues. This was in addition to the university ethics process. A panel of supervisors oversaw the project, including an Aboriginal woman recognised for her long-term involvement in Aboriginal women’s activism. She was nominated by other Aboriginal women in the community as the appropriate person to be a cultural supervisor and to assist in any cultural dilemmas. She worked with the other two supervisors who additionally provided specific research roles within the university environment. Twenty Aboriginal women participated in in-depth semi-structured, face-to-face interviews in a participatory-action research process, which incorporated the principles of an Indigenous methodology as put forward by Rigney and decolonising concepts asserted by Smith. In addition the process drew heavily from the field of ethnography. Ethnographic data collection as understood from the writings of Creswell can include documents, observations and interviewing. These were all tasks that were undertaken in this project. The benefits of ethnography allow for interviewees to provide ‘rich and quotable material’, and ‘enable them to give their opinions in full on more complex topics’. Moreover, it allows for concepts of reciprocity and reactivity to be enacted within the research process and for the researcher to be immersed in the day-to-day lives of the members of the research group. For me as a member of the Rockhampton Aboriginal and Torres Strait Islander community this was imperative.

It is important to note that this research process was developed in consultation with Aboriginal women in the community and through discussion with other Indigenous researchers in Australia and overseas. Research processes were sought and discussed that would not only be academically...
rigorous but that would not perpetuate further disempowerment and marginalisation for the Aboriginal women involved and the Aboriginal women in the community. The interviews that resulted presented a powerful insight into the lives of Aboriginal women, past and present. The insight and information gained is valuable in contributing to a deeper understanding of the past and present interactions between Aboriginal women and health services. One of those interviews is presented within this paper.

A background of Aboriginal women’s health past and present is presented before the interview with Kay to provide a backdrop to the changes within Aboriginal women’s lives. The interview with Kay provides a present-day reality of the lives that Aboriginal women and Aboriginal people face as a result of history. Her story demonstrates how colonisation, discrimination and racism have been enacted at the coalface of everyday life. Furthermore that life today for many Aboriginal women is lived as colonised peoples who continue to be subjected to racism and kept impoverished by policies and behaviours that have their origins in history.

**Aboriginal women’s health: past**

Prior to 1788, Aboriginal Australian women generally had a relatively good lifestyle and generally good health**, and Thomson claims that when Australia was invaded in 1788, Aboriginal Australians were ‘physically, socially and emotionally healthier than most Europeans of that time’**. This is additionally stated in other sources.**

The information relating to pre-invasion health of Aboriginal peoples, including women 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**. Phillip, Australia’s first Governor’s view of the land mass, is outlined in Stone** 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**. There are many other similar accounts from historical records.**

The National Aboriginal and Torres Strait Islander Health Council (NATSIHC)** and Franklin and White** 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.** What can be established
is that Aboriginal women were of generally good health prior to invasion and the subsequent colonisation.

Colonisation had a profound impact on Australia’s Aboriginal women. 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. 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’. It was thought that separating children from their families and giving them to white families, white missionaries and white institutions would make them white. Documents of the early 20th Century reveal the belief that Australian Aboriginal peoples would be exterminated or assimilated as time went by and that these policies were in everyone’s (including Aboriginal peoples) best interests.

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’. 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’. The destruction that began in 1788 continues to impact on Aboriginal people’s lives, cultures and health and wellbeing today. Aboriginal peoples also know the impact that the history of colonisation has had on them and what it means in terms of health status. As is evident from Kay’s statement, Aboriginal women know what this health status means in terms of the lived reality.

**Aboriginal women’s health: present**
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’. 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. 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 outlines that three out of every four deaths among Indigenous Australians now result from either 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. 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 (30). 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 (31). Aboriginal and Torres Strait Islander women are dramatically less healthy than Australian women and Australian people.

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 (32). What is alarming for Aboriginal women is that there are still higher rates of stillbirth, neo-natal and post-natal deaths accompanied by low birth weights of their children (33). 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’ (34). The average birth weight for an Aboriginal child is 3140g compared with an Australian average of 3349g (35). 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) (36). While 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 birth weights 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 (the site of the Aboriginal women’s study), which focuses on education for young pregnant women and girls and provides support during pregnancy, birthing and after the new baby is born (37).
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 (38). 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 (2002)(39).

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. The Aboriginal women who participated in the study in Rockhampton were conscious of the reality of a shortened life expectancy in comparison to non-Indigenous women.

What can be ascertained is that Australian Aboriginal women experience greater incidence and levels of illness throughout their lifetimes and that 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 HealthInfonet suggests that, ‘the disparity between Indigenous and non-Indigenous health, at least measured by mortality, has widened in recent years’ (40). 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’ (41).

Kay’s story: lived experiences
Kay is an Aboriginal woman and at the time of the interview Kay was 46 years old. 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.

I have selected parts of Kay’s story to feature in more of a case study approach to demonstrate a range of issues connected with Aboriginal
women’s health past and present. Kay’s story contains many of highlights the complexity of some Aboriginal women’s lives and how they try to deal with historical and present day issues, and how they might choose to move to a position of empowerment. Kay told me at the time of interview that she was still continuing this journey.

**Significant events in Kay’s life**

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 gallstones ... 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 in reflecting on this experience, ‘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 ...’.

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 of the past 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 the other Aboriginal women I interviewed 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.

**Trauma connected to the medical system**

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’ (42). What was additionally revealed during the interview was that it was a medical 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. Phillips explains that a range of people, including health professionals carried out questionable practices and ‘operated in concert to suppress local Aboriginal sovereignty, steal their lands, and destroy their languages, cultures and social cohesion’ (43). These are broadly documented. (44). Phillips 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’ (45). The removal of Kay from her mother as a
six-year old girl by a medical practitioner produced such trauma and has left unresolved issues. Kay has what could be described as ‘soul wounds’ (42).

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 wellbeing 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 wellbeing 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’. In accessing services Kay says ‘I still put myself there even though ...’ and ‘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. What Kay also gives an understanding of is that Aboriginal people can’t just get over the past, or move on. Past events and experiences are powerfully active in Kay’s life as they are in other Aboriginal people’s lives. The past is ever present in interactions with other Aboriginal people and with non-Indigenous peoples in the way they interact and interpret Aboriginal people.

**Reflections on the health system and reality of life**

In her discussion around accessing health services, she described how she accessed some of the Aboriginal specific services. 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 ...’. She identified the Aboriginal and Torres Strait Islander health service as 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’.

In her interview Kay referred to the ancestors throughout, linking the past to the present and to the future. Kay revealed that she is very much aware of her life span issues and her past health problems. She stated, ‘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’. Kay 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 paper is evidence of her awareness and her sense of reality. I am not suggesting here that Kay or any of the other Aboriginal women that were interviewed as part of the research project that was undertaken 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 paper in which she compares herself to that of non-Indigenous people and a number of women in the study stated their aspirations of being grannies (grandmothers) and watching their children and grandchildren grow.

**Women centred health services**

In undertaking a study exploring 'how the relationship between health services and Aboriginal women can be more empowering from the viewpoints of Aboriginal women?' I did ask Aboriginal women about women’s centred services. It needs recognising that women specific services have historically evolved through advocacy and strategic action by women along with policies by governments (46). It should not be assumed however, that Aboriginal women have been part of the long-term advocacy, strategic action, design, operation or clients of women centred health spaces, merely due to being the same gender (47). Kay’s words in relation to a specific women’s service show a disconnection from the place and service that is specifically designed for 'women'.

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 that particular service 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.

Kay raised some powerful concepts and a high level of analysis when discussing 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 within a range of health arenas. One needs to wonder if this is a remanent of the cultural tourism that Europeans use to partake in when they visited ‘the colonies’ years ago. It is also known that there were medical practitioners, medical anthropologists and other health professionals who additionally undertook such activities.

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...it’s 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 meaningfults 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. In this too the hold of historically held stereotypes may also be maintaining a strong hold.

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 (48). 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 (49). What can be understood is that there is a need for an historical analysis of racism and 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. Assumptions could also be drawn from the explanations that these issues are not limited to women’s centred services, but that they cut across all health services. As both male and female health professionals and health services that cater for the broader population in Australia have arisen and been developed from the same historical context in relation to Aboriginal peoples.

Conclusion
The arrival of the colonists, and the subsequent 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.
What can be ascertained is that the roles of Australian Aboriginal women, men, children, family life and community life, were 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 through the lives of Aboriginal women such as Kay that we are able 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. It is women such as Kay that we are able to gain an understanding in regards to history, sociology, psychology and the health system within this historical context.
References
1. See Fredericks Bronwyn, “Us Speaking about Women’s Health: Aboriginal women’s perceptions and experiences of health, wellbeing, identity, body and health services” (PhD thesis, Central Queensland University, 2003).


7. Ibid.


9. Consultation took place during Indigenous Postgrad ..


12. 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 Saggers & Gray (1991), Thomson (1984) and others support this view.


(1928) (series of articles across same volume, different editions, available at University of Queensland).


17. National Aboriginal and Torres Strait Islander Health Council (NATSIHC) *National Aboriginal and Torres Strait Islander Health Strategy, Consultation Draft* (Canberra: National Aboriginal and Torres Strait Islander Health Council, 2001) p.3.


25. Ibid.


31. Ibid, p.8. 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).


49. Links can be made here to numerous health and human service professions.