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Introduction

The initial aim of this work was to investigate the health status of a minority population in the world for the "Immersion in Community" part of our medical curriculum in the Public Health field.

Little by little, it became much more than a simple academic work; it became a real source of joy and pleasure to report on an outstanding experience and adventure lived with outstanding people; it became an opportunity to express our gratitude towards fantastic people with whom we had the chance to work and to live.

In trying to report as fairly as possible, the data we have been collected, we hope we can make you aware of the situation of a people suffering from one of the worst health problems existing in third-world nations, and shared with us a sense of injustice knowing that these people live in one of the wealthiest nations of the world:

We wish to present to you :
The well-being of the most disadvantaged citizens of a continent:
The Aboriginal People of Australia.

The plan of our discussion is based on the understanding of the different factors that influence their well-being: the psychological and sociological aspects with the cultural and historical issues, and the physical aspect of health with the health system and the health status.

We would be glad to discuss any questions arising from this report and may be contacted at the following e-mail address darwich7@etu.unige.ch or phone number 00 33 4 50 38 68 62.

Vanessa Broughton and Rola Darwiche

Methods:

-How did we get in contact with the local people?

May 2000, we were watching an internet research program: *yahoo* in order to find some contact with Aboriginal People. We simply wrote down *Aboriginal People* and thereby found several web-pages on this subject. Some of them were related to health issues, so we took their e-mail address and telephone numbers and tried to get in contact with about 5 of them in this way:
We introduced ourselves as 2 medical students from Geneva who wanted to investigate the health situation of the Aboriginal People of Australia, and that we wanted to know more about their culture and history.
Jenny Poelina, from KAMCS (Kimberley Aboriginal Medical Council Service), Coordinator of the remote areas, with whom we had a chance to talk, was very delighted to know that we were interested in their culture. After explaining our objectives, she warmly invited us to come to Broome (a small town in Northern Australia) and to meet on the second week of June. There, she would help us with our research and introduce us to some remote communities.

On the 8th of June, we took off from Geneva to Perth, and on the 12th of June, after 3 hours by plane from Perth, we arrived to Broome.
The first day there, we only had an address, KAMCS, and a name, Jenny Poelina. We looked for this place and asked at the reception's desk to see this lady. We met her and from this point our adventure began.
Jenny suggested that we stay in Broome for the first week, in order to explain a bit more of the organisation of the AMS (Aboriginal Medical Service) and prepare us for the weeks ahead where we would go with her to the remote areas to visit several communities using KAMCS's 4 wheel-drive.
-We spent our first week in Broome in a back-packer, a small hotel full of tourists, from where we went to KAMSC by foot, to get us much information as possible on the aboriginal medical health service, to the library or to a bookshop. This first week was interesting in the way that we managed to learn more about the administrative issues of the Health System. Jenny presented us to the other staff of KAMSC: secretaries, chair person, doctors and treasurer with whom we had some discussions about the organisation of the medical service.
The other Aboriginal people we were able to meet during this week were on the streets or in parks and sadly mainly drunk people surrounded by beer cans.
-During the following weeks we went with Jenny to remote areas in aboriginal communities listed as follows. These communities are not open normally to non-aboriginal people and one has to have some sort of permission to enter them. The main condition is to know someone there who can introduce you to the rest

of the community. As we were with Jenny, the Coordinator of the remote areas, we managed to enter them without any difficulties, the other condition, once there, was to respect their traditional rules.(see culture)
Indeed there were traditional aboriginal people in most of the communities we have visited, who still practiced some of their ancestral customs. We could see a difference between them and those of the town. By becoming friends with some of them, we were offered hospitality in their friend's communities. Thus, the last weeks, having personal contacts in this way, we went alone to two communities without Jenny.
-On each week-end, we went back to Broome in order to get some food, oil and other necessary stuff before going back to the outback. There, we could meet some non-aboriginal friends again, such as an anthropologist and lawyers who also helped us in our research.

-How did we gather the information presented in this report?

The materiel presented was researched and collected mainly during the period of our stay in Australia from the 12th of June until the 25th July 2000.
The first week in Broome, we mainly gathered books from KAMCS, from the municipal library and from a bookshop.
The information from the following weeks, was mainly collected in discussions with local people: nurses, doctors, drivers, aboriginal people, anthropologists and lawyers. We also had the chance to get other health reports there on certain communities and a book on aboriginal traditional medicine.
Before and after our stay in Australia, we also sought information: some sources came from the Musée d'Ethnographie de Genève, Switzerland, others from the municipal library of Torquay (England) and others from aboriginal and international websites. All in all, we have tried to present the most recent and complete data which have been available to us.

THE POPULATION

I. Geographic Situation

Communities visited during our stay in Australia
From Perth, we landed in Broome; and from Broome, we visited six remote communities in the Kimberley by car:

1. Broome :

It is a small tourist town with more than 10,000 inhabitants of which 60 % are Aborigines. It is home to the headquarters of the Kimberley Aboriginal Medical Services : KAMSC, as well as other main aboriginal services such as legal, welfare or land council. The Aborigines live in certain districts, in houses allocated by the government. There are several different Aboriginal ethnical groups living all together in the town. One of us lived for two days with an aboriginal family in Broome who had come originally from a community called Beage Be in the North. Broome also became a sort of headquarters where we went back every week-end to buy food and other necessary stuff before returning to an other outback community.

2. Gibb River Communities

a) Imintji

This community is located 227 kilometres from Derby and has a population of about 100 people. Road access is available via the unsealed Gibb River Road which is closed to heavy haulage and small vehicles during the wet season. Otherwise, travel time to Derby (the nearest service centre) is about 3 hours during the dry season. The community has no airstrip.

b) Dodnun

Located 344 kilometres east of Derby and has a population of about 50 people. Road access is once again available via the unsealed Gibb River Road to certain vehicles depending on the season (as mentioned above). Travel time to Derby during the dry season is about 4.5 hours. The community has access to an unsealed airstrip that is located at Mt Elizabeth Station (about 15 kilometres from the community) and is equipped with flares but is subject to closing during and after moderate to heavy rainfall.

c) Kupungarri

Located 306 kilometres east of Derby and has a population of about 90 people. Road access via the unsealed Gibb River Road which is closed to certain vehicles during the wet season. During the dry season, travel time by road to Derby is about 4 hours. The community has its own unsealed all weather airstrip, equipped with flares which may be subject to closing during heavy rainfall. The airstrip is accessible by road and is about 10-15 minutes away from the community during the dry season, since there are two creek crossings along this road, it may become inaccessible during the wet season.

d) Ngallagunda

Located 369 kilometres east of Derby and has a population of about 100 people. Once again, road access is via the unsealed Gibb River Road which can be closed to certain vehicles during the wet season. During the dry season, travel time to Derby is 5 hours. The community is equipped with an unsealed all-

weather airstrip that has flares, and may close during heavy rainfall. As for Kupungarri, the airstrip is accessible in 5-10 minutes by road but may become inaccessible during the wet season due to a creek crossing that may render the road impassable.

3. Bidyadanga:

This community is located 170 kilometres south of Broome (Seacoast) and has an estimated population of about 700 people.

It is accessible by road all year round (travel time to Broome varies between 1.5-2 hours depending on the season) and has an all weather airstrip that permits air access. However, the airstrip is not equipped with lighting and therefore night evacuations by air are impossible. In such circumstances, people are evacuated by road. Often evacuations are 'Half ways' in which the patient is driven half way by the Community Clinic Ambulance and is met by a St John Ambulance half way between Bidyadanga and Broome.

4. Djarinjin:

This community is located approximately 200 kilometres north from Broome in the Dampier Peninsula, has an estimated population of 100 people.

Also a traditional community that hasn’t been displaced by the white colonizers and still perfoms a traditional way of life.
The road access is an unsealed road which can be totally closed during the wet season. Even during the dry season, only very well equipped 4-wheel drive cars can get there. The airstrip is accessible in 5-10 minutes by road but may also become inaccessible during the wet season.

II. Aboriginal population in Australia

The word 'Aborigine' means literally, *the people who were here from the beginning.* In Australia this term refers to the **A**boriginal and **T**orres **S**trait **I**slander people (ATSI) i.e. the Aboriginal people of Australia as well as those that originated from the Torres Strait Islands. This report concerns principally the Aboriginal people of the Kimberley region of Western Australia (yellow region of the map).

Since the end of World War II, Australia has evolved into a multicultural society with a current population of about 18 million people. Between 250,000 to 500,000 of this population is of Aboriginal or Torres Strait Islander descent (the exact figures are unknown due to problems with the census), corresponding to 2.2-2.5% of the total Australian population.
The distribution of these people Australia wide is given below:

State	% of total population
New South Wales (NSW)	28% (68,660)
Victoria (Vic)	6% (16,200)
Queensland (Qld)	27% (76,600)
South Australia (SA)	6% (15,800)
Tasmania (Tas)	3% (8,700)
Western Australia (WA)	16% (40,100) ??
Northern Territory* (NT)	16% (40,100) ??

*NT has the highest proportion of Aboriginal people among its population (26%).

It is also worth noting that the Aboriginal population in 1996 was younger than the non-Aboriginal population (in 1996: 40% of Aboriginal people were under 15 years of age compared to 21% of non-Aboriginal people. Only 2.6% being 65+ years of age compared to 12% in the non-Aboriginal population).

The Kimberley Aboriginal Population :
The population and its distribution

Based on estimates compiled by the Australian Bureau of Statistics (ABS), the Health Department of Western-Australia (WA), the Education Department of WA, Centrelink and the Aboriginal Medical Services of the Kimberley, the Aboriginal population of the Kimberley on the 30th of June 1996 was taken to be about 14 600, with a projected population of 15 500 in mid 1999. The largest proportion of this population is thought to live in the Broome area, followed by Derby and Halls Creek.

This population is fairly young: about half of the population is under 20 years of age and rapidly growing with births outnumbering deaths. The number of males and females is quite similar. However, data from the ABS has shown that there is a tendency for populations of the more remote communities to have a larger proportion of older people whereas those in the towns have a smaller proportion.

III. History:

It is impossible to consider the present plight in term of health, employment, education, living conditions and self-esteem without an understanding of the social and political history of Australia. What is happening now is largely due to what has happened in the past.

1. Before the Colonisation: 1788

The origins of the first Australians is not clearly defined. It is believed that they came to Australia some 50 000 years ago.
At this time Australia was joined to Papua New Guinea in the north and to Tasmania in the south and people were able to move over this land bridge into Australia, populating the fertile coastal regions and then the inland. They may have also travelled great distances by sea from Asia. At the end of the last Ice Age (some 15 000 years ago), the drowning of the land masses between Australia and Papua New Guinea lead to the disappearance of areas of land that were once home to several Aboriginal groups in the north,
north-east, and north-west of Australia.

Archaeological evidence has shown that the Aboriginal people that lived during these times mastered the land, developed social organizations, adapted refined technology, controlled plant growth, utilized scarce resources, and evolved a highly complex religious explanation for relationships between themselves and the land. Ethnographic evidence shows that there were once 600 to 700 political units that shared a common language/dialect. Families that originated from one common ancestor formed clans that were reunited from time to time in order to perform important ceremonies, arrange marriages, and settle any disputes.

The exact date of arrival of the first visitors to Australia is not known, however, contact with the people of Papua New Guinea dates back thousands of years. The following is a list in date order of visitors:

• It is believed that Cheng Ho, a great Chinese admiral of the Ming Dynasty may have landed in what is now known as Darwin in 1432.

• In 1606 the Dutch explored the northern, western and southern Australian coasts but were unimpressed by what they saw. They left some names on the Australian map but did not lay claim to any land being dissuaded by their initial encounters with the Aborigines. Willem de Vlamingh ordered some land surveys on the western coast in 1697, but when confronted with the Aborigines quickly withdrew.

• In 1769 Captain James Cook takes possession of the eastern part of Australia in the name of King George III, declaring the country was unoccupied and unowned (terra nullius) despite the presence of the Aboriginal people.

• On the 18th of January 1788, the first fleet of ships from England sailed into Botany Bay bringing with them convicts, marine guards and the officers that were sent to govern them. The 26th of January marked the proclamation of a new British colony.

• For a period of about 200 years just after the end of the 19th century, many Macassans came each year from Sulewesi with their fishing prows. Their visits have been well documented in Aboriginal art and stories and some of their words are used in a few of the Aboriginal languages. The Australian government put an end to these visits in 1907 because of their threat to English pearling interests.

2. The colonisation

The story began on the 26th August 1768 when Lieutenant James Cook in the name of King George III of England was preparing to undertake a journey of exploration as commander of the Endeavor. His assignment was to sail into the Pacific Ocean to see if he could discover the Southern Continent now know as Australia. His orders instructed him: *"to proceed to the southward in order to make discovery of the Continent in the Latitude 40 degree(…) and with the Consent of the Natives to take possession of Convenient Situations in the [Southern Continent] in the Name of the King of Great Britain; or if you find the Country uninhabited take Possession for His Majesty by setting up Proper Marks and Inscriptions, as first discoverers and possessors." (Beaglehole,1955,pp514)*

Prior to sailing from England a number of enlightened people predicted that if Cook discovered and claimed any lands for the British Empire, that this would usurp the natural rights of any *'natives*' who lived there. In particular James Douglas, Earl of Morton, president of the Royal Society of London advised him that any *'natives'* he would meet were the *'natural and in the strictest sense of the word, the legal possessors of the several regions they inhabit."*

James Cook had the task in front of him of deciding if the land was occupied by a race of people or not. He had to determine whether they simply occupied the land or if they owned it. It involved establishing whether the people had a form of government; whether they lived in towns or villages that were connected by a system of roads or carriage ways and whether they 'tilled' the soil and grew crops. A lack of these signs would be interpreted to mean that the people were simply occupants.

After his arrival at Botany Bay, Cook described them later as: "*far more happier than we Europeans; being wholly unacquainted, not only with the superfluous by the necessary Conveniences so much sought after in Europe, they are happy in not knowing the use of them. They live in a Tranquillity which is not disturb'd by the Inequality of Condition: The Earth and sea of their own accord furnishes them with all things necessary for life; they covet not Magnificent Houses, Household stuff etc they live in a warm and fine Climate and enjoy a very wholesome Air; so that they have little need of Clothing and this they seem to be fully sensible of for many to whom we gave Cloth etc to, left it carelessly up on the Sea beach and in the woods as a thing they had no manner of use for. In short they seem'd to set no value upon anything of their own for any one article could we offer them this in my opinion argues that they think themselves provided with all the necessary's of Life and that they have no superfluities.* (…)

From the appearance of these People we expected that they would have opposed our landing but as we approach'd the Shore they all made off and left us in peaceable possession of as much of the Island as served our purpose."

He had made his assessment: the people were a "*primitive race"* as evidenced by a lack of towns, connecting roads, a form of government and no evidence of the growing of crops. They were "*happy occupant"*, that couldn't "*be the legal possessors of the several regions they inhabit."*

If the great explorer and navigator did claim the continent in the name of the King (as his journal testifies), he did so on the basis that no other country had laid claim to the east coast. However he certainly usurped his instructions *to take possession with the consent of the natives. "After landing I went upon the highest hill (…) South down to this place I am confident was never seen or visited by any European before us, and Notwithstanding I have in the Name of His Majesty taken possession of several places upon this coast, I now once more hoisted English Coulers (sic) and in the Name of His Majesty King George the Third took possession of the whole Eastern Coast from the above Latitude down to this place by the name of New South Wales(…)"*

Joseph Banks had described the lifestyle, food, weapons and other details of the Aborigines of Stingray Bay (the original name given to Botany Bay). In one part he philosophized about 'the human condition' : *I almost said happy people, (who are) content with little nay almost nothing, Far enough removed from the anxieties attending upon riches, or even the possession of what we Europeans call common necessities: anxieties intended maybe by Providence to counterbalance the pleasure arising from the Possession (sic) of wish'd for attainments, consequently increasing with increasing wealth, and in some measure keeping up the balance of happiness between the rich and the poor. From them appear how small are the real wants of human nature, which we Europeans have increased to an excess which would certainly appear incredible to these people could they be told it. Nor shall we cease to increase them as long as Luxuries can be invented and riches found for the purchase of them; and how soon these Luxuries degenerate into necessaries may be sufficiently evinced by the universal use of strong liquors, Tobacco, spices, Tea &c. &c. In this instance again providence seems to act the part of a leveller (sic), doing much towards putting all ranks into an equal state of wants and consequently of real poverty: the Great and Magnificent want as much and may be more than the middling: they again in proportion more than the inferior: each rank still looking higher than his station but confining itself to a certain point above which it knows not how to wish, not knowing at least perfectly what is there enjoy'd.*

Joseph Banks and James Cook both failed to see that Aboriginal and Torres Strait Islander Australians had a form of government (if a government is a system of decision making by Elders); that they lived in communities that were connected by well established 'routes' (Songlines) and that they fostered the growth of crops through highly developed land management practices. They were a people who had always considered that they owned a particular geographical area of what has become known as tribal land.
But from 1770 to 1992, British and Australian Law denied them this ownership: With the concept of *terra nullius* : the fiction - that the land was empty and belonged to no-one, deprived Aboriginal and Torres Strait Islander people from any legal rights to their land - Misunderstanding or perhaps ignorance of Aboriginal culture was (and always will be) a mitigating factor.

The invasion and occupation of the Australian continent began on the 18th of January 1788 with the arrival of the First Fleet under the command of Captain Arthur Phillip from England sailed into Botany Bay bringing with them convicts, marine guards and the officers that were sent to govern them.
The 26th of January marked the proclamation of a new British colony.
Shortly after the colonization of Australia, clashes began between the Aboriginal clans (the Eora) who lived in the areas bordering the harbour where settlement had began and the newcomers, over food resources, possessions (ex. Spears, baskets, fish nets), and interference with the Aboriginal women.
By March and May of the same year, the Eora were reported as having speared several convicts.

On the 10th of December 1790, Pemulwuy, the first of a series of Aboriginal guerilla leaders, speared the Governor's gamekeeper in retaliation over the crimes that had been committed against the Eora thus marking the beginning of 12 years of guerilla warfare. Pemulwuy, along with guerilla bands fought against the New South Wales Corps until he was killed by two bounty hunters in 1802.

In June 1795 fighting over land also arose between the Dhurak people of the Cumberland Plains (an area beyond Paramatta) and the New South Wales Corps. From 1788 until 1830 the Eora, Dhurak and other coastal people to the north and south of Sydney had their lands taken from them, their warriors and hunters killed, and their families decimated by murder and disease. Thus, until the end of the 19th century the Aboriginal people resisted the occupation of their lands by the British and as a result, each area of white settlement became a battlefield, the Aboriginal people suffered dispossession and what turned out to be almost a genocide.

The Aboriginal population of Australia in 1788 was estimated to be between 500 000 and 1 million people. The arrival of the British and the resulting warfare and diseases that were introduced lead to a rapid decline in the Aboriginal population to fewer than 50 000 in 1901.
From the earliest times the relationship between Aboriginal peoples and non-Aboriginal people was characterised by a lack of understanding from both sides, deceit, cultural imperialism and arrogance from the non-aboriginal and fear from the aboriginal people.

References and Notes:

Beaglehole.J.C: The Journals of Captain James Cook, Vol 1, The Voyage of the Endeavor 1768-1771, Cambridge: Hakluyt Society, 1955. Bennett. Samuel: Australian Discovery and Colonisation, Vol 1 - to 1800; originally published in 1865; fac.ed. by the Currawong Press,1981. Kenny. Tom: In the Footsteps of Captain Cook, J.C.Trenear, Printers, 1979.

3. Evolution of the policies :

The Government policy toward the indigenous people has passed through distinct phases, beginning with a clear policy of **dispossession and colonisation** immediately following the establishment of the European settlement at Port Jackson.

When Phillip arrived in 1788 to establish the penal colony of New South Wales he arrived under orders to "establish friendly relations with the natives". Instead, the colony developed on a basis of active non-recognition of Aboriginal peoples and their rights. The Commonwealth since 1901, continued their legal basis for the establishment and development of the various colonies to be based on the doctrine of Terra Nullius.

When Australia became a Federation of States in 1901, the Constitution decreed that Aborigines and Torres Straight Islanders were not to be counted as citizens. Each State was responsible for these people and as a result they were subjected to different State legislations that restricted their freedom of movement and segregated them from other Australians. A deliberate exclusion of Aboriginal people from active participation in the new nation was indeed undertaken.
One of the first Acts passed by the new Australian Parliament was the *Immigration Restriction Act (1901).* This Act articulated the predominant social policy of the time, the "White Australia Policy". This policy was designed to exclude all non-European and non-British.

During this Federation period, policies were developed under the banner of **protectionism :**
Aboriginal people were herded in to reserves or missions and the entirety of their lives controlled by mission managers and ultimately "protectors" at state level. It was under these policies and later assimilationist policies that **Aboriginal children were forcibly removed from their parents** in a deliberate attempt to destroy and eradicate Aboriginal people - in other words “genocide”. These removed children have become known within Australia, as the "Stolen Generations".

The policies of protection were followed by a policy of **assimilation** that prevailed from the 1930's to the 1960's. This policy, based on 19'th century racial theory held that Aboriginal people ought to be assimilated (in other words “subsumed”) into the general white Australian society. It didn’t take in to consideration any importance of their traditional culture. During this period, and later, an effort was made to hurry up the process of assimilation of the forced removal of Aboriginal children, particularly those of mixed descent.

In 1967, white Australian voters agreed to make an amendment to the Constitution which gave the Aborigines and Torres Straight Islanders Australian citizenship and the right to vote: The principle of Self Determination was developed. Policies based on the recognition of the fundamental rights of Aboriginal people and that these people should be responsible for their own affairs, were put in place. With the birth of the **self determination movement** came the development of Aboriginal Community Controlled Health Services.

These changes included a move from a policy of assimilation (integration of Aboriginal and Torres Strait Islander people into mainstream society), to a policy of self determination.
Self determination or self management has empowered ATSI people to address disadvantages in Aboriginal communities through the establishment and funding of Aboriginal Medical and Health Services, Aboriginal Legal Services and other community organisations such as Aboriginal Land Councils. Self determination has also seen the establishment of a large bureaucracy of State and Commonwealth Public Servants. The initiatives have also resulted in funding for the engagement of anthropologists, solicitors, barristers and consultants to assist Aboriginal organisations. Collectively these people have become known as the Aboriginal Industry.
A most significant change, has been the replacement of traditional Aboriginal management or governance approaches, to a Western model. A change from the management of Aboriginal communities by Elders, to management by bureaucrats, professional people such as Doctors and Nurses, but also by Aboriginal people who have been elected to Management Committees.

Normal establishment difficulties were taking place in a number of Aboriginal organizations. Some abnormal ones were also occurring. At least that was the perception of some people who considered that Aboriginal and other bureaucrats were making decisions that were questionable. In other words the people who were allocating money appeared (to at least some) to be providing funds as favours in a network of cronies and nepotism.

.In 1990, the Aboriginal and Torres Strait Islander Commission (ATSIC) was formed. An organization that held great promise for the implementation of the self-determination policy in which ATSI people would identify and address needs in their communities: needs including those in the areas of health, unemployment and housing. However the credibility of the organization has been dented by a number of investigations. The organization has been found to be at least negligent in not following through on reports that have highlighted mismanagement and fraud in organizations that were funded by ATSIC.
During the 1990's, Australians continued to see and read media reports about Aboriginal disadvantage. *Many Aboriginal people remained living in sub-*

standard conditions; Aboriginal children continued to go blind from trachoma and other eye diseases and suffered respiratory illnesses; Aboriginal babies continued to be born lighter (weight wise) than non-Aboriginal babies; Aboriginal adults continued to have the highest incidents of diseases such as diabetes and cancer; their mortality were known to occur at a much earlier age than non-Aboriginal Australians; alcohol abuse was known to be high; petrol sniffing by young ATSI people was a killer; juvenile offences were high as were incarceration rates of juveniles and adults; unemployment was high in the Aboriginal community and Aborigines were rioting in some country towns.
By 1990 there was an attitude in mainstream society, that ATSI people were lazy no-gooders who were only interested in getting drunk. This was an image that was difficult, if not impossible, to reject and the media rarely (if ever) recorded success stories. Such as those ATSI people who were employed, who had worked all of their life and owned, or were buying, their own homes. Stories of successful outcomes of Aboriginal organizations were rarely publicized: for example, the early detection of cervical and other cancers that saved lives; stories of Aboriginal people (unlike non-Aboriginal Australians), working-for-the-dole instead of simply receiving social benefits and programs of drug and alcohol rehabilitation.

Perhaps because of the lack of publicity of success stories, society was asking the question: *where are all the benefits from all the money being given to ATSI people?* The question appeared in the public domain on 27 November 1995, when the Sydney Morning Herald (Sydney newspaper) published a front page story under the heading: "*Australia $2 billion failure to help Aborigines.*" The opening paragraph of the article stated: *"Aboriginal Australia costs the Federal and State Governments about $2 billion a year. Yet most Aborigines are too sick to go to school, too poorly educated to work and too remote from paying jobs to survive without welfare."* The reporter then wrote: *"After two centuries of white settlement, almost 200 Aboriginal communities are without local medical services; more than 300 have water supplies that fail National Health and Medical Research Council guidelines; more than 250 have no electricity"* and went on to elaborate on both success stories and inadequacies.

The following day, Alicia Larriera (Health Writer for the "SMH"), detailed existing Aboriginal health problems pointing out: *"...Aboriginal communities are expected to prove their needs and to demonstrate on paper why they deserve the health dollars they are asking for."* She also pointed out that Aboriginal Medical Services rarely if ever received the amount of government funding they sought. This was a time when the majority of Australians also expected that the amount of expenditure that had been devoted to improving Aboriginal health, should have solved the problem.

On the 29th the “SMH” published *The Truth about Aboriginal Australia.* The article highlighted Commonwealth funding received and distributed by the Aboriginal and Torres Strait Islander Commission (ATSIC), to Aboriginal organizations. An expenditure of $1,335 million in the 1994-1995 Federal Budget - $803m to ATSIC presumably for administration costs; $292m on Education and Training; $278m on Community Development employment; $83m on Community infrastructure; $80 on Community housing; $68m on Health programs; $40m on housing loans; $34m on Community Youth support and $33m on Law and Justice programs. The article also highlighted criticism that had been levelled at ATSIC including the criticism from Aboriginal people and organizations. Criticism of the organization being a bureaucratic dinosaur, unaccountable, wasteful, full of Aboriginal politicians on the make, remote, biased and ineffective in delivering outcomes.

Following growing media interest and publicity, the Liberal-National Federal Government (under Prime Minister John Howard) reacted by seeking a report from ATSIC. As the Opposition Party, the recently elected Federal Government had promised to ensure greater accountability from Aboriginal organizations. In April 1996, the Minister for Aboriginal and Torres Strait Islander Affairs, Dr John Herron, ordered a report from ATSIC. The organization refused to provide it, citing the order as a government witch-hunt based on racism and discrimination.

This appears to have been a strategy used by ATSIC to delay or perhaps circumvent carrying out the government order. The government reacted by transferring responsibility for the funding of Aboriginal Medical Services from ATSIC to the Commonwealth Department of Human Services and Health. Co-incidentally or otherwise, the Registrar of Aboriginal Corporations then began a systematic auditing of Aboriginal organizations.
From 1996 until the present time, the Registrar has issued hundreds of Section 60 notices requiring Aboriginal organizations to account for deficiencies in providing annual reports and other alleged breaches of the Act - including the keeping of Minutes and a Register of Members. Fourteen such notices were issued in 1998-1999 with a number of external consultants (Accountants or Accountancy firms), completing another 35 Section 60 examinations with another 10 in progress. In the same period, 74 Aboriginal organizations registered under the Aboriginal Councils and Associations Act (1976) went into liquidation and a further 23 had an Administrator appointed. A staggering 276 Aboriginal organizations were deregistered.

-In **1993**, with the self-determination movement:
the concept of **Terra Nullius** was **finally overturned** in the celebrated Mabo Case that established, at least in terms of articulation within Australian law, the concept of Native title.
The **Native Titles** are a response to the fiction of Terra Nullius: they are titles that recognise the fact that Europeans took their land by usurping their natural rights to the land as 'natives'. Still their battle is not won. They must now prove, with claims to the Federal Court all over the Kimberley: that the non-Aborigines were mistaken 200 years ago in regard to their rights.

We had, during our stay, the opportunity of attending a case of one of these native titles at a remote community called Bidyadanga. A group from the Community had to prove (to testify), in front of a judge, that the land is the land of their ancestors, that they still have a strong relation with their land, much stronger than we Europeans could have.
"The land doesn't belong to us, we belong to the land !" Indeed, as we will see further in the culture section, how deeply the land affects the principles of their life.

This case let us think about the major impact on their mental well-being if they lose their land, as it has already been seen in towns : where Aboriginal People have been literally cut from their roots and where they seem torn between both cultures, whereas in the remote areas they seem much happier and more peaceful.

Photo of the Federal Court of Australia in Bidyadanga (in open air)

On the right side : . aboriginal lawyers and anthropologist
. an aboriginal witness of the Karanjari group testifying his traditional way of life
In front : the judge
On the left side : the state and federal government against the sovereignty of the land to the aborigines. (not seen on this photo)

Conclusion:

Self determination has been both a blessing and a curse for ATSI people.
On the positive side, it is a policy that has overturned previous paternalistic treatment of the people: “the 'white' *have the best* approach” and allowed good accomplishments, as we will detail them further. On the negative side, the policy threw ATSI people into management roles in which many floundered due to low or average academic qualifications: a situation that should have been obvious to governments who provided funds to ATSI organizations without providing management training.
In many instances, ATSI people have (and do) complain to the media about instances of fraud, cronyism, favouritism and dubious funding decisions.
Currently, Aborigines and Islanders are making many efforts to demand equal rights with other Australians and a final acknowledgement of all the injustices with which they have been living for 200 years.

References:
Media Monitors Pty Ltd; transcript of Sunday program 31st March 1996, p 1
from an aboriginal web-site : www.ion.unisa.edu.au/ind

4. A Historical Overview of the Kimberley:

The Kimberley was the latest region colonized by the British, as it is evidenced by its wildness. It has few main towns. The only ones we visited were Broome and Derby.

Some of the Communities we visited were forced to move due to poisoning of their water or to other biological substrate of their ecosystem. Others have seen their babies taken away by force as a whole Stolen Generation, displaced from the native territory and placed in Catholic missionaries where they were maltreated, exploited and abused.

Over the 6 communities, four still perform a traditional culture and over the four, two were still very traditional Communities. This capability of still being able to perform their traditions depends on how much they have been forced away from their roots. A general feeling left us thinking that the more the community has the chance of keeping its culture, the more peaceful it appears : less violence and alcohol problem. We noticed that these latter problems appeared specially in towns as Broome or Derby, where the hopeless Aborigines were literally torn between both ways of life : unable to return to their lost land and unable to integrate into the white conformist society. This can also be evidenced by the several drug and alcohol rehabilitation programs (sober-up) we saw rather in towns, than in remote areas.

IV.Culture System:

Contrary to the first description given by Captain Cook as a “primitive race”, the Aboriginal People appear to have a sophisticated, complex and spiritual culture. It has been recognised by scientists as being the oldest one in the world : 60 000 years old.

From 1788, various British Governors attempted to educate and Christianise the Aborigines, aiming to convert them into productive British citizens. Part of the strategy involved the replacement of Aboriginal law with British Law. This began, for example, with the undermining of tribal leadership lore when the Europeans crowned some people as Kings. The people who accepted this title were those who had assisted explorers as guides and generally showed a willingness to adopt the newly introduced culture and lifestyle. Later babies were taken away from their families and placed in Catholic missionaries. However, despite these attempts to break down their culture, the Aborigines resisted, especially those from tribes where the Elders had the opportunity to transmit their knowledge before passing away. After 200 years of struggle, the Aboriginal culture is still alive in some of the remote areas of Australia.
Today many (if not all) traditional Aboriginal people do not accept elected ATSIC or Land Council officials as being their leaders, they retain their traditional leadership lore which empowers Elders with decision making, particularly in matters of culture and heritage.
We had a great opportunity of seeing and talking to surviving traditional people, demonstrating to the Federal High Court of Australia that traditional spirituality is still in the centre of their personal belief system in order to claim back their plain and sacred right to their traditional land.(see History Section : Native Tittles)

The description of the culture as follows, has been mainly reported from what we were told by traditional people and from, what we noticed during our stay, as well as, from literature. It reflects mainly the level of culture of Bidyadanga, the community we lived in for the longest period.
Their culture has to be taken into account every time you wish to understand their behaviour and avoid hurting them as so often happens by unaware health workers. It also has to be acknowledged to understand their deep despair when they are dispossessed from their land and separated from the members of their community.

The parts encircled as this one give concrete examples of the direct implication of culture in the health field.

1. Life cycle :

a) Birth

Let’s start from the beginning, before an Aboriginal child is born :

Generally it is recognised that sexual intercourse is necessary for conception but is not considered to be of major importance : that it is not in itself a prerequisite for childbirth, but merely prepares the way for the entry of a spirit child. The spirit child depends on when a women first realizes she is pregnant in the vicinity of the track of a particular ancestral being (see birth and conception totemism).

The birth used to take place outside the camp in a special shelter assisted by her mother or husband's mother. Nowadays, the birth takes place in the nearest major hospital.

Once born, the life of the community goes on all around the child. Its affection is diffused by a wide range of persons. The baby spends most of its time with his mother, or someone who deputizes for her. She breast-feeds him. Although the mother is especially important at this time, the child is not expected to concentrate its affection on her to the exclusion of others. It learns almost as soon as it is born that there are likely to be substitutes who will nurse it and even feed it, for example women who its mother calls sisters.
Likewise, although the child has a special relationship with its own father, it is not an exclusive relationship. There are other men who will call it “son” or “daughter” and behave towards it much as it own father does.
Up to a certain age the traditional way of life training of children is quite informal. However, during the week, Catholic schools are compulsory. Only on week-ends are they with their elders, They then have the opportunities to learn about their culture. They learn about their kinship system in order to build up their knowledge of the people around them. They learn how to get on with other people, in terms of what it is expected of them and what they themselves can expect from others, as well as the responsibilities they have towards each other. They also learn things more related to the practical issues of living such as Bush-medicine and Bush Food, hunting and fishing.
Pressure towards conformity is exerted on the child from infancy, but before initiation the range of tolerated behaviour is much wider than it will ever be again.

b) Puberty :

- Once they reach puberty, the boys have to go through an initiation ritual.
The Initiation is in fact an introduction to a long series of ceremonies and rituals. A youth, indeed, does not learn all the secrets of his culture at his first initiation. He will learn about it little by little all through his life in series of stages. Initiation merely opens the door to the secret-sacred and esoteric life of the men of his community.
After it, the boy is classified socially as an adult, as such he has to be treated fully as a man.

An interesting anecdote about this "young Man notion":
During our stay, a non-aboriginal nurse, unaware of this cultural aspect, had been strongly criticised by a community as she over showed affection and attention on a young man, considering him as child, without any bad intention. As you will see later many problems occurred and still occur between the health-workers and the communities, due to a lack of understanding of the culture.

- The girls do not have to go through the same kind of formal training and teaching as boys do.
At the first sign of puberty, they are taught songs and myths by old women or instructed as to how they should behave when they marry and so on.

For boys, the process is more complex and more arduous, and there is more to be learnt because, at least, some of them are expected to become not merely active participants but leaders in the religious life of the community, this does involve more in the way of formal learning and teaching.

The difference in role behaviour between the sexes is made clear at the onset of initiation, by the removal from the influence of women, to symbolise the expectation of changes in behaviour over and above the fact of physical change. Initiation is the core of Aboriginal social and cultural life. Among a non-literate society, the knowledge of the society is indeed transmitted through initiation. The kind of knowledge transmitted is kept secret from foreigners.

c) Marriage :

The marriage marks, conventionally, the turning point of adulthood.
In the past, women were expected to marry the man chosen for them, whereas nowadays they may choose among several different potential partners, or in the urban and country communities marriages are left to the individual to choose
Generally, the girls marry much younger than the boys.
Polygamy is a legitimate form of marriage, nevertheless the majority of unions are monogamous. Pre-marital and extra-marital relations shade into each other. As far as we understood, they are not totally banned everywhere.

d) Death :

Unless the victim is a baby, too young to have made much of an impact as a person, death is not simply a family affair. It affects everyone living in the community where it occurs.
Traditionally, the name of a newly dead person can not be spoken. Sometimes, the taboo remains in force for years.

An other anecdote : a non-aboriginal Nurse, named Juliana, whom we had met in a remote community, had to be called Juls after the recent death of a person also called Juliana and we had to be very careful in this matter : not to offend the community.

Except in regard to the very young or the very old, or from the viewpoint of a person deliberately responsible for a killing, the impression given is that any death is unnatural. That it should not have happened, and would not have happened if there had not been any malevolence on the part of another human being.

An important consequence of this belief, that we experienced, is that, for example, if a member of the community dies in a clinic. The Doctor or the Nurse will be fully responsible for their death even though it was a natural death. The community blaming him or her, they will request them to leave.

2. Religion:

a) The Dreamtime:

According to Aboriginal beliefs, life began in the *Dreamtime*. During this period, the world and all that it contained (sky, water, land, animals and plants) was created by beings known as the ancestors. The ancestors were men and women who had the ability to transform themselves into other forms of life (animals, birds and reptiles). They were responsible for every waterway, the land that a tribe occupied and every plant, animal, insect, reptile it contained as well as the sky above and all it contained.
During the Dreamtime the creators had also created men and women. Birth was considered to be the result of actions of the creators whose power was present in the birth of every person and species.

Their *Dreamings* is their link with the *Dreamtime (their ancestors)* : each aboriginal child receives a dreaming name at its birth : for example one can have the Honey Ant Dreaming. He, or she, would be able to bring the dreamtime of their dreaming the Honey Ant back to life by performing certain ceremonies.

If a person loses that link with its ancestors, he or she will lose its soul : This is one explanation of the moral dispossession that has followed the colonization.

The creators were also believed to have taught men and women how to hunt and gather food; how to make spears and utensils. They gave the tribe their laws and instituted their ceremonial life (particularly initiation) and required each generation to perpetuate the Dreamtime by maintaining the status quo.

The Dreamtime resulted in a number of practices by the Aborigines which have been examined as a possible source of the existence of an Aboriginal religion. In particular Aboriginal cosmology and their ceremonial practices.

b) Aboriginal cosmology:

Cosmology is the study of the universe - what it was, what it is now and what it will be in the future. Traditional Aborigines are vitally interested in every-thing in their world.

To survive it was essential for the Aborigines to acquire *"a profound knowledge of the rhythm of their country (and) from early years they learned when the vegetable foods ripened and where they may be gathered; the seasons of the year when the reptiles wake from their winter sleep, when the animals reproduce, and in what places there will be water to drink. The Aborigines developed a calendar, based on the movements of the heavenly bodies, the flowering of certain trees and grasses, the mating calls of the local birds, and the arrival of immigrant ones. All these signs are related to the food-cycles on which their living depended."* (Roberts and Mountford,1965,pp10-11)

Aldo Masso pointed out: *"The appearance of certain stars (indicated) the propitious time to gather certain foods. The arrival of the star we call Arcturus told the Aborigines of the Victorian Mallee the larvae of the wood-ant was in season and called the star Marpeankurrk."* (Massola,1971,pp45)

These authors used objective methods of describing Aboriginal practices. Bruce Chatwin is one person who described Aboriginal cosmology by using religious metaphors: *"To get to grips with the concept of the Dreamtime...you have to understand it was an Aboriginal equivalent of the first two chapters of Genesis - with one significant difference. In Genesis, God first created the living things and then fashioned father Adam from clay. Here in Australia, the Ancestors created themselves from clay, hundreds and thousands of them, one for each totemic species...."* (Chatwin,1987,pp12-13)

c) Beliefs in Gods:

If there is any such thing as an Aboriginal religion there would be evidence of a belief or beliefs in a God or Gods.
The only possible common creator to all Aboriginal tribes, was the Rainbow Serpent or snake. Rainbows are a common phenomenon throughout the country accounting for the presence of such a creator in Aboriginal mythology. This particular creator was associated with water and new life. However, traditional Aboriginal people told recorders that the ancestors were just like us. They were men and women who had the ability to transmute (change) themselves into other forms of nature such as animals, birds and reptiles. For the Aborigines these actions and abilities of the ancestors pointed to mysterious and powerful factors in the world.

In Western Australia the great snake was known by a variety of names, pointing to the difficulty of a common religious association throughout the country.

d) Ceremonies:

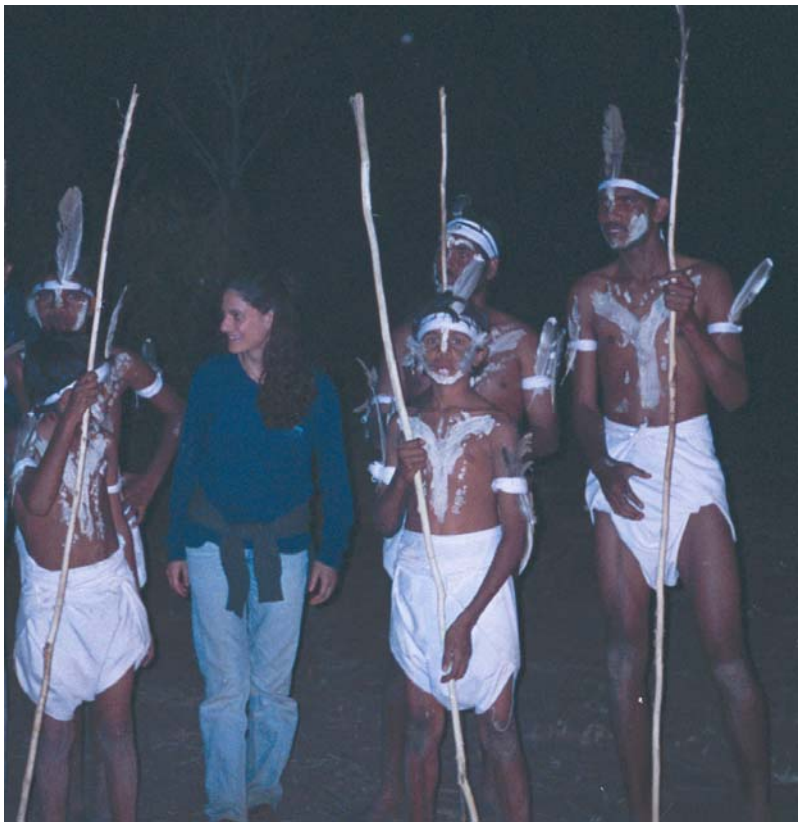
Nowadays, ceremonies are celebrated as a worshipping act to these hero creators :

Corroboree :

These are an important (significant) part of Aboriginal life. In 1836-1837 William Govett (Surveyor) attended a Sydney corroboree. He described it as *"one of those dances"* adding *"a more extraordinary spectacle was never beheld by Europeans"*.
The fact is that corroborees involve music, song and dance that are symbolic and full of meaning for Aboriginal people, because the ritual was instigated during the Dreamtime. and they were full of meaning.
"Meaning is often seen in symbols or symbolically, rather than by explanations. For example there is a conscious awareness that many elements of rites designated things of nature. As a case in point, the rhythmic cries that punctuate dances, chants or songs are meant to simulate the calls of birds, the sounds of surf, tides and streams and the winds; rites are arranged in spatial patterns - in geometric idioms of different combinations of the same elements. Everyone who participates in the rites becomes familiar with them and patterns are incised on bullroarers and other ritual tools." (Stanner,1959-1963,61-61)

During our stay, one of us had the opportunity to attend this ceremony performed once every 50 years by the kharanjari group at Bidyadanga.

Traditional dances around fire



Young people wearing traditional clothes

The old people were not wearing their traditional clothes,
but using the traditional boomerangs as music instruments

Initiation:

A.P. Elkin described initiation as a religious practice: "everywhere in Aboriginal Australia the young male, on approaching or reaching puberty, leaves behind him the interests of childhood. Henceforth, he speaks and thinks more and more as a man. In an unforgettable ceremonial manner, he is taken from the camp and scenes of his irresponsible early years (and) becomes the subject of a series of rites, extending with intervals over several years. The trials that he undergoes and the operations performed on him vary in different parts of the continent. But the general pattern and purpose of the ritual are the same. (Elkin,1997,pp3)

Burial ceremonies:

The people believe in a personal spirit and that the spirit of a deceased person could visit living people and harm them.

After the death of a person, some members of the community come to the hospital with smoking ashes to burn the person's spirit. This is an important act for the aboriginal patients around. It should not be forbidden by the health workers because it assures the aboriginal patients that the spirit has definitely left the area and will not hurt them, even though it could seem unhygienic.

Ceremonial places:

To support the concept of an Aboriginal religion it has been said that ceremonies were conducted at special places (which infers the notion of outdoor churches). It is certain that Aboriginal Australians consider particular geographical areas to be highly significant and sacred. This is evidenced by the way they describe their land as "mother, my country or my spiritual place", but also in the ways they avoid certain areas and use other areas for special purposes.

During our stay, we had to be careful of the places we were walking on.

Conclusion on Religion :

The efforts made from 1788 to Christianise the Aborigines at least exposed them to the tenets of those beliefs. From the 1840s there were concentrated efforts on the part of missionaries to save the Aborigines and many became Christians. However even though if they became Christian, contemporary Aboriginal people still express their beliefs in terms of the Dreamtime, their personal Dreaming and references to spirituality. In particular to having spiritual links with a particular area or belonging place. This is why it so important for us to understand how much the dispossession of their land affects their Self-Esteem and mental Well-being.

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3. Social Organisation and Structure:

a) Family Life

One of the most notable characteristics of Aboriginal people is the strength of their family ties and the awareness of the obligations that they bear towards their family.
The Aboriginal system of kinship is very complex. Among the important relatives of the children are the sisters of their mother who they call 'mother', and their fathers brother's who are known as 'father'. Of particular importance to the boys is the brother of their mother who will later be responsible for their initiation.

b) Tribe:

Aboriginal society is organized in a number of social groups:

Each tribe is made up by *a number of people* who speak the same language, believe in the same Dreamtime origin stories (religion) and celebrate the same cultural practices such as initiation, as well as by a *smaller social units* that live in specific geographical areas who are called bands, clans, sub-tribes and family groups.

Totemism or Relationship system :

The word “totem” is an American Indian term that Europeans adopted to explain the relationship system (Totemism) in Australian Aboriginal tribes. Overall the system is best understood by a dictionary definition of the word.
Totemism is *the use of totems (emblems or image of an animal or bird) to distinguish groups of people in terms of tribes, clans or families.*
Scientists generally agree that there were six forms of Totemism. Overall the system provides answers to existential questions such as: Who am I? and Where do I belong?
On a practical level, Totemism formed individuals into social groups and dictated obligations in regards to teaching , initiation, marriage, ceremonial life and death.

Local Totemism links each person to a specific geographical area.

In this case, people share a common totem by virtue of their association with a particular site, or locality (rather than on the basis of kin relationship or of descent.)
The 'conception' theory states that during the creation period, the ancestors create spirits of every living creature. Birth of men and women is believed to be the result of a *spirit-child* entering a woman's body (not during the sexual intercourse).
Each individual is linked to the place where his or her mother was believed to have become pregnant. This may have happened when a woman is visiting an area or within the area she lived. When a woman becomes pregnant she may have 'remembered' where this happened, or the circumstances, e.g.., a snake may have crossed her path. Either her husband or an Elder decides where the spirit-child entered her body.

Clan Totemism is closely associated with local Totemism.

The system identifies each person with a particular social group : clans, bands, sub-tribes and family groups, that live in a specific geographical area. It establishes ritual ties to a particular area : the people who are linked to the same social group have a number of 'legal' rights relevant to rituals, sacred objects and stories associated with their Dreaming Place.

Individual or personal Totemism :

Every person is involved in a special relationship with some natural species. The relationship is a personal one, not usually shared or inherited. Each person has to protect the natural species of his own totem.

Sex Totemism divides the whole tribe into two groups:

Male and female, each has their own totem. This division implies to a certain extent a solidarity in one sex as distinct from the other. This distinction results in the separation of male and female ceremonies and what has euphemistically been called “men's and women's business”.

Some good examples experienced on the direct implication of this sex totemism in the health field are: - women Doctors are not allowed to talk about sexual diseases with a man or to examine his sexual organ… (reciprocally for the male Doctor with women)

- as far as health promotion is concerned, each sex receives a different leaflet about AIDS for example : one blue for the men, one pink for the women.

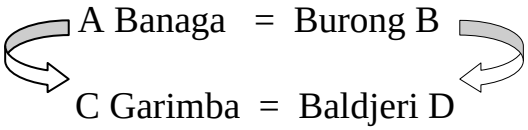
Moeity Totemism also divides the tribe into two intermarrying groups - let's call them A and B. (matrilineal or patrilineal sytems)

A	Banaga = Burong	B
A1		B1
A2		B2
A3		B3

People from group A can not marry people from the same group. However, each marriage moiety is subdivided into a number of smaller divisions. Let's call them A1, A2, A3 and B1,B2,B3.
Again, people who belong to the same moiety or sub-section, could not marry each other. The Aborigines identify these groups by totemic names based on Dreamtime creation beliefs. They 'express' their totemic names, using the names of animals, birds, reptiles and other species or phenomenon. So the marriage moieties are identified (say) as Red Kangaroo, Mullet. Using these totems it has been that Red Kangaroo people married Goanna; Black Snake married Lizard; Bull-frog married Mullet.
This may sound a bit strange, but when understood in the context of the stories, it makes sense. Indeed, an examination of these relationships reveals some underlying 'logic' about them. For example Red Kangaroos hop on the ground and Goanna move on the ground; Bull-frogs and Mullet both live in water. On the other hand Goannas and Black Snakes also live on the ground but they are not companions, in fact, they could be said to be enemies.

The fact that each person, in a blood-line relationship, has a different totem prevents the marriage of fathers and their daughters, mothers their sons, sisters their brothers, or other close cousins.

The following example is a section system that comes from around Broome and Bidydanga (communities we have been working in) :



The sign = connects intermarrying sections.
The arrow sign connects the sections of mother and child
If A, a Banaga man, marries B, a Burong woman, then the children will be Baldjeri and so on. A's mother is C, B's mother is D, A's father is D, B's father is C. The father's section is not significant in regard to descent. A person's section or subsection, depends on their mother's, but is not the same as hers. It is called indirectly matrilinieal.
The ideal choice is that A marries B and so on; but an alternative choice may be C marries B then generation levels are out of alignment.

An other significant point is the distribution of kin among the 4 sections :
If we take the above pattern, that is, a person A marries B and the children are D, category A would include the person himself and his siblings, B would include his wife and her siblings. C would include his mother and her sibling, B's father, D's husband and or wife as the case might be. D would include not only his own children, but his father and father's siblings.

4. Law

According to the ways of the Aborigines, it is the Ancestors that determined the laws governing the rights and responsibilities of all things in the land that they had created. These laws were encoded in the stories about the Dreamtime and were handed down from generation to generation in the form of dance, music, and art of the religious ceremonies. They are also passed on in the form of oral tradition by the different guardians of those traditions who had gained access to them as initiates.

Whenever a dispute arises the senior members of the community investigate the matter to discover the seriousness of the offence. Acts such as killing, sacrilege, incest, adultery, theft, unauthorised physical assault, insult and neglect of kinship obligations are considered as offences that are punishable by law. Once the guilt and gravity of the act has been established, a punishment to which the community is in agreement is fixed. The punishment could range from making compensation over an agreed period or to having to face a squad of spearmen.

Health workers are not allowed to provide health care to the injured who has been punished.

Today in many parts of Australia, the Aboriginal people are often subject to two systems of law, i.e. the Aboriginal law and the Australian system. Unfortunately, punishment under the former system is often considered an offence under the Australian system. For example, an Aborigine who had speared an Aboriginal woman, because the community blames her, is then prosecuted under Australian law.

a) Marriage law :

Every tribe is divided into a number of small social groups, but for marriage purposes, into two main groups called marriage moieties. (see moiety totemism)

b) Punishment:

In some stories involving stealing, murder, elopement or rape, the perpetrators are always punished by being beaten, speared, or through the actions of spirits. Women often threaten their children to stop misbehaving because a Goonge (spirit) might get them.

In some tribes an individual who offended against his tribe is ordered by the Elders to be speared.
This involves holding a person on the ground and spearing them in the upper thigh of one or both legs.

Early colonists often considered Aboriginal punishment to be crude. Yet the Aborigines never tied a person to a triangle or a pole and lash them till their body was converted to a pulverized bloody mess and they never tied people in chains and confined them in the hulks of ships, as Europeans had done.

5. Territory:

Each Aboriginal and Torres Strait Islander tribe considers that their land has been created for them by the ancestors. There were no wars of invasion in which one tribe took over the land of another tribe - because the creation of the land by ancestral spirits was a common belief among all tribes. This means they believed in the involvement of spirits in creation and they were too superstitious to want to conquer another tribe and live in their lands among strange and hostile spirits.

Early scientific investigations of various tribes soon revealed these facts. They also revealed that the boundaries of each tribe's land were well recognized. No doubt this involved demarcation points such as rivers and mountain ranges. However, the exact boundaries are as precise as if they have been identified by a surveyor. Within the territory of a tribe, smaller areas are 'owned' by each sub-tribe (sometimes called clans, hordes and bands etc). In other words, the territory of a tribe is comprised of the territories of all of the sub-tribes. *"It is in fact not generally known that among the Aborigines of this (country), previous to the encroachment of the white man - and at the present day in the remote parts of the country - very exact divisions of territory among the various tribes prevailed. Yet such is the fact."* Reference: The Aborigines of Australia, Roderick J. Flanagan, 1888, pp 45-46

The exact boundaries of each tribe had been established in the Dreamtime. Aboriginal people did not choose their territory and particularly not on the basis of aesthetics. The ancestors had chosen the tribe's land. They had created it and people lived in precisely the same place as their ancestors had. Walking on the land is often considered (even today) to be walking in the footsteps of the ancestors.

6. Tools:

The tools used by the Aboriginal people varied in design:

-*spears* are used to kill animals and as ceremonial objects in clan rituals, (were as weapons of war) thus their designs are based on their purpose and the materials available for their construction. They are sometimes (in parts of the Northern Territory) used in association with a spear thrower or *woomera*, a tool used to increase the force and extent of the spear throw;

-*throwing sticks* are used to stun or kill animals and reptiles and to frighten birds into catching nets;

-*boomerangs* have a similar function to throwing sticks and can be of the returning or non-returning type. They are used for hunting, in ceremonies, to clear grass and soil in order to prepare campsites or ceremonial grounds, to cut up a cooked animal, for digging holes, in fire making, and some serve as sacred objects (were also used as a weapon in wars);

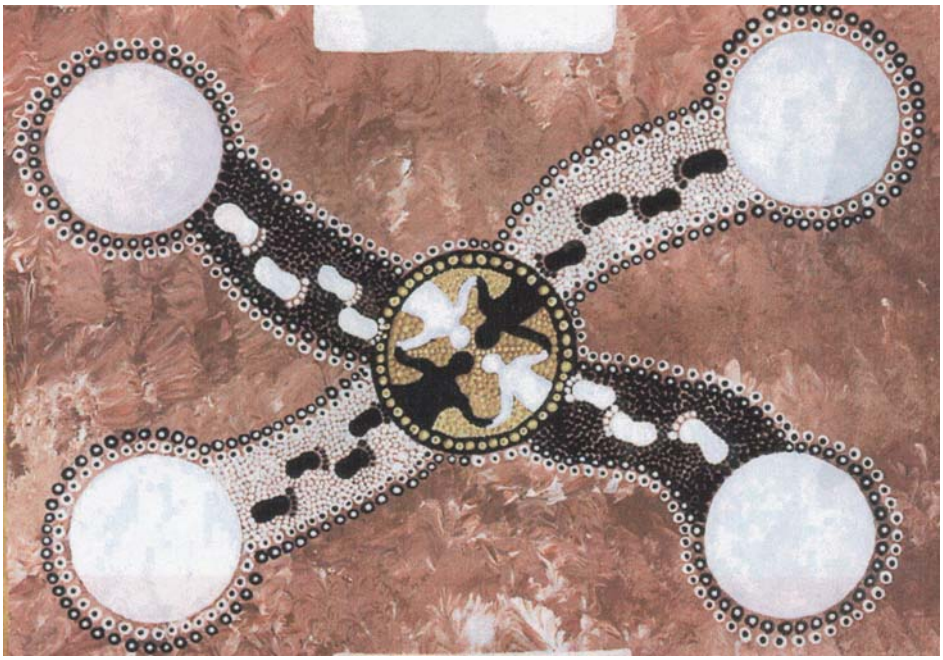
-*digging sticks* are multi purpose tools used by the women.

A man from Bidyadanga fishing with a spear

7. Aboriginal Art:

Around 40 000 years ago Aboriginal Art began with the painting the corpses of the dead with ochre.

Aboriginal and Torres Strait Islander Australians use picturegraph methods of recording important information. They do not have a written language in the sense that they do not have an alphabet. However they do use art as a form of communication or language which they express in a number of different forms such as rock carvings, cave paintings and designs (symbols) cut into trees, wooden articles such as boomerangs and on their bodies (scarification). The symbols, designs and replications of their artwork are not random or for the purpose of amusement or creativity. Their art was in fact 'expressions of their beliefs', their Dreamtime and personal stories (Dreaming) a view of life or, in some cases, records of historical events. Whatever they draw, engrave or paint onto such surfaces as sand, earth, rock, trees or wood, it has deep, significant, meanings. In a broad sense, the term “art” also includes story telling, song, music and dance.
Today many Aboriginal people use artwork to record stories that are relevant to their tribe. But also to their personal life or their Dreaming. The expression 'every painting tells a story' is particularly true about the artwork of the Australian Aborigines.



This painting, made by a tribe as a health promotion’s tool:
explains how Aboriginal people catch HIV and how to prevent it.

Nowadays, beautiful aboriginal Paintings can be sold for expensive prices, which can be a great economic help.

8. Language

Prior to 1788, as many as 270 separate and distinct languages, each with many different dialects (as many as 600 to 700) were spoken in Aboriginal Australia. The Aboriginal languages fall into two broad categories. In the *first category* the words inflect for case, tense and mood as in Latin or Greek, in the *second*, the verb carries information about the person and the number of the subject and the object. The latter type is found only in north-western Australia with the former being found throughout the country. The Aboriginal languages use about 20 different sounds, some used in English and some not at all. The language also has a grammar that permits great flexibility. Studies of the language have not related them to any of the other language families.

Nowadays, at least 50 of the original languages are no longer spoken and this is largely due to the fact that Aborigines were encouraged to abandon their own language for English. For some of the remaining languages, as the last speakers of the language die, so too will their language. There also exists a certain amount of pressure within the Aboriginal communities that pushes the learning of the 'strong' Aboriginal languages leaving the 'weak' languages in peril. There exists about 50 'strong' Aboriginal languages, each of which is the first language of several hundred people and it is generally spoken throughout the day.

The implications in the health field are:
We faced some problems of communication with the Elders of the Kimberley, most of them do not speak an understandable English.

V. Education

A school of an Aboriginal Community on the Gibb Rover Road

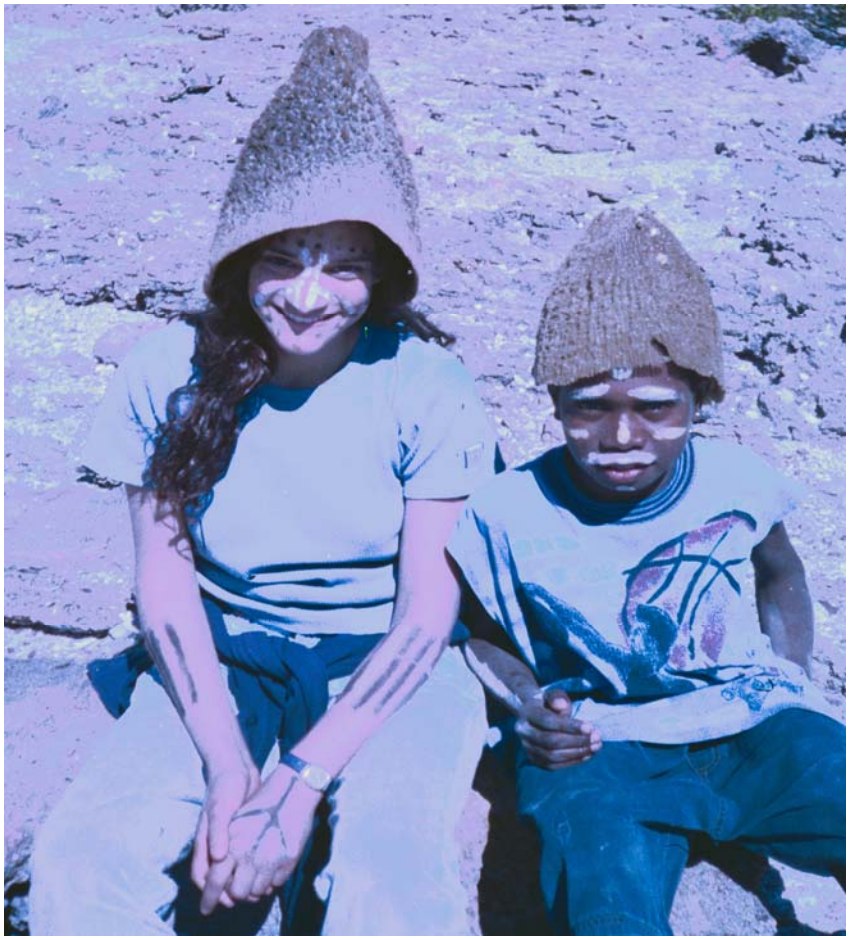
The poor levels of education of the Kimberley Aboriginal people is another factor that contributes to the low incomes and ill health of these people. Only 30% of Aboriginal children attend secondary school and a meagre 1.6% continue with post-secondary education.
This is partly due to:

-the rather strained relationships that exist between non-Aboriginal educators and the Aboriginal communities,
-the need to quit the Kimberley in order to obtain secondary and post-secondary education,
-difficulties in obtaining Abstudy[c] and increases in fees,
-the unfelt need of learning: the children are not encouraged by their parents to go to school and the children do not see the necessity of learning writing and reading (as their culture is based on an oral transmission of the knowledge by songs and dance).

Although, generally aboriginal children are not interested in the "western schools", we have been impressed by their brightness, and their intimate knowledge of the flora and fauna around them: they know the food-chain cycles of each animal and each plant : which one is poisonous, which one is edible, which one can cure; how, and where, they can find water.

[c] Abstudy is a government subsidy allocated to Aboriginal people.

These Children from Bidyadanga, showed us their traditional way of fishing for example here turtles (that runs very fast!), warned us on the dangerous animals, dangerous places to walk on, where to find water in the soil, let us taste some delicious wild fruits…
they had no distrust in strangers, as we were and used to say :
" paint yourself or let us paint you as a black fellow, and follow us".



In Djarindin: an other child, Kassy, carrying a spear, and her mother, Evelyne, showed the Aboriginal traditional way of fishing oyster, mussel, crabs, and other fishes.

An interesting Aboriginal way to kill fishes is to find in the bush a plant that produces a sort of potato-like fruit.

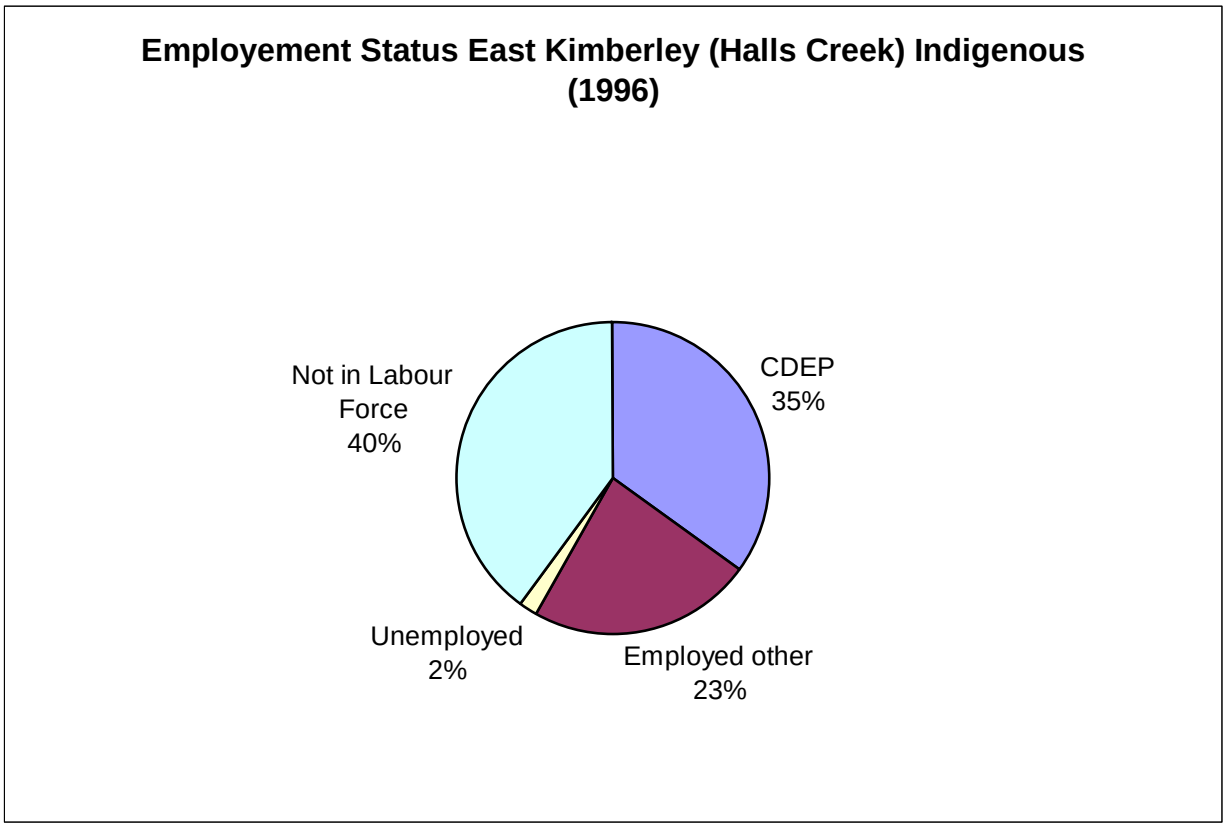
Once we find this “potato”, we gave it to Uncle Andrews, Kassy’s uncle that also became our own uncle (as we have been integrated to their family).

Here Uncle Andrews is rubbing this “potato” against a rock in order to get its juice.
Once the juice is put in the sea, it catches the O2 of the water and kills the fishes. Then, we just had to pick up the dead fishes floating on the water.

In comparison to our western societies, where violence at schools and generally distrust towards strangers is becoming more and more important, where our children are usually just brought up by their own parents and have very little contacts outside the small family unit.
In the remote areas, the Aboriginal children live in a supportive society where each member of the community behaves as a farther and mother towards them, teaching them their traditions and giving them attention and love, they live without the understanding of the word “racism”, and did develop a highly sense of respect towards strangers, as we were.

VI.Employment

These low levels of education contribute to unemployment, since most of the people with formal education in the Kimberley are non-Aboriginal. In addition, other factors such as racial discrimination by employers and the lack of employment opportunities in remote areas also contribute to unemployment.



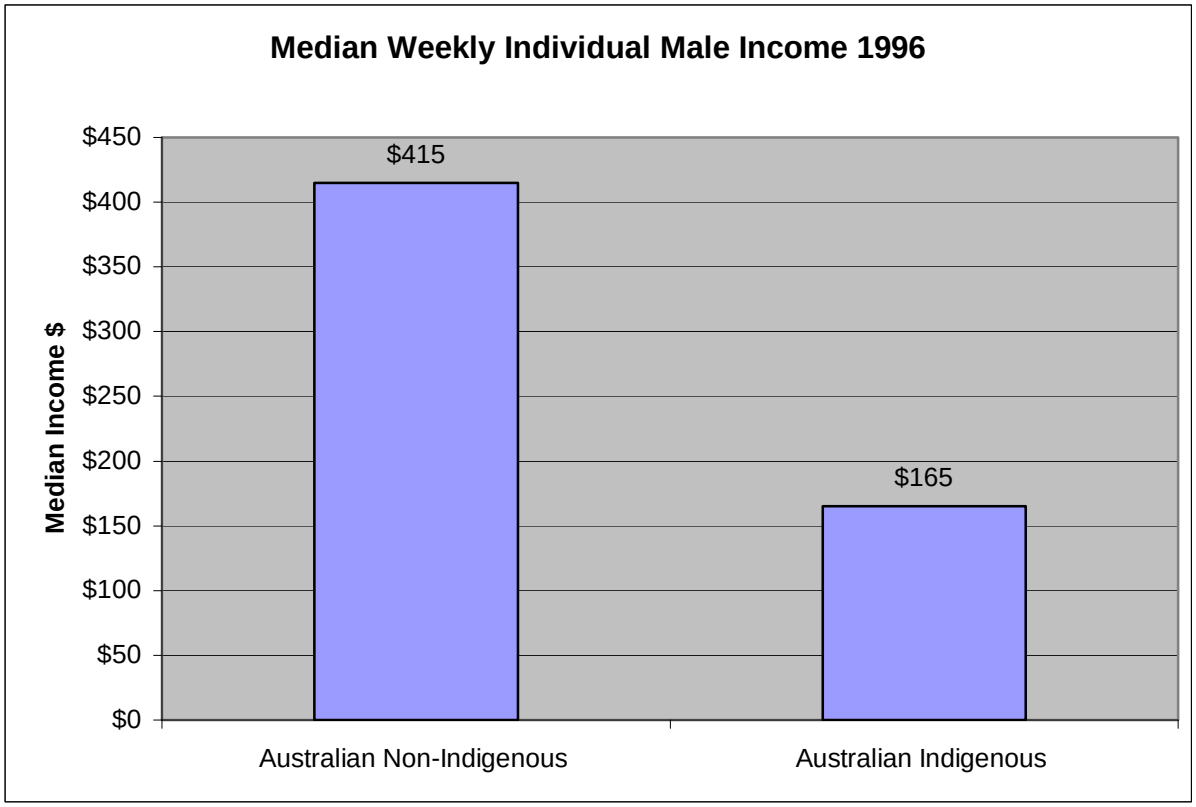
As far as the Kimberley is concerned, the largest employment initiative introduced is known as the Community Development Employment Program (CDEP) which began in the mid 1980s when the Aboriginal people became the first group who were required to work for the dole[e]. This program is administered by ATSIC and functions in the following manner:

- the communities decide on their own projects which may include housing, road maintenance, the production of artefacts and horticulture, i.e. projects aimed at improving the development of the community;
- unemployed Aboriginal people may participate in the scheme and in doing so must forego their unemployment benefits;
- the aim of the program is to help Aboriginal organisation to set up small businesses and thus become independent and to aid in the development of skills.

[e] The dole is the Australian unemployment allowance.

VII. Income

Obviously education and employment are important determinants of income. Estimates of the median income in 1996 for Aboriginal people of all ages and both sexes was estimated to be $150-$180 per week by the ABS, substantially lower than the median figure of Australia as a whole.



In the June quarter of 1996 : the Henderson poverty line for a single person was a weekly income of $228.99.
Given the high cost of living, especially food, most people are living below the poverty line.
Poverty has profoundly negative effects on the health status of this people affecting ability to access food, personal hygiene products, good houses and education.

THE ENVIRONMENT

In the early years, many Aborigines were forced to live in camps near homesteads in order to provide labour for the pastoral properties. These camps often had little or no facilities. As these people were slowly moved out of the pastoral industry and away from the land (during the first half of this century and into the 1950s), missions and reserves were established. In the 1970s, policy changes have allowed some Aboriginal people to return to their country. However, there exist many difficulties with respect to the essential services that are required in the resulting communities. During all this time, the poor environmental conditions encountered have contributed to the poor health status of a large proportion of the Kimberley Aboriginal population.

In this chapter, we will focus on the main aspects of the man-made environment which impact most directly on the health of communities.

As an introduction to our discussion, a 1997 state-wide survey conducted by A.T.S.I.C Region in Western Australia to determine the extent of environmental health needs in Aboriginal Communities showed that Aboriginal Communities in the Wunan Rgion (East Kimberley) had the worst environmental health indices in the state (Western Australia).

Key results are listed below :
Water supplies :
.4 % of population had inadequate water supplies
.30 % of population had no testing of water supplies
.85 % of communities had no disinfections of water supplies
Electricity :
.2 % of population had no electricity
.37 % of communities had regular interruption to electricity supplies
Housing :
.19 % of dwellings were improvised dwellings.
.Adjusted persons per dwelling was 8,4
.1/ 3 of dwellings had none of the following facilities : toilet, hot water service, bath or shower, sewerage disposal, laundry trough.
Other:
.55% of population affected by excessive dust
.½ of small communities and ¼ of large communities had no dog control
.98 % of communities had fence around rubbish tip.

Other services which are problematic for the Aboriginal people of the Kimberley include electricity, sewerage, rubbish disposal, general access by road and the improvement of general environmental conditions such as

We will develop each point as follows:

I. Housing :

Historically, aboriginal people in the Kimberley lived, as nomadic people, under shelter in Camps: their camps were comprised of a number of bark huts, but people also lived in caves or in the open air. Some camps were comprised of as few as 6 to 10 people while in others there were up to 400 people. No doubt the availability of food was a factor in the size of a camp. Each day, various members of the group would leave the camp to hunt and gather food
and return to the camp to share the catch with others.
Due to a mild climate and a short period of settlement between each expedition, they never felt the necessity of building a house.

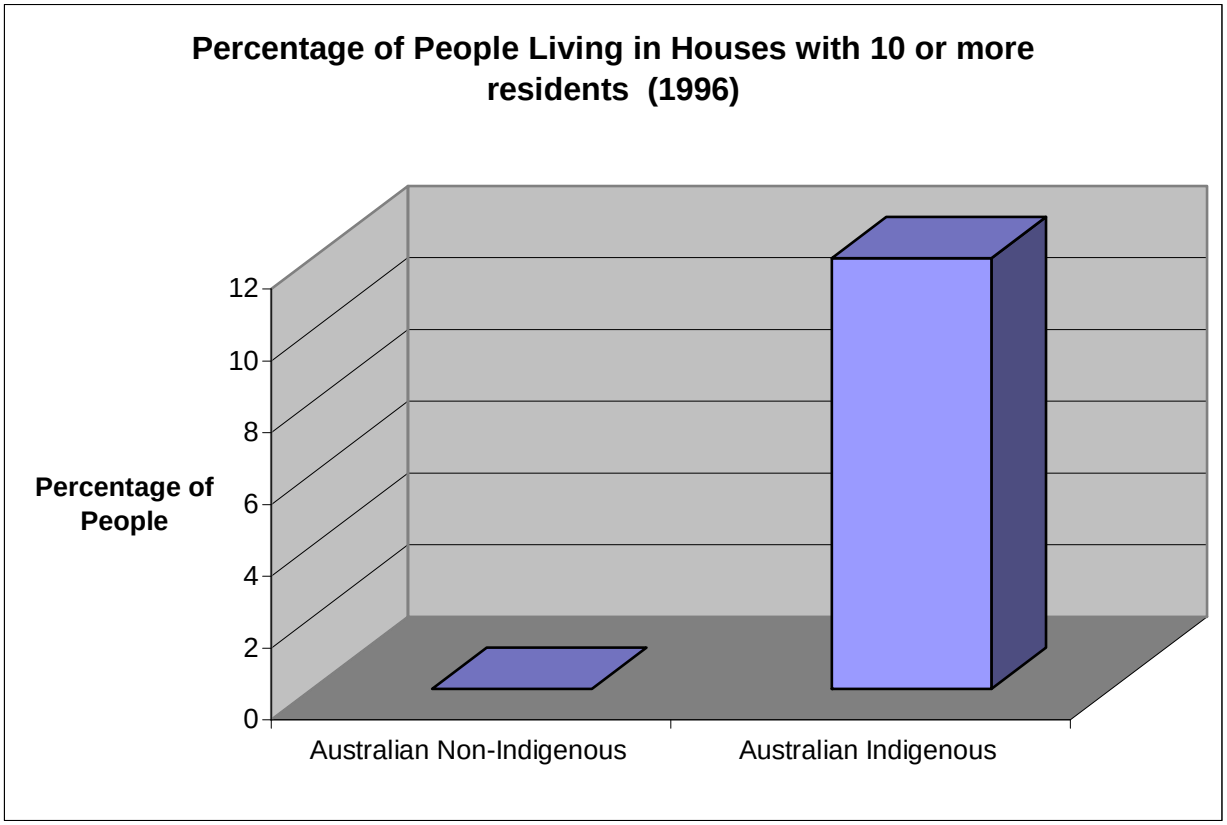
It was only in the early 1980's that the Government provided each family with a house. Housing had a beneficial and dramatic effect on the residents :
Nowadays most of the people believe that housing has been good for their community. The privacy provided has been well valued. They also say that the provision of housing has given many residents a degree of stability, hope and esteem which they had not previously known.
However, several people after having given generally favourable remarks, added that the houses would be even better if they were properly maintained.

From our sedentary point of view : their houses seemed to us not only badly maintained, but also overcrowded and very badly cleaned.
We will try to see first why, and second, to discuss the strategies developed by the Community Health Staff as to how to solve these problems, and finally the impact on their health.

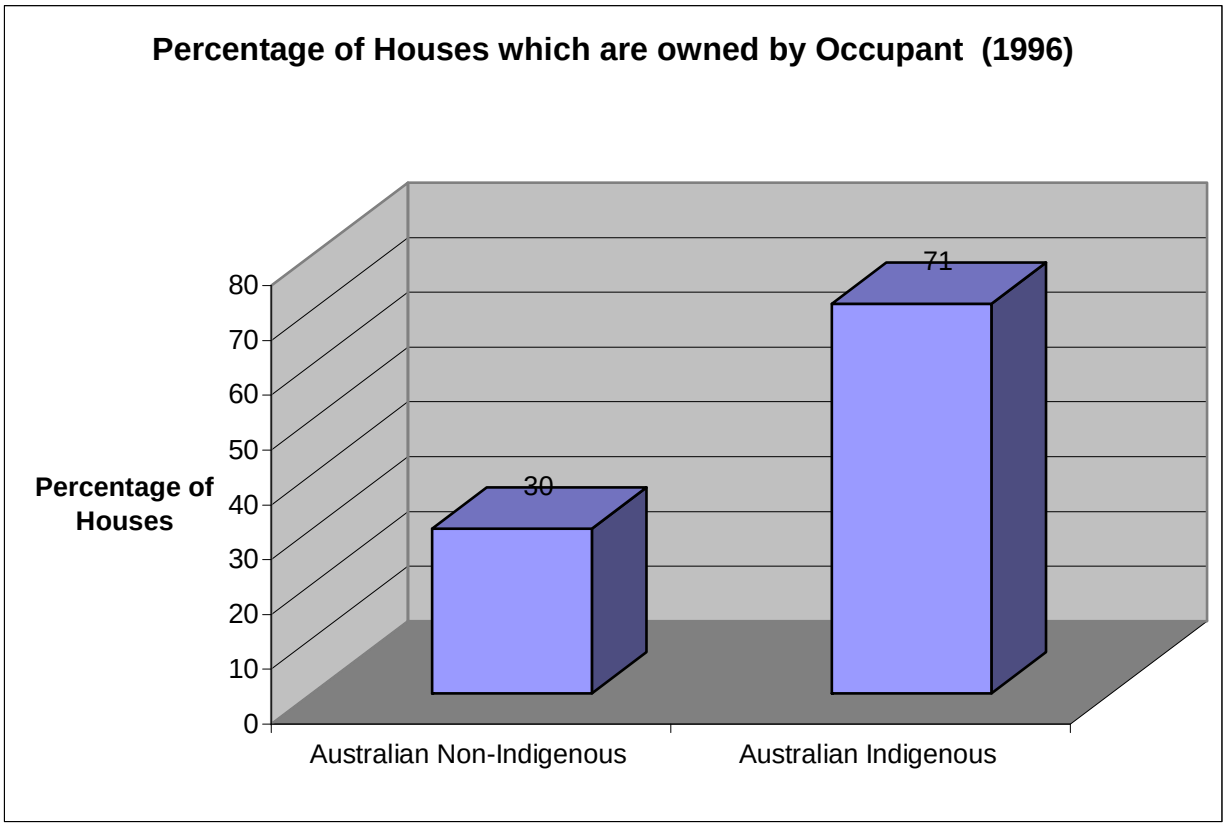
1.Overcrowded houses :

The figures below are from the 1996 Australian Bureau of Statistics (A.B.S) census on population and housing.

There exists a lack in the amount of housing for Aboriginal people living in remote areas. According to the Australian Bureau of Statistics1, almost 18% of Aboriginal households have more than one family living in them.
In addition, not only are there many people living in the same house but the houses have a tendency to be small with a small number of bedrooms. This is once again illustrated by data from the ABS 1996 which showed that between a quarter and a third of all Aboriginal people in the Kimberley live in households with more than 8 people and most of these are living in houses with 3 or fewer bedrooms.



Other data supplied by the ABS has indicated that the Aboriginal people of the Kimberley are much less likely to own or purchase their own homes as their non-Aboriginal counterparts. It has been suggested that home ownership may be an incentive for improving the standard of housing for Aboriginal people but with a median income of less than $200 per week, coupled with the current demand for housing, home ownership appears to be very difficult for these people.



Rental accommodation is a problem shared by all Aboriginal people throughout the country. This includes long waiting lists for housing, problems encountered with obtaining timely repairs, repairs are often difficult to afford, high levels of eviction, discrimination in the private housing market and payment of rent and other service charges.

The levels of overcrowding in the area are a significant contributor to the high levels of infectious diseases in the community and this needs to be addressed in the future. The low levels of home ownership reflect the levels of poverty.

2.Housing repair and maintenance (or more accurately the lack of it) :

From our experience in most of the communities visited is concerned, the state of most of the houses is alarming :
broken windows and fly screens,
defective latrines that finally lead to a shared community use of the remaining functional ones instead of private use,
leaking shower bases and drain pipes,
cracks in walls,
poor ventilation,
broken or missing tiles on the floor,
faulty electrical wiring (fans, lights and power points).

Residents blame many defects on the work undertaken during the construction phase, proving the possible use of inferior materials; absence of floor waste and vents in some areas; poor jointing or plaster ceilings; wall plugs which had fallen out; and incorrectly fitted fly-screen doors.

The response to these problems is money.

It should also be acknowledged that the way in which residents use their house is generally not a positive factor to the repair and maintenance problems. The general feeling is that they are not accustomed to taking care of a house.
The general view amongst the Community Health Staff is that the more the residents get accustomed to the demands associated with living in their own home, the more they will look after their houses. Thus health promotion and education programmes have been conducted in the household sanitation field.
Another point: the access to cleaning products at a reasonable price is quite limited in remote areas and often contributes to the poor hygienic conditions observed in these areas.

These overcrowded and unhygienic living conditions contribute to the spreading of infections such as pneumonia or discharging ears and noses. (see Health Status)

II. Transport

The Aborigines used to be excellent walkers. Their hunting and foraging expeditions were planned in advance in order to allow sufficient time for low-speed travel.
Nowadays, a small minority owns a car in the remote areas:
These rare owners transport others for long expeditions.
The result is a decreased time of walking in comparison to the past, leading to a lessening of physical effort and a gain of weight. (we will approach later the repercussion on health).

Some communities visited have a completely closed access during the wet season: either because they do not own an airstrip, or because the road access to it is blocked.

implication for the health field: certain emergencies can not be treated.

III Nutrition :

1.Food access and Availability

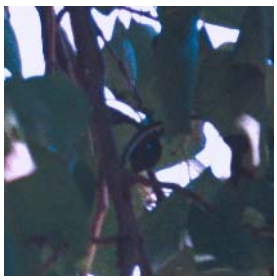
The accessibility and quality of food available plays an important role in determining the health of an individual. A balanced diet that contains an adequate amount of calories, vitamins and minerals is necessary to keep the body healthy.

Historically, Aborigines benefited from a healthy and balanced diet, which was based on bush food (any food collected by Aborigines).
During the 19th century, a number of observers said that the Aborigines ate better than most Europeans because of the diverse range of food that was available to them: reptiles, insects, birds, plants and marine life were part of their staple diet - depending on the type of food available in any area.

The following photos shows some typical aboriginal food we had the chance to taste during our stay:

On an open fire, they cook the Kangaroo. The Aborigines simply singe the food to remove feathers, scales and fur and eat partly cooked meat.

One of the food cooked by the Aborigines was a type of bread which was also popular among early European settlers who called it “damper”. This is made by grinding seeds into flour, mixing this with water into a doughy paste and cooking it in the ashes of a warm fire.



Here are some wild fruits showed by the children of Djarinjin

Nowadays, more and more aborigines prefer the easiest way to get their food. They shop more often than they fish, gather or hunt.

Thus the types of food consumed today depends largely on:

the type of food available:

unfortunately, the access to fresh food and vegetables at a reasonable price is quite limited in remote areas and often contributes to the poor health observed in these areas.

the income:

most people are living below the poverty line

the personal education of nutrition needs:

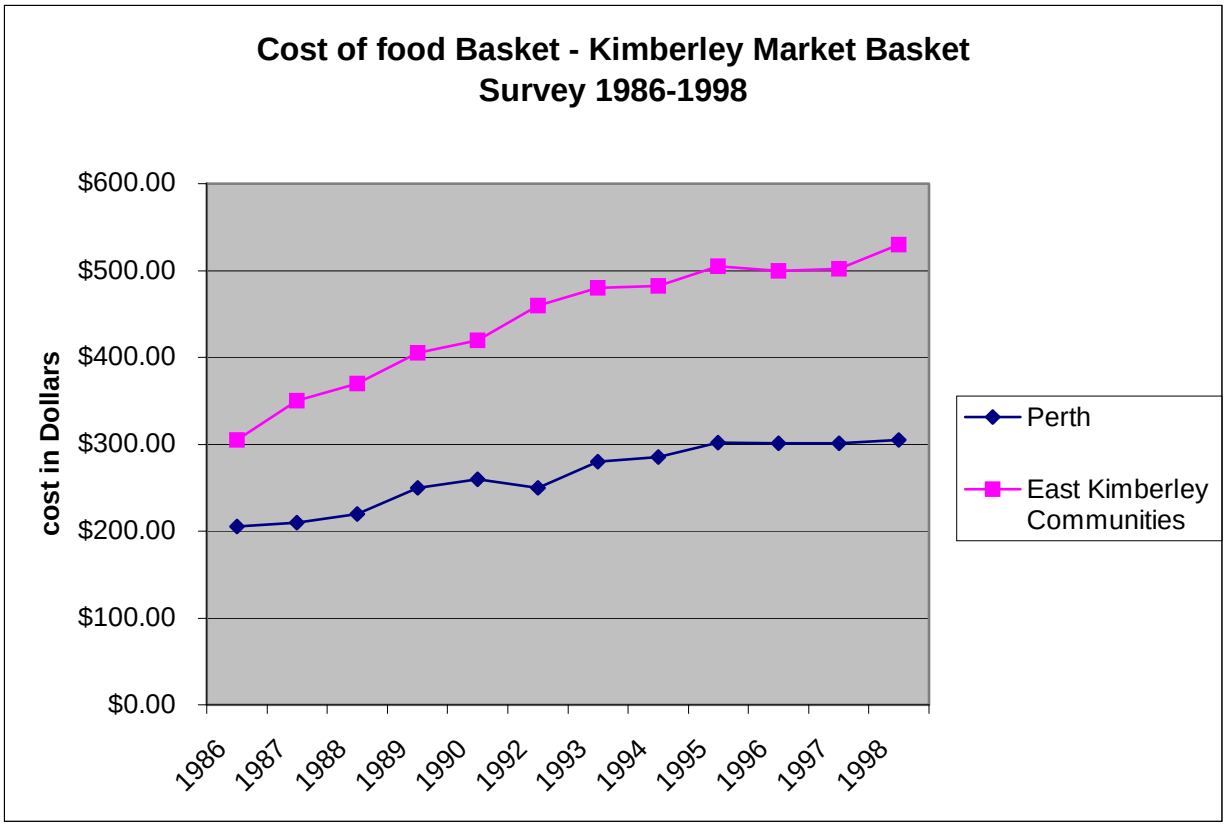
most Aborigines don't really know what to choose from the stores: as they buy the less expensive items, they usually eat greasy, non fresh and non green food. Nutrition education programs have been conducted by the Community Health Staff in schools, and amongst diabetics, during which the importance of fruits and vegetables are stressed.

Nutrition plays an important role in the health status of the Aboriginal people. Nutrition related diseases encountered by the Aboriginal people living in the Kimberley include:

- ischemic heart disease,
- stroke,
- non-insulin dependent diabetes mellitus (NIDDM),
- atherosclerosis,
- some types of cancer[2],
- infections due to reduced resistance, consecutive to poor nutrition.

2. Food costs :

These data below are published in the Kimberley Public Health Bulletin (K.P.H.U). They are obtained by means of an annual survey of shops and community stores around the Kimberley.
The dollar amount represent the actual cost of a standard "basket" of groceries.



The price of food in remote areas is higher than those observed in the larger cities. For example, in 1998, a local market basket (based on the most popular grocery items from the relatively restricted range of products available across the Kimberley), costs just over $305 in Perth and about 15% more in Derby, which can be considered as one of the cheapest towns in the Kimberley. The cost was more in the other towns (ex. Broome 25% more, Wyndam 38% more) and is substantially more in the community based stores (e.g. the average price for West Kimberley communities being $463 or 51% more than in Perth, and for the East Kimberley communities $541 or 77% more than in Perth)[a].

[a] Note that these figures are averages and some communities may pay even more.

The graph shows that prices are consistently higher than in Perth.
When one considers the poor income levels of the Aboriginal Communities, it is clear that affordability of food is a major consideration for the local residents. The higher prices in the more remote centres are reflected in the higher rates of childhood malnutrition.

3. Community Stores

The community stores are those which are located in the community, supply most of the goods to the community and are often the biggest enterprise that exists within the community. These stores are owned under various administrative and legal arrangements made by Aboriginal councils and other incorporated bodies. Those that are owned directly by the community council receive profits directly into community accounts whilst others are commercial enterprises that are kept separate from the community both from a legal and administrative point of view. There are many problems associated with the running of these stores which have an influence on the cost and quality of goods available to the community:

- -recruitment of reliable managers and staff;
- -the poor quality of goods received by the store due to packing and transport;
- -poor stock control;
- -high transport cost : not only because of the distances involved but also due to the poor roads;
- -inability to secure lower prices through bulk purchasing;
- -credit mismanagement.

III. Air :

The 55% of population is affected by excessive dust in the East Kimberley (according to the survey i.e. Introduction) which contributes to eye, skin and lung diseases.

Some solutions in order to reduce the wind blown dust have been suggested :

- *the paving of roads within the communities,*
  this initiative would also contribute to decreasing direct contact with contaminated soil, earth floor (concerning diseases caught by walking bare-foot);
- *the provision of wind breaks;*
- *the cultivation of plants.*

IV.Water :

The 1992 National Housing and Community Infrastructure Survey by the Aboriginal and Torres Straight Islander Commission (ATSIC) showed that 17% of the Aboriginal communities surveyed had water supplies that did not conform to the National Health and Medical Research Council guidelines. By 1997 the situation had improved but was still an issue for some communities and although most communities had access to water, the quality of the water being received was not being regularly assessed. This has important implications on relation to gastroenteritis and other infectious and parasitic diseases[3], as well as for dental health.

During our stay at Bidyadanga, an epidemy of Giardia diarrhea was revealed.

V. Climate :

The tropical weather favorizes the proliferation of mosquitoes and other vectors of diseases. During the wet season : certain communities are complety cut off from the outside help.

VI.Animals :

Vectors of diseases:
.dogs and cats,
.mosquitoes,
.cockroaches and rats (in the houses).

Dangerous animals :
.dingoes (wild dogs),
.snakes,
.sharks.

THE HEALTH SYSTEM

I. “modern” medicine :

The “modern” medicine practised in Australia is by any point of view, the same as any other in a developed country. The main difference, as far as the Aboriginal People are concerned, is that its patients who represent a population with an excess of :

- morbidity;
- social, educational and economic disadvantage;
- discrimination;
- cultural barriers;
- geographic isolation.

In order to cope with the geographic and cultural barriers, we will see in this chapter what has been introduced and how it functions.

1. Health Services in the Kimberley:

a) Primary Health Care Services

This concerns the *first level of contact* between individuals in the health system. Services included in this definition are community organisations that deal with issues such as:

- hospital outpatient services;
- waste disposal;
- alcohol related services;
- services designed to promote different community; health issues.

The two largest providers of primary health care services in the Kimberley are the Aboriginal Community Controlled Health Services (**ACCHSs**) and the **K**imberley **H**ealth **S**ervice (**KHS**).

-**The ACCHSs :**

the **A**boriginal **C**ommunity **C**ontrolled **H**ealth **S**ervices or primary care health services, also called Aboriginal Medical Services **AMS**, are initiated by local Aboriginal communities, their aim is to promote a holistic and culturally appropriate health care.

The benefits of the ACCHSs, is that the organisation is run by Aboriginal people and employs only Aboriginal or culturally aware non-Aboriginal people, this means:

- better access to the members of the local community;
- complete, targeting of the needs of the community and culturally appropriate primary health care: take into account the traditional preventive care, healing practices and medicines of the Aboriginal people.

The services provided by each individual ACCHS is planned and managed by *a board* that is *elected from the local Aboriginal community*. There exists about 100 ACCHSs Australia wide which are of varying size. Some of the larger ones employ several medical practitioners whereas the smaller ones may only be staffed by *an Aboriginal Health Worker and a nurse*.

Aboriginal Health Workers (AHW) are *Aboriginal people* with a clinical function and/or a health promotion function and/or a role in community development who also *play the role of cultural broker: a sort of liaison officer between the Aboriginal and white Australian cultures.*
They are the first points of contact for the patients at an Aboriginal Heath Service.They are the "on the ground" workers who deliver culturally appropriate health services to Aboriginal People and contribute to improving the health of the local community.

Some of their duties:

- helping Aboriginal People to use mainstream services,
- speaking on the patient's behalf (translation work) with the doctors and nurses who are usually non-aborigines,
- providing transport to the hospital for medical treatment,
- providing emotional and practical support to the patient and their family,
- clinical work such as taking blood pressure, assisting with injections or bandaging an injured person,
- office work such as keeping patients' medical records, ordering medical supplies and writing reports and submissions,
- making appointments and reminding patients about specialist's appointments,
- informing patients about the importance of preventive health and immunising their children.

Each ACCHS is autonomous therefore independent on the other ACCHSs and of the government. However, together these services form a network.

The ACCHSs that function in the Kimberley region are:

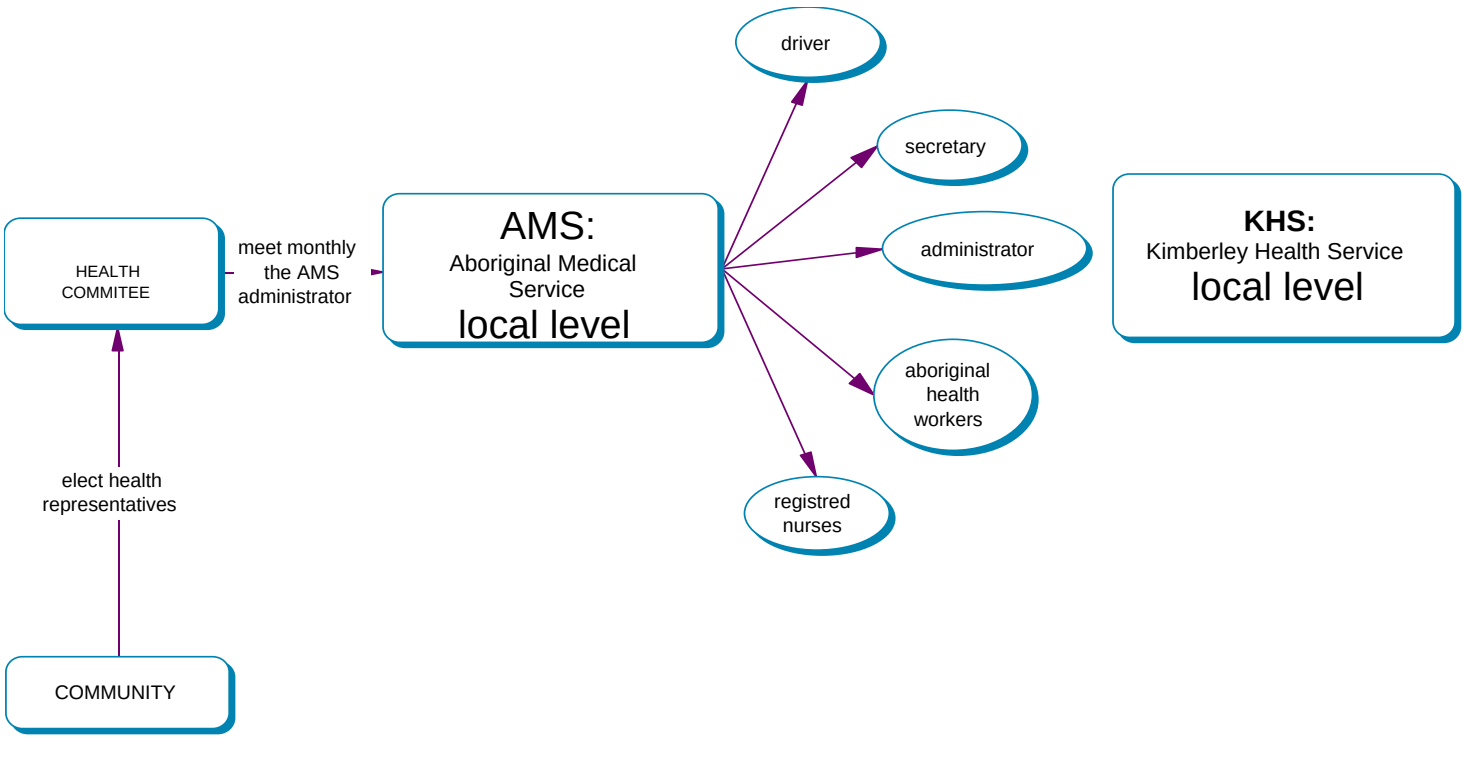
- Broome Regional Aboriginal Medical Service (BRAMS) in Broome
- East Kimberley Aboriginal Medical Service (EKAMS) that serves Kununurra as well as a number of nearby communities
- Yura Yungi Health Service for Halls Creek and surrounding communities
- Derby Aboriginal Medical Service (DAMS) serving Derby and surrounding communities
- Nindilingurri Cultural Health Service serving Fitzroy Crossing and communities in the Fitzroy Valley
- Jurragk Health Service serving the Gibb River Road area.

These health services provide clinical services by Aboriginal Health Workers (AHWs), doctors and nurses to the various Aboriginal communities listed above.

- The KHS :

Kimberley **H**ealth **S**ervice is responsible for :
.the running of hospitals in each of the six main towns in the Kimberley. (These hospitals provide: access to outpatient nursing and medical services)
.visiting medical services to Aboriginal communities and other primary health care services.

The main difference between the AMS and the KHS is that the AMS are run and controlled by Aborigines, whereas the KHS is a non-aboriginal organisation. Both are on a community local level.
We learned more about the AMS since we mostly worked with them.



-The Royal Flying Doctor Service (RFDS) is responsible for:

- providing health services to remote communities by air;
- emergency evacuations to secondary and tertiary;
- health services;
- the transport of medical staff;
- access to a range of specialist clinics to many towns and communities.

Such clinics are carried out using chartered aircraft and are run either by the local health service in the nearest town or from Derby. Those that are run out of Derby function with RFDS nursing staff (either an RFDS flight nurse or primary health care nurse) and Derby Regional Hospital medical staff (which can include specialists). At present, the RFDS in the Kimberley does not have its own medical staff and therefore all its medical services are either provided by the KHS or one of the ACCHOs.

b) Secondary and Tertiary Health Care

.Secondary health care is provided by the KHS via the six hospitals (Broome, Derby, Kununurra, Wyndham, Fitzroy Crossing, Halls Creek) that are found within the Kimberley region.
.Tertiary health care is provided mainly by Perth's tertiary hospitals, some are also being provided by Northern Territory Hospitals as well as being supported by a range of specialist services.

II. administrative issues :

- **KAMSC :**

the **K**imberley **A**boriginal **M**edical **S**ervices **C**ouncil is the regional representative body for all of these ACCHSs. Its roles include:

- accounting, administration and human resource management support;
- policy support, representation and advocacy at a regional, state and national level;
- public health program development and coordination;
- centralised purchasing of pharmaceuticals, medical and other supplies;
- a registered training organisation for Aboriginal Health Workers;
- an Aboriginal health promotion unit;

- a regional centre for social and emotional well being;
- computer systems support.

The governing council of KAMSC is comprised of representatives from the member ACCHSs, health service communities and health committees from across the Kimberley and meetings of the council are held every 3 months.

- WACCHO :

The **W**estern-**A**ustralia **A**boriginal **C**ommunity **C**ontrol on **H**ealth **O**rganisation represents the Aboriginal community controlled health services on matters relating to Aboriginal health and well-being on a state level.
Australia is a Federation consisting of six States :
(New South Wales, Queensland, Victoria,Tasmania, South Australia and Western Australia) and two territories (the Northern territory and the Australian Capital Territory).
Each of these has its own Parliament and its own bureaucracy, including a health department. There are, added to the Federal Parliament and the Commonwealth Department of Health and Aged Care in Australia, nine Parliaments and nine Health Departments.

- *NACCHO :*

The **N**ational **A**boriginal **C**ommunity **C**ontrolled **H**ealth **O**rganisation is the peak national body representing Aboriginal community controlled health services on matters relating to Aboriginal health and well being. Around 100 Aboriginal community controlled health and health related services throughout Australia are members of NACCHO.
In keeping with its major objective of delivering holistic and culturally appropriate health and health related services to the Aboriginal community, some of NACCHO's major activities include:

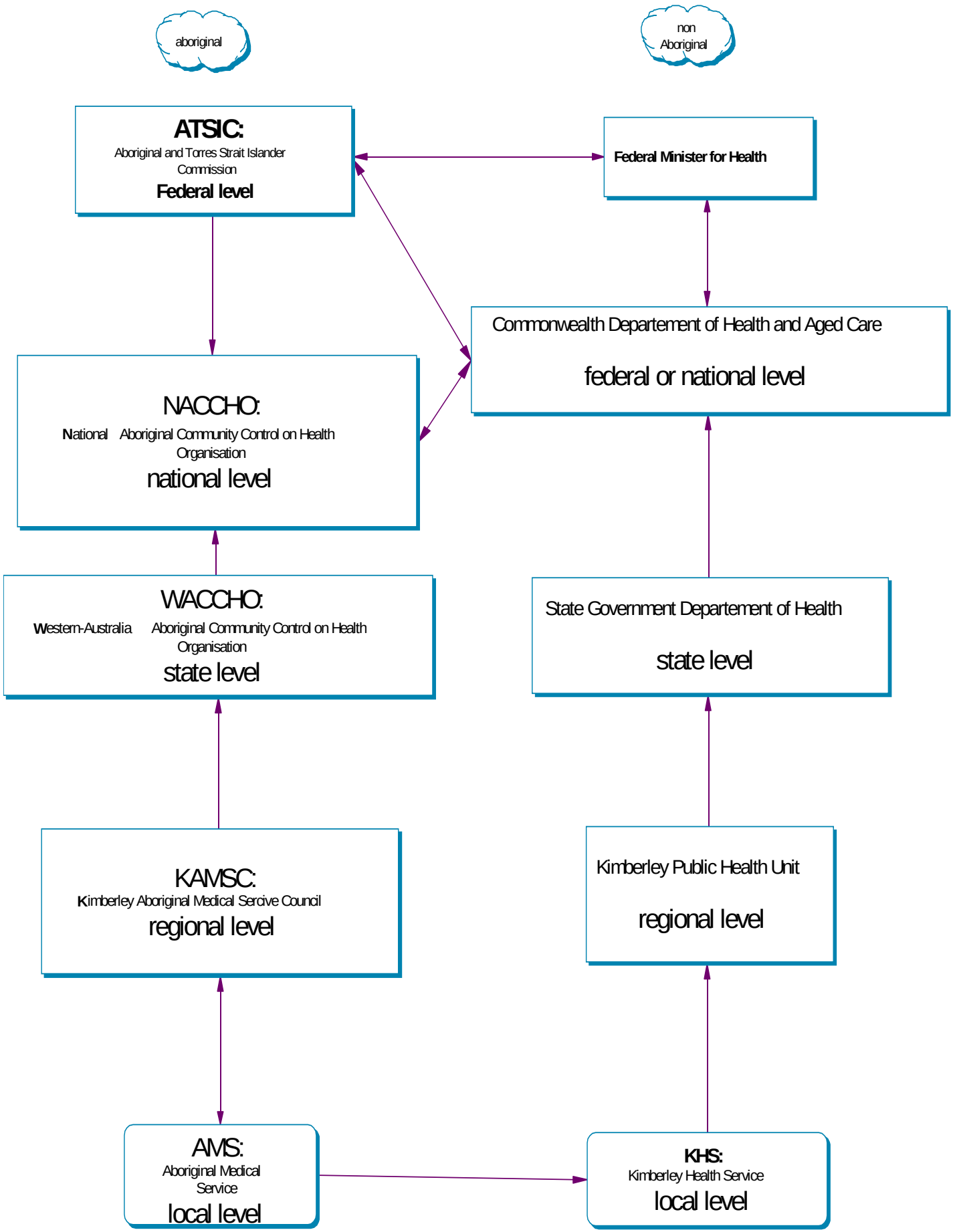
- Promoting, increasing, developing, and expanding the provision of medical and health services through local Aboriginal community controlled primary health care services.
- Liaison with governments, departments, and organisations within both the Aboriginal and non-Aboriginal communities on matters relating to the well being and health of Aboriginal communities.
- Representing and advocating for constituent Aboriginal communities in matters relating to health services, health research, health programs, etc.
- Assisting member organisations to provide Aboriginal people with medical services and other health services.

• Assessing the health needs of Aboriginal communities (through research, data analysis, surveys, etc), and taking steps to meet these needs.

- ATSIC :

The **A**boriginal and **T**orres **S**trait **I**slander **C**ommission is an organization, formed in 1990, that held great promise for the implementation of the self-determination policy in which ATSI people identify and address needs in their communities. *Needs include those in the areas of health*, unemployment and housing on a federal level.
Unfortunately as any organisation to whom funds were provided without any management training has led to mismanagement and fraud. In 1996, the government reacted by transferring responsibility for the funding of Aboriginal Medical Services from ATSIC to the Commonwealth Department of Human Services and Health.However, we should not forget the positive sides of the Organisation that has managed to overturn the previous paternalistic treatment of the people, by the 'white' communities and produced good accomplishments, as the following example where ATSIC denounced the breach of Human Rights in Australia towards the Aboriginal People.

A parallel between the Aboriginal and non-Aboriginal Medical Services, from a local to a federal level: (see the following graph)


aboriginal
non Aboriginal
ATSIC:
Aboriginal and Torres Strait Islander Commission
Federal level
Federal Minister for Health
Commonwealth Departement of Health and Aged Care
federal or national level
NACCHO:
National Aboriginal Community Control on Health Organisation
national level
WACCHO:
Western-Australia Aboriginal Community Control on Health Organisation
state level
State Government Departement of Health
state level
KAMSC:
Kimberley Aboriginal Medical Sercive Council
regional level
Kimberley Public Health Unit
regional level
AMS:
Aboriginal Medical Service
local level
KHS:
Kimberley Health Service
local level

- UNO :

ATSIC seeks UN action on human rights in Australia :

Statement by Acting Chair Man, Ray Robinson :

« I am releasing ATSIC's submission to the current session of the United Nations Committee on Human Rights (Geneva 20-21 July).

As the major representative Indigenous organization in Australia, ATSIC has made this submission to bring attention to our concerns about the situation of Indigenous human rights under Australian governments.
None of the issues we have listed are new, nor are our concerns unknown to governments in this country.
Yet we have yet to see satisfactory responses to our concerns.
We usually encounter stonewalling and denial whenever we attempt dialogue with Australian governments over the trend towards diminishing the rights that our people have achieved after decades of struggle through Australia's legal system. I emphasize that those few rights have been won through the legal processes administered by the non-Indigenous community.

ATSIC is dismayed that the Australian Government continues on its path of undermining Indigenous self-determination, in defiance of trends in comparable countries with Indigenous populations.
The ATSIC submission to HRC covers developments:

- in native title and land rights,
- protection for Indigenous heritage,
- indigenous deaths in custody,
- mandatory sentencing,
- the stolen generation.

In these matters - particularly in respect of mandatory sentencing in the Northern Territory and Western Australia – Australia is in significant breach of its international obligations under various international instruments.

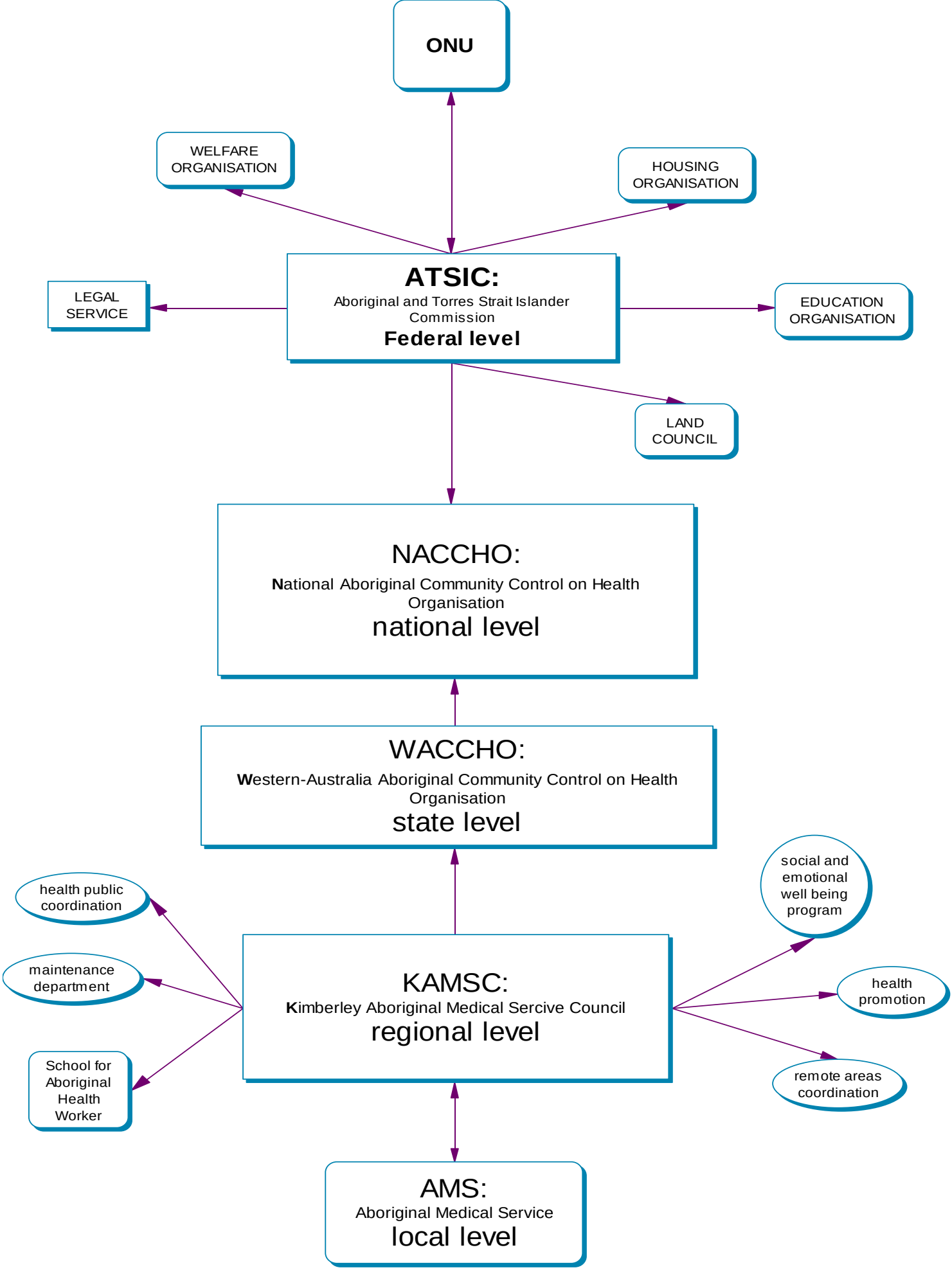
ATSIC requests that HRC use its independent expertise to:

- identify areas where Australia is not meeting its international obligations
- establish human rights benchmarks for the Australian Government in respect of Indigenous peoples
- provide suggestions to guide Australian authorities towards compliance, possibly as part of the Government's National Action Plan for Human Rights
- indicate its willingness to enter into constructive dialogue with the Government. »

Ray Robinson , Acting Chairperson

(To view the submission go to the International Indigenous Issues section in the Issues area of the ATSIC home page. http://www.atsic.gov.au/nav/home.asp)

From a local to an international level (see the following graph)


ONU
WELFARE ORGANISATION
HOUSING ORGANISATION
ATSIC:
Aboriginal and Torres Strait Islander Commission
Federal level
LEGAL SERVICE
EDUCATION ORGANISATION
LAND COUNCIL
NACCHO:
National Aboriginal Community Control on Health Organisation
national level
WACCHO:
Western-Australia Aboriginal Community Control on Health Organisation
state level
health public coordination
maintenance department
School for Aboriginal Health Worker
KAMSC:
Kimberley Aboriginal Medical Sercive Council
regional level
social and emotional well being program
health promotion
remote areas coordination
AMS:
Aboriginal Medical Service
local level

III. financial issues :

Contrary to common belief, Commonwealth Government expenditure on Aboriginal health is not high. Knowing that Aboriginal health services are funded through the Office for Aboriginal and Torres Strait Islander Health (OATSIH), and other Commonwealth programs, and taking into account the Medicare expenditure and Pharmaceutical Benefits Scheme (PBS) expenditure, the Commonwealth currently spends significantly less per head on the health of each Aboriginal person than on the health of each non-Aboriginal person.

Approximately 63 cents per head is spent by the Commonwealth on health services to Aboriginal and Torres Strait Islander people, for each dollar spent per head on the health of other Australians ($472 per capita for Aboriginal and Torres Strait Islander people, compared with $748 per head for non-Indigenous people). (from Deeble et al, Expenditures on Health Services for Aboriginal and Torres Strait Islander People, May 1998, p11 (table 2.2))

As the *House of Representatives Standing Committee Inquiry into Indigenous Health (1999)* reported:

> *"The level of expenditure on Aboriginal and Torres Strait Islander health ...is not excessive and would generally seem to be insufficient to meet the present level of need for health and related services."*

Organized and comprehensive preventive health care delivered by primary heath care services is potentially very cost effective. This is particularly true in delivering comprehensive programs to the Aboriginal population who suffer a greater burden and risk for disease.

For example, screening 20,000 people with a low risk for renal disease will prevent one case of end-stage renal failure (ESRF). However, the same screening applied to high-risk Aboriginal Clients could prevent at least 40 cases of ESRF. This translates into a considerable reduction in cost relativities.

IV.Health promotion and education :

The main programs are conducted by the Aboriginal Health Workers against :

- poor personal hygiene and household sanitation;
- unbalanced diet;
- sexually transmitted diseases.

V. Infrastructures :

Of the clinics visited during our stay in Australia and the report of our activities in them.

There are 3 kinds of clinics :

.remote clinics : example,
- AMS on the Gibb River Road
- AMS in Bidyadanga
- KHS in Djarindjin
-

.regional clinics : example,
- a bigger AMS in Broome (Brams)
- National Health Service Hospital in Broome

.state clinics : example,
- a bigger Hospital in Perth

Broome :

The Broome Regional Aboriginal Medical Service (BRAMS), established in 1978, was the first Aboriginal Community controlled health service in the Kimberley region. Today BRAMS provides a comprehensive range of curative, and public health, services.
These include :

.clinic consultations by doctors and AHW's (Aboriginal Health Workers, the liaison officers between the Aboriginal and white Australian cultures);
.field orientated public health programs : women's health, sexual health, chronic disease;
.specialist appointment notification and provision of transport to facilitate access to specialist services.

This clinic is staffed permanently by 8 Health Workers and 3 Doctors and is considered as a *regional clinic*, as opposed to the others that are considered as *remote clinics*.

Gibb River Communities

- Imintji

The clinic at Imintji is staffed by a senior AHW once a week: each Wednesday and one day every two weeks by a remote area nurse. Every second Tuesday a clinic is conducted at either Ngallugunda (Gibb River) in the morning and Ulumboo in the afternoon, or Kupunjarri (Mt Barnett) in the morning and Dodnun in the afternoon, by a medical officer (doctor) from the Derby Health Service who is accompanied by a primary health care nurse (AHW) and a remote area nurse. These people are flown in via an RFDS aircraft and their visits alternate between the different communities along the Gibb River Road where one clinic is conducted per month in each of the communities.

- Dodnun

The clinic at Dodnun is staffed by a senior AHW each Monday and by a remote area nurse every second Thursday. One Tuesday of each month the clinic is staffed by a medical officer from the Derby Health Service, accompanied by a primary health care nurse and a remote area nurse. These people are all transported on site by an RFDS aircraft.

- *Kupungarri*

The clinic at Kupungarri is staffed by a senior AHW each Thursday and by a remote area nurse on alternate Tuesdays. On one Tuesday of every month the clinic is attended by a medical officer from the Derby Health service along with a Primary Health Care Nurse that are transported onsite via an RFDS aircraft.

- Ngallagunda

The Ngallagunda clinic is serviced by a senior AHW: Narelle (that actually lives within the community) each Tuesday and by a Remote Area Nurse on alternate Wednesdays. As for the other communities on the Gibb River Road, a clinic is held *on one Tuesday of each month* by a *medical officer* and a Primary Health Care Nurse from the Derby Health Service who flown in via RFDS aircraft.

Summary of our visit to the Gibb River Communities

We spent 4 days visiting some of the communities on the Gibb River Road. We drove up there one Monday morning with Jenny Poelina, the Remote Services Coordinator, who took care of us during our time in Broome. The drive from Broome to Ngallagunda lasted from 8.00 am till about 5.00 – 6.00 p.m. with a few stops along the way. We were housed at the senior AHW, Narelle's place.

On the road in Kamsc's
4 wheel drive

During a break:
A photo with Jenny Poelina

A child from Ngallagunda's community

The next morning was the Tuesday of the month where Clinics of the Gibb River Road were held by a medical officer and a remote area Nurse from the Derby Health Service who had flown in via RFDS aircraft. In other words it was the doctor's day, we drove to Kupunjarri (Mt Barnett) along with Narelle and her trainee and were joined there by the medical officer, the registered nurse and another medical student from England.

The nurse and medical doctor from the RFDS with Narelle, our host.

In front of the clinic, Vanessa playing with the children

We spent most of the morning observing the senior AHW at work whilst the doctor attended to people that specifically wanted to or, needed to, see him.

Appointments are not necessary at these clinics so people show up whenever they feel they need to see any of the medical staff and simply wait until the person is free to see them.
Example of patients we met:

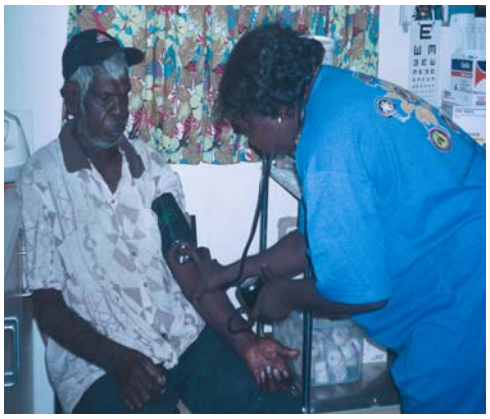
- One of the patients that the AHW saw was a young man consulting for an ulcer on his leg. His treatment consisted of cleaning up the wound, dressing it and he was given an antibiotic injection and a course of antibiotics to take along with instructions to come back within a few days in order to get the dressing changed.

Vanessa and the medical student from UK are cleaning the wounds.

- One of the other patients was a young boy who had an insect stuck in his ear. Despite several attempts by the AHW, nurse and doctor, the insect could not be removed and the boy was scheduled to be flown to Derby the next day on an RFDS aircraft so that it could be removed by a specialist at the hospital. Apparently it is very common for the children to have insects in their ears.
- Many of the consultations by the doctor concerned patients suffering from diabetes.

By mid-afternoon the number of patients visiting had dwindled to zero so after visiting a gorge and taking a quick walk with the RFDS staff, we headed back to Ngallagunda for the evening.

The next two days we spent at the Ngallagunda Clinic which was attended only by the senior AHW. Most of the people that we saw were consulting mainly for routine check ups of blood pressure and blood glucose (diabetics).



The senior AHW is taking blood pressure to a patient suffering from diabetics.

There were not as many patients visiting on the days that we were there which gave us an opportunity to visit the community.
The community itself was quite small with perhaps 10 to 15 houses, a clinic, a store, a homestead which used to belong to station owners, a Catholic school, the Community Office and the house of the AHW where we were housed. Ngallagunda itself is a cattle station which is relatively unique in that it is now owned by the Aborigines living on the station. Thus, during the day most of the young and older men were out preparing for the muster. We saw, mainly, the women around the community during the day who were principally occupied in taking care of the younger children whilst the others attended school.

Some photos of the community

From the outside, it is difficult to figure out how dirty and badly maintained are the houses from inside

Bidyadanga:

Bidyadanga is the biggest and most traditional community we've worked with: 6 different "ethnical groups", 700 inhabitants, above 70 houses, a bank, a take-away fast food, a Police Station, a Farm, the Community Office, Women's centre, School, Basket-Ball, Football Parks … and 2 Health Workers' Houses where we were housed.

The Bidyadanga Health Service consists of one AHW, three remote area nurses, a driver and a secretary. At any one time, the clinic is staffed by three health care professionals. Clinic hours are from 08:30-16:30 Monday to Friday with a 24 hour on-call service available 7 days a week. This service is alternated between two registered nurses every 48 hours. Each of the clinic employees live within the community and are permitted 5 days of leave every 2 weeks. On each Thursday of the week, one medical officer (supplied by BRAMS) is flown in from Broome by the RFDS and two medical officers visit every second week.

We drove up to Bidyadanga one Monday morning with Jenny Poelina.
The drive from Broome to Bidyadanga took us around 2 hours.
One of us spent 5 days, the other 14 days, in the community. We stayed in one of the Health Worker's house. The next morning, we went to the Clinic by foot from our house. There, We met 2 remote area nurses on duty that day: Aaron and Juliana, and the AHW Barbara who was able to speak the 5 different languages of 5 different subgroups gathered in the community.

Appointments are also unnecessary at this clinic, as in the case of Communities on the Gibb River Road: people show up whenever they feel they need to see any of the medical staff and simply wait until the person is free to see them.

We spent most of our first and second day observing the senior AHW and the 2 nurses at work: Most of the people that we saw were consulting mainly for routine check-ups of blood pressure and blood glucose (diabetics), or for bandaging their injuries.

The third day: was a Thursday, a doctor's day at Bidyadanga, where we saw 2 doctors: Katherine and ? supplied by BRAMS and a medical student from Perth flown in from Broome by the RFDS. Each of us had the chance to follow a doctor in its consultation. Many of the consultations by the doctor concerned patients suffering from diabetes.

Thursday was the most interesting and active day in the Medical Field, as the rest of the week was mainly nurses's work where we could not do real medical things apart from taking blood pressures, blood glucose tests and bandaging in the clinic. The rest of the week became, in this way, the most interesting time for learning about the community: culture, history and daily activities (as it has already been described).

On Friday morning, one of us went back to Broome to take her flight back to Perth. The other stayed in the Community for 10 more days.

During the time we were at Bidyadanga:
A claim in form of a Court called "the Native Titles" (see History) was taking place : where the traditional owners of the Karrajarri group were trying to prove (to testify) in front of a federal judge and lawyers that the land of Bidyadanga and around it is the land of their ancestors and that they still have a strong relationship with it. Their claim was for the acknowledgement of their natural rights to the land**.**
This event was of major importance for the future of these people.
During the trial, anybody could come and listen to the important testimony given by the traditional people who were explaining their culture, describing and showing their traditional sites, ceremonies, food, way of finding water, way of fishing and hunting.
The last 10 days left to one of us at Bidyadanga, was mainly spent with the federal court of Australia travelling around the countryside, listening and discovering with the judge, Aboriginal, federal and state government lawyers and journalists … the impressive richness of the aboriginal culture.

A common point in these Communities: on the Gibb River Road and in Bidyadanga, is that the funding for, and the administration of, the health services are offered and controlled by KAMSC with the clinic being owned by the community. Also the Clinic staff are KAMSC employees and are managed by a Broome Health Services Coordinator, whereas the clinic of the last community visited, Djarinjin, is funded and administrated by the Kimberley Public Health Unit (which is a non-aboriginal medical service) and is called a KHS while the others were called AMS.

Djarinjin :

Some photos of Kassy Sampy's community.

Djarinjin is the last community visited by one of us. It is also a very traditional community, much smaller than Bidyadanga, which resembles the Communities visited on the Gibb River Road much more in the sense of its size:
More than 60 people and 15 houses. The Djarinjin Health Service consists of one remote area nurse who is present the whole week. On each Friday of the week, one medical officer is flown in from the Derby Health Service, by an RFDS aircraft. Appointments are also unnecessary at this clinic, people come whenever they feel they need to. The drive from Broome to Djarinjin took around 3 hours. One of us spent 5 days in this community and was housed in an aboriginal family named Sampy.
The purpose of the stay was more for research on traditional medicine practised in the area than for a work at the clinic.

Nevertheless, after having discussed for several hours with the nurse of the clinic, who had more than 10 years of experience in several AMS around the Kimberley and 1 year in the KHS of Djarindin, a comparison between the AMS and the KHS was established:

	AMS	KHS
Maintenance of the clinic and the health worker's houses	Apart from the clinic of Bidyadanga, which was a brand-new one, the health worker's houses and clinics on the Gibb River Road seem less well maintained: - defective latrines - cracks in the walls - poor ventilation - broken windows and fly screens - leaking shower bases and drain pipes	Although the Clinic was an old one, it seems to be well-kept: the nurse didn't complain about any unrepaired items, as it happens in the AMS.
Equipment	Some nurses at Bidydanga complained about their old and unrepaired equipment	No complaints Best technology: computers, the latest and newest equipment.
Moral support for the remote area nurses and AHW	a lot of complaints from the nurses about the indifference of KAMSC on certain problems	No complaints

Although it ca not be legitimate for us to compare the infrastructures of these 2 different services with the very little time we spent and experienced there, we decided to keep this table of comparison in order to describe to you the feelings and thoughts of nurses of the AMS and KHS who work there.

VI.Aboriginal Traditional Medicine:

1.Bush Medicine or Remedies:

In the traditional communities, minor illnesses such as aches and pains, toothache, bites and stings, wounds, boils, constipation and diarrhoea are usually treated with bush remedies. Throughout the generations, most Aboriginal men and women have acquired a knowledge of the different plants and minerals that can be used as medicines.

Historically most Europeans confirmed the great power of Aboriginal Healing and many colonist were cured dramatically by native practitioners.

If a patient fails to respond to a bush remedy, the patient goes to the modern clinics.If the modern clinics also fails, then a traditional healer is consulted.

The following information is believed to be correct but we take no responsibility about the details. It has mainly been collected in Bidyadanga and Djarinjin communities.

- Eucalyptus the sap of various species, mixed with water is spread over wounds as a disinfectant.
- Melaleuca *Melaleuca stytpheloides* cured headaches.
- Native Sarsaparilla (Smilax glyciphylla) was a rich source of vitamin C and was used by the early colonists as a tea.
- She Oak and Swamp Oak produced an invigorating drink.
- Tea Tree leaves *Leptospermum flavescens* leaves and twigs emitted a vapor when placed on a fire and eased breathing difficulties.
- Turpentine Tree *Syncarpia glommulifera* could be used to treat heart pain.
- Native Fushia cure fever and headaches
- Mother’s milk is used for the ear infection : it is said that it kills flies.
- Scratched Ants cure mouth sores

Bunaangu
You only eat the sap on the bunaangu. It has a bitter taste. You boil it up to drink. It helps toothache and a bad chest

Buduway
You only use the young shoots of the buduway. You boil it up when you are sick.

Malhanggaa
This bush medicine is called lemongrass by white fellas. It is best when it is dry for headaches and colds.

Bardirri

The camel tree (Bardirri) is used for bush medicine. You burn the outside bark in a fire and rub the ashes in your hands. Put it on your body to keep yourself cool.

Bungaa

The bungaa has black berries that you eat raw

Biwiyu

You boil up biwiyu and wash your eyes with it

2. Traditional healer:

According to the Aborigines, serious sickness and death are caused by sorcerers, spirits or the Ancestral beings.
According to western studies, only one half of the plant remedies are pharmaceutically effective, the rest are placebos. Thus, the aboriginal healing is mainly based on the power of positive thinking and strength of belief.

The healer diagnoses the problem and then prescribes a treatment. If the patient dies, the healer also determines the cause of death.
Traditionally, the healer is someone with great spiritual powers that may have been learnt during his apprenticeship, or are inherited. These special powers allow the healer to diagnose the cause of the illness, to cure it, to tell the future, to protect people against sorcery, to travel faster than would appear humanly possible, anticipate events, know what is happening in far away places and be able to appear and disappear at will. During times of illness, the role of the healer is much like that of a priest, he reassures the patient and his family, promotes the right kind of atmosphere necessary for the sick person to regain faith and confidence that he will get better.
The methods used by the healer include:

. massage,
. songs: it is said that certain sounds help the drainage of the inflammatory liquids,
. ointments made of oils and plants,
. the removal of foreign objects from the patient’s body,
. practices of bloodletting and blistering. Now they are considered useless, as do the Europeans, who used to place so much faith in bleeding.

Sorcerers are people that can cause illness or death by projecting an evil spirit or object into the person by 'pointing the bone' or by capturing the person's spirit in a piece of hair or food. Bone pointing is a practice in which short pieces of bone pointed at one end and tipped at the other with a small lump of gum to which is attached a length of human hair as a string. This is placed in the ground and curses are repeated over it. Later, the bone is pointed at the victim and magical chants are repeated. The victim later develops bone sickness and will die unless a traditional healer can determine what is wrong and remove the evil powers responsible.

Usually Aborigines believe strongly in the power of magic and in the unseen. Guided by such a powerful belief system, it is, thus, no wonder that their medicine works.

THE ABORIGINAL HEALTH STATUS,[4] *JUNE 2000*

The first colonizers, who arrived in 1788 documented some of the principal ailments of the Aborigines:

.Eye infections: trachoma may have been present: Dampier in 1688 reported that Aborigines on the Northwest Coast had their eyes half closed and could not see far unless they held up their heads.

.Tooth decay due to a coarse gritty food that wore teeth down to the nerves.

.Leprosy may have been indigenous, as well as Yaws and Boomerang Legs (characterised by arthritis, osteitis and periostitis) due to long periods of walking.

.Bites by snakes, jelly-fish and other venomous animals.

Colonization imposed changes on their previous environment :

- massacres or flight from their traditional land to make way for farms and settlements;
- death by new diseases such as influenza;
- destruction and (or) pollution of their traditional food sources and land;
- reliance on “western food from the stores” (such as chips);
- reliance on alcohol and tobacco;
- reliance on modern houses and its equipment : as electricity, drainage of water, etc;
- reliance on the western health system due to the apparition of new western diseases;
- introduction of a less supportive and harmonious world view;

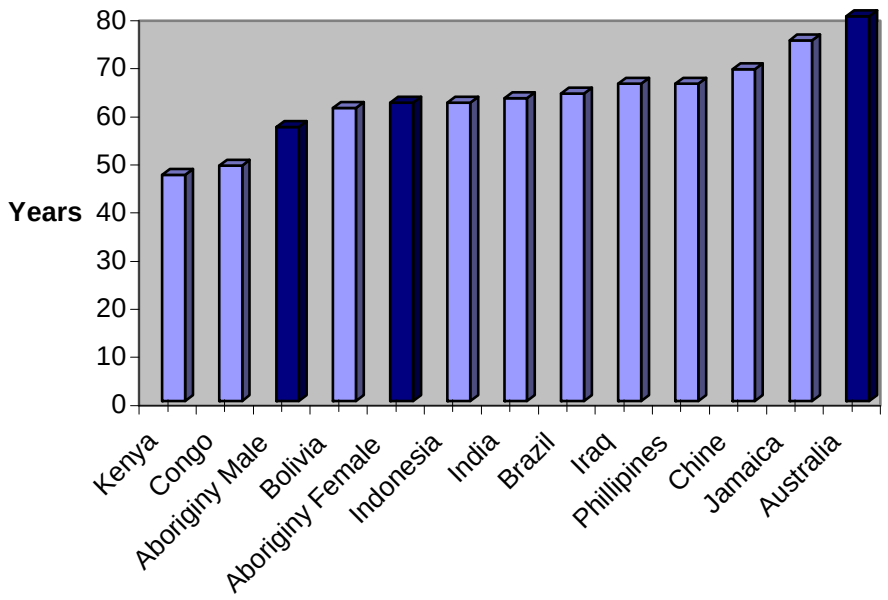
Indeed colonisation set up a chain of a dependence towards those who brought all these changes about. Suffering from new “modern diseases”, aborigines have turned for support to the Western Health System : this is how and why nowadays our understanding of their diseases is very well documented as you will see in this chapter.

I. Mortality

1. Life expectancy :

The data shown in Figure 1 for Australia and the developing countries are taken from the United States Bureau of the Census International Data Base.

figure 1 :
Life expectancy at birth



Based on census figures and death data from 1991-1996, the Australian Bureau of Statistics (A.B.S) calculated the life expectancy at birth of the Aboriginal people Australia-wide as 57 years for males and 62 years for females. These expectations are around 18-19 years less than those calculated for non-Aboriginal people at that time (75 years for males and 81 years for females).

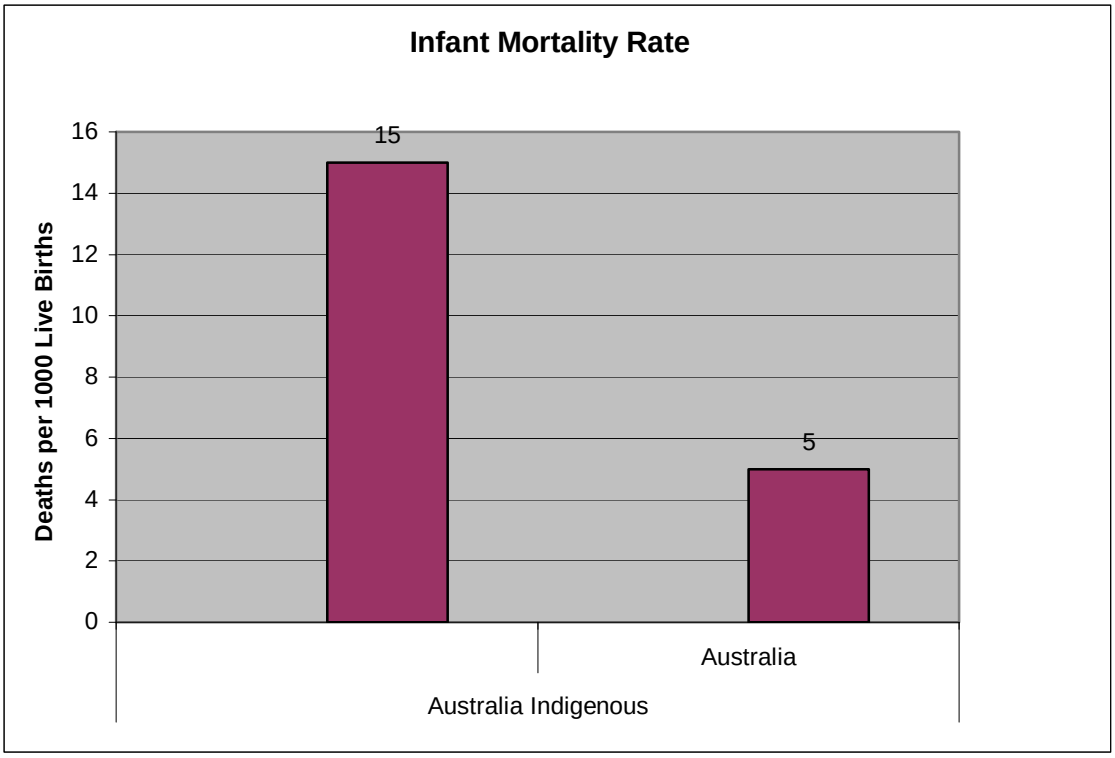
The life expectancy figure does not appear to have improved since 1970.
This is consistent with current thinking which suggests there has been no significant improvement in Aboriginal Health or mortality in the past 20 years. (chapter 1: “Aboriginal Primary Health Care –An Evidence-based Approach” by Cousos and Murray 1998)

2. Death rates :

The combined data from death registrations of Aboriginal people in Western Australia (WA), South Australia (SA) and the North Territory (NT) from 1995-1997 revealed:

- Standardised mortality ratios (SMRs) (the ratio of the number of Aboriginal deaths to the number expected from non-Aboriginal age-, sex- and cause-specific rates) for all causes of death were 3.0 for both males and females;
- Death rates for Aboriginal males and females were higher than those for non-Aboriginal males and females for every age-group;
- Death rates of Aboriginal people were 5 to 7 times than those of non-Aboriginal people in the 25-54 year age range;
- Disease of the circulatory system (including heart disease and stroke) was the leading cause of death for Aboriginal people, with an SMR of 2.9 for males and 2.5 for females. The next most common causes of Aboriginal deaths were injuries, disease of the respiratory system, neoplasms (cancers), endocrine diseases (particularly diabetes) and digestive disorders.

The combined infant mortality rate for Queensland, WA, SA and the NT in 1998 was 15.2 infant deaths per 1,000 live births, about three times higher than the overall Australian rate of 5.0 per 1,000. Of these deaths, about half are likely to be attributable to the effects of malnutrition. The death rate from pneumonia is also greater than the state average.



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The data on death rates and infant mortality reflect the consistent pattern of a very poor health status.

II. Hospitalisation

Due to problems with the identification of Aboriginal people in hospital records (studies have shown that the NT is probably the only State for which the level of identification is very good), under-identification should be taken into consideration when examining the following data:

- In 1997-98, admissions for Aboriginal males across Australia were 1.8 times more than other males, and Aboriginal females 1.9 times more than other females.

- Apart from renal dialysis (requiring multiple admissions for a relatively small number of people), which was responsible for 25% of Aboriginal admissions in 1997-98, the main causes of hospitalisation for Aboriginal males were injuries (13%) and respiratory diseases (13%), and for Aboriginal females pregnancy and childbirth (17%), respiratory disease (9%) and injury (8%).

III. Selected health conditions

Main causes of illness and death :
- 26% circulatory conditions
- 16% injury and poisoning
- 15% respiratory conditions
- 8% diabetes

1.Cardiovascular diseases

Compared to other Australians and excluding Aboriginal people that live in remote areas, Aboriginal people of all ages are more likely to suffer from cardiovascular diseases.
Although there were relatively few deaths from heart failure and peripheral vascular disease in Aboriginal people between 1995-1997, the high level of cardiovascular disease did result in the following differences in death rates between Aboriginal and the total population:

- overall deaths from cardiovascular diseases were twice as high,
- coronary heart disease; 1.7 times higher for stroke, 3 times higher in males and 1.7 times higher in females,
- rheumatic heart disease was 19 times higher in males and 13 times higher in females.

2.Injury and poisoning

Injury:
Most of these deaths are due to motor vehicle accidents.
Death due to injury is 3-3.5 times more common in Aboriginal people and is the most common cause of hospitalisation for Aboriginal males and the 3rd most common cause amongst Aboriginal females.

Poisoning:
Suicide is responsible for 1/3. It affects mainly men.
Tobacco smoking and unsafe alcohol intake are common.
Alcohol problems are mainly present in towns and fairly absent in remote areas.
In town, alcohol leads to a multi-system disease and serious social consequences:

. family disruption
. unemployment
. depression
. suicide
. violence
. homicide
. incarceration in prison

The non-Aboriginal responses to Aboriginal Alcohol use has been the introduction of harm minimisation social models such as Sobering-up shelters, decriminalisation centres because of perceived inadequate self control and incarceration for “deviant” behaviour.

3. Respiratory diseases

- chronic bronchitis consecutive to smoking has improved
- classical lobar pneumonia still common :

an invasive pneumococcal disease has been reported as one of the highest anywhere else in the world.
Death due to overwhelming respiratory infections occurs across all age group.

Deaths from respiratory diseases are much more common in Aboriginal people (five to six times that of non-Aboriginal people) with infections being responsible for almost half of these deaths (nine to eleven times more common than among non-Aboriginal deaths).
Deaths due to chronic respiratory diseases were 3-5 times more common than those expected from total Australian rates. Aboriginal people are more likely to be hospitalised for respiratory disease (twice the rate of non-Aboriginal people) and it is the second most frequent cause of hospitalisation within this group.

4. Cancer

Based on data available for WA, SA and the NT between 1987 and 1996, the incidence of cancer amongst Aboriginal males was lower whilst that of Aboriginal females was similar to that of non-Aboriginal females. However, the death rates from cancer were much higher for Aboriginal people. An analysis by the SA Cancer Registry concluded that this is probably due to the diagnosis of cancer at more advanced stages of tumour growth. In terms of the different types of cancers; lung, cervical and liver cancers were high in Aboriginal people while those for colon, breast, skin and lip were low.

5. Diabetes

Diabetes is a disease in evolution in indigenous communities world-wide:
It has been called “the new Leprosy”: with its complications of skin ulceration and loss of limb.

NIDDM is a major health problem amongst Aboriginal people and its overall prevalence has been estimated at 10-30% (2-4 times higher than for non-Aboriginal people) and occurs at a younger age than in non-Aboriginal people. Between 1995-1997 deaths were 9 times more common for Aboriginal males and 16 time more for Aboriginal females living in WA, SA and the NT. Hospitalisation rates of diabetes in Australia from 1997-1998 were around 6 times that of the non-Aboriginal population.

6. Renal diseases

For the whole of Australia, the crude incidence of End Stage Renal Disease (ESRD) between 1993 and 1997 was 295 cases per 1 000 000 for Aboriginal people and 60 per 1 000 000 for non-Aboriginal people. These rates were particularly high for Aboriginal people of the NT (750 per 1 000 000) and WA (495 per 1 000 000).

Diseases of the urogenital system (mainly kidney disease) was responsible for around 2% of deaths in Aboriginal males and 4% in females in WA, SA and the NT between 1995 and 1997, with the rates being 7-8 times higher than that expected for the total Australian population.
These diseases accounted for 29% of all hospital admission for Aboriginal people between 1997 and 1998 with renal dialysis alone being responsible for 25% of these admissions.

7. Communicable diseases

The following information about communicable diseases has been collected from a variety of sources:

- ***tuberculosis*** for 1996; the rate of notification of new diseases was 16.1 per 100 000 for Aboriginal people compared to 1.2 per 100 000 for non-Aboriginals.
- ***haemophilus*** from 1996 to 1998; was 1.7 per 100 000 for Aboriginal people compared to 0.3 per 100 000 for the total Australian population.

- ***meningococcal*** infection from 1996 to 1998; the notification rate was 7.9 per 100 000 for Aboriginal people compared to 2.5 per 100 000 for non-Aboriginal people.
- ***salmonellosis*** for 1996 to 1998; the notification rate was 102 per 100 000 for Aboriginal people compared to 43 per 100 000 for non-Aboriginal people.
- ***syphilis*** for 1996 to 1998; the notification rate was 115 per 100 000 for Aboriginal people.
- ***gonococcal*** infection from 1996 to 1998; the notification rate was 619 per 100 000 for Aboriginal people compared to 33 per 100 000 for the total Australian population.
- ***HIV*** from 1992 to 1998; the notification rate was 5.2 per 100 000 for Aboriginal people compared to 5.5 per 100 000 for non-Aboriginal people. However, despite the similarity of these rates it should be noted that for non-Aboriginal people the rate declined steadily over this period whereas the rate for Aboriginal people did not. In addition, the proportion of Aboriginal women infected was higher than for non-Aboriginal women (27% compared with 9%) and that infection was more commonly acquired heterosexually by Aboriginal people (37% compared with 15%).

8. Births and pregnancy outcome

Generally, Aboriginal women tended to have more babies and at a younger age that non-Aboriginal women. For example, in 1996 the highest birth rates were for the 20-24 year old age group in Aboriginal women and in the 25-29 year old age group in non-Aboriginal women. The total fertility rates were 2228 birth per 1000 Aboriginal women compared with 1790 per 1000 for non-Aboriginal women. Babies born to Aboriginal mothers had a mean birth weight of 3149 grams compared to 3365 grams in non-Aboriginal women. In addition babies born to Aboriginal women were twice as likely to be of low birth weight[*] (12.4%) than babies born to non-Aboriginal women (6.2%). The perinatal[+] death rate for babies born to Aboriginal women (21.8 per 1000 total births) was twice more than that observed for non-Aboriginal women (9.7 per 1000).

[*] low birth weight is defined as a birth weight of less that 2500 grams.

[+] a perinatal death is either a stillbirth or a neonatal death (within the first 28 days of life).

9. Health expenditure

As can be observed from all of the above data, there exists a rather substantial disparity in health status between the Aboriginal and non-Aboriginal people of Australia.
However, despite these differences it is interesting to note that health spending on Aboriginal people was only 8% higher than that on non-Aboriginal people in 1995 to 1996. Per capita spending by State and local government was twice as much for Aboriginal people than for non-Aboriginal people and was largely due to the much higher rates of hospitalisation observed for Aboriginals. In contrast, for every dollar per capita spent by the Commonwealth on non-Aboriginal people, only 63 cents was spent on Aboriginal people (this is thought to be mainly due to the much lower per person Medicare and Pharmaceutical Benefits Scheme Expenditures).

IV. Aboriginal Health in the Kimberley region

1. The health status of the Kimberley population

As has been observed for most of Australia, the health status of Aboriginal people in the Kimberley is worse that that of non-Aboriginal, this can be said of Aboriginal living within the town and in remote communities. The health problems faced by this group of people can be summarised as follows:

- ***diseases associated with aspects of the 'western lifestyle';*** cardiovascular diseases, diabetes, cancers, chronic lung disease. These can be prevented by changes in diet:
  .decrease intake of fat and refined carbohydrates
  .increase intake of fresh fruit and vegetables
  .increase physical activity and to stop smoking.
- ***diseases related to dispossession and the social environment of recent times (such as cultural dislocation, discrimination and institutionalisation)***; suicide, alcoholism, violence, accidents, infections.
- ***diseases related to the physical environment people live in;*** infectious diseases due to overcrowding, problems with waste disposal and access to clean water.

a) Diseases associated with aspects of the 'western lifestyle'

- Diabetes

The statistics for diabetes among Aboriginal and non-Aboriginal people have already been mentioned. Diagnosis is based upon the following criteria:

Methods of prevention include: controlling obesity; encouraging good nutrition and exercise; education about the role of family history, weight gain, exercise, diet and their role in diabetes; increased screening for diabetes as well as some of its associated illnesses (renal disease, hypertension, eye problems, cardiovascular disease, obesity, foot disease); increased public awareness; decrease smoking; decreased alcohol intake.

Treatment requires a trial diet of 8 to 12 weeks duration. Should this fail to maintain glucose levels within the target range then oral hypoglycaemic medication is prescribed (ex. metformin, α-glucosidase inhibitors, toglitazone and sulfonylurea drugs). Insuline is indicated for pregnant women with pre-existing diabetes and for women with poorly controlled gestational diabetes. Patients are encouraged to self-monitor their glucose levels.

Diabetic nephropathy

This is one of the most common causes of End Stage Renal Failure (ESRF) among Aboriginals and the commonest cause of death in diabetes. Here are some definitions:
-*Diabetic nephropathy*: the presence/persistence/ouvert proteinuria (> 300mg/24h or 200 μg/min) and is usually accompagnied by hypertension.
-*Chronic renal disease*: a serum creatinine level > 200 μmol/L or a calculated GFR < 50 ml/min on 2 occasions at least 1 month apart or in the absence of illness.
-*Chronic renal insufficiency*: a serum creatinine between 0.12 – 0.20 μmol/L.
ESRF: < 95% irreversible reduction in renal function.

Diagnosis is by measurement of serum creatinine levels, proteinuria and microabluminuria. Measures of prevention include: prevention of streptococcal pyoderma and their sequelae; control of post-streptococcal glomerulonephritis; screening for chronic renal disease; treatment of hypertension; avoidance of radiocontrast media; control of blood glucose levels, blood pressure, the intake of dietary proteins, calcium and phosphorous; the use of ACE inhibitors; screening for microabluminuria and creatinine; urinalysis.

Diabetic retinopathy

One of the leading causes of blindness in Aboriginal people between 20-65 years of age. Screening should be performed at the time of diagnosis of diabetes and every 1-2 years thereafter.

Diabetic foot diseases

Defined as any infection, ulceration or destruction of the deep tissues associated with neurological abnormalities. These can be prevented by adequate glycemic control, education on foot care, increased physical activity and screening.

- Hypertension

The statistics for cardiovascular diseases has already been mentioned and it should be noted that in 1989 the prevalence of hypertension among Aboriginal people is 2 to 3 times higher than in non-Aboriginals. Hypertension is a risk factor for renal disease, ischemic heart disease, cerebrovascular disease and peripheral vascular diseases, with the risk increasing with the increase in blood pressure, it is also commonly associated with diabetes. Hypertension is defined as a blood pressure of greater than 149/90 mm Hg on at least 3 occasions over a period of 3 months.

Treatment includes: weight loss; increasing physical activity; decreased intake of salt, alcohol. Should these measures fail after 3 months than drug therapy should be started.

b) Diseases related to the poor living conditions

- Skin infections

Skin infections are 6.8 times more prevalent in Aboriginal people than in non-Aboriginal people. Aboriginal people of the Kimberley are particularly susceptible due to a limited access to clean water, heat, humidity, insect bites and overcrowded living conditions. The main cause is streptococcus A (GAS) with others being fungus and scabies. Consequences of a GAS skin infection include rheumatic fever, glomerulonephritis and S. pyoderma (impetigo).

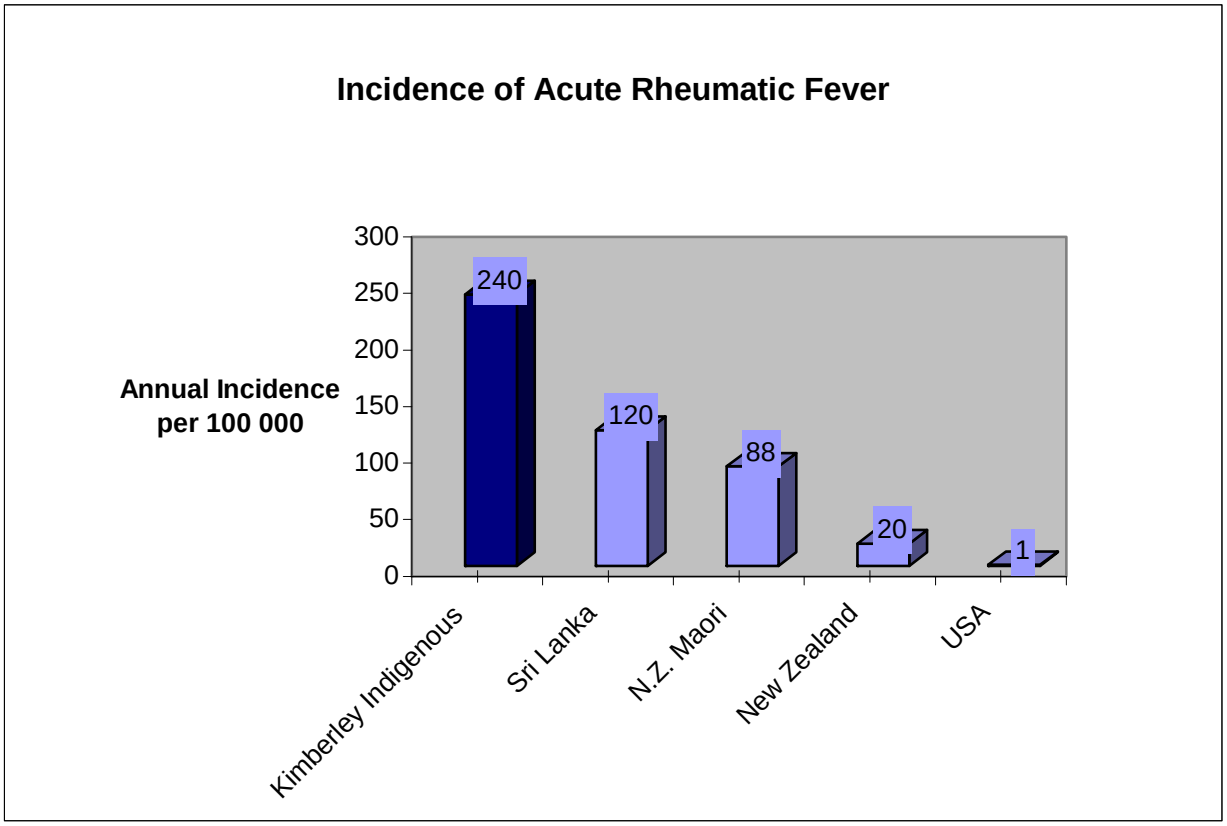
Suggested methods of prevention include: an increased supply of clean water, increased hygiene by improving bathing facilities, reduction of overcrowding, control of infections, antibiotic prophylaxis and pharmacological prevention of the consequences of these infections.

- Rheumatic Fever

The figures below have been supplied through the Kimberley Public Heath Unit (K.P.H.U).

Rheumatic Fever is a serious disease which may cause permanent damage to the heart and is sometimes fatal. It is associated with overcrowding, poor sanitation facilities and malnutrition. As such it is a good marker of poverty and social disadvantage.

It has essentially disappeared from non-Aboriginal society in Australia and in most areas it is not a notifiable disease, therefore no meaningful national figures are available.



In the period from 1989 to 1993 in the Northern Territory (NT), the incidence of rheumatic fever was the highest in the world with 282 per 100 000 aboriginal children in the age range of 5 to 15 years being infected.
The main precursor of these infections is the GAS. Major criteria for diagnosis is the observation of 1 major (carditis, polyarthritis, Sydenham's chorea, erythema marginatum, subcutaneous nodules) and 2 minor manifestations (arthralgia, fever, an elevated ESR or creatine protein, a prolonged PR interval) of the disease, a positive culture from a throat swab or and increase in anti-Dnase B. Rapid AG testing is rarely used since acute rheumatic fever is quite common and it is more economical to treat all children that present the symptoms of pharyngitis.

Methods of prevention include:
- Decreased exposure to GAS infections.
- Prophylaxis of initial episodes of acute rheumatic fever, bacterial tonsillitis/ pharyngitis, asymptomatic throat infections and recurrent episodes of acute rheumatic fever.

- Regular injections of penicillin prevent repeated attacks. Unfortunately, in the Kimberley, the implementation of this long-term follow-up falls far short of best practice. The principal reason for this is the lack of staff and resources in the health sector.

World Health Organisation estimates suggest that for every 3.14 injections given, a day of hospitalisation is prevented from Rheumatic Fever. The achievement of better follow-up would result in considerable cost savings for the health system. The challenge for funding bodies is to direct resources to areas of real need such as this and thereby reduce unnecessary waste of public funds on hospital care. Needless to say, this would also reduce the considerable suffering and mortality associated with recurrent attacks.

- Ear Infections

Otitis media is much more common amongst Aboriginal people and is responsible for many of the hearing problems faced by these people. A 1979 survey of Aboriginal children living in the Pilbarra showed that 25.6% of children under the age of 10 years had Otitis media.

Diagnosis is mainly by otoscopy and an evaluation of hearing. Methods of prevention include: reducing the risk factors associated with ear infections (ie. breastfeeding, reduction of passive smoking, reduction of infections due to swimming); treatment with antibiotics, improved screening for hearing loss and infections; surgery.

- Trachoma

This disease affects primarily Aboriginal people of north and south Australia. The major cause of trachoma is chlamydia trachomatis of the eye (serotypes A, Ba, B and C) and children are the main source of infection to others.

Diagnosis involves the observation of the 5 signs of trachoms (trachomatous inflammation (follicular or intense), trachomatous scarring, trachomatous trichiasis and corneal opacity). Trachoma can be prevented by limiting repeated trachoma infections, surgery to correct trachomatous trichiasis, antibiotics to reduce the reservoir of chlamydia infections, teaching facial cleanliness to pre-school children and environmental changes in order to reduce transmission of trachoma (e.g. decrease the number of flies, reduction of overcrowding, increase hygiene).

2. Epidemy during our stay:

A Giarda Diarrhea epidemy caused by a protozoaire that infects waters and food, has been identified during our stay in Bidyadanga.

3. An Analysis on Child Malnutrition in Halls Creek Shire (East Kimberley) :

taken from A Summary of local issues prepared by the Halls Creek failure to thrive committee, April 1999.

The total Shire population is around 3200 persons of whom 80 % are Aboriginal. About half of the population is under 20 years of age.
According to a recent case-note audit based on Health Department of WA growth charts : the results showed that 40 % of children were moderately or severely malnourished according to WHO criteria : below minus 2 standard deviations from median weight for age from reference population.
A further 32% of children in the sample demonstrated milder degrees of malnutrition as evidenced by downward crossing percentiles.

Childhood malnutrition is known be associated with many health problems:

- reduced immunity leading to an increase in infectious disease
- behavioural disturbances : learning difficulties and poor educational achievement
- recent evidence suggests that perinatal deficiency of essential fatty acid and iron deficiency in infancy can permanently impair mental function through inhibition of normal brain development. Deficiency of other specific vitamins and trace elements is associated with a variety of cognitive and developrnental deficits.
- predisposition to a number of diseases in adult life : ischaemic heart disease, non insulin-dependent diabetes and renal failure.

Aboriginal children still die at rates three to four times that of non-aboriginal children. Extrapolation of information from studies in developing countries would suggest that more than half of the excess deaths in Aboriginal children are attributable to malnutrition**.**

As in Third-World countries, the causes of child malnutrition in Halls Creek Shire are largely related to broad social, political and economic factors including :

- poverty,
- poor housing and sanitation,
- lack of education,
- difficulty in accessing health services,
- high cost of food,
- dispossession from traditional lands and disruption of traditional culture and relationships.

Internationally, much work has been done in evaluating strategies for the alleviation of child malnutrition.
Planned interventions could be implemented with the support and involvement of local people :

. The impact of didactic nutritional education as an isolated strategy is generally disappointing, especially when poverty or other environmental factors prevent people from putting into practice what they have learned;
. School-based supplementary feeding programs implementation could improve attendance, behaviour and school achievement;
(International studies have shown this to be a cost-effective public health intervention.)
. Regular worming programs and provision of essential nutrients such as iron and zinc have proved effective in a number of studies;
. Home visiting programs are highly effective but require significant resource allocation. Whilst such strategies may offer significant relief, it is only through substantial improvement in political, social, and environmental conditions that permanent solutions are likely to be found.

Child malnutrition in Aboriginal communities has been around for more than a century. Its extent has been described in medical and scientific journals and in other forums on many occasions over the last thirty year. It is an important determinant of the future of the aboriginal people.

General Conclusion

Thanks to an aboriginal person we found through internet from Geneva, we spent 6 weeks in the Kimberley region which allowed us to meet aboriginal people, doctors and nurses, anthropologists and lawyers working with them. Our 6 weeks alternated between 2 ways of life: the Aboriginal life in outback communities and the Western life in towns.

Aboriginal people, in towns and in remote areas, live in *poor conditions* which lead to high rates (in comparison to non-Aborigines) of infections, and diseases such as cardiovascular diseases and diabetes, due to unfresh, cheap and unbalanced food brought from stores. The Aborigines in towns, in contrast to those of the remote areas, suffer more from diseases related to dispossession, cultural dislocation and discrimination in the form of suicide, alcoholism and violence. All in all, the Aboriginal *physical health status* is the worst one of any other ethnic groups in Australia. Although the health care provided to them seemed very similar to any practiced in a developed country, the gap between the Aborigines and non Aborigines in the physical health field is explained by the social, educational and economic disadvantages due to their long history of discrimination and cultural barriers.

No matter how alarming their physical health status is, we have noticed a subjective positive point concerning the *health* of the outback communities, those communities that had the chance to keep their culture alive: In contrast to the Aborigines of the towns and to a larger extent to our "western societies" in Europe or in the rest of Australia, these people seem happier, less stressed and hopeless. We also felt as 200 years ago Joseph Banks and James Cook reported: " they are *far more happier than we Europeans; being wholly unacquainted, not only with the superfluous by the necessary Conveniences so much sought after in Europe, they are happy in not knowing the use of them. They live in a Tranquillity which is not disturbed by the Inequality of Condition. (…) Far enough removed from the anxieties attending upon riches, or even the possession of what we Europeans call common necessities. From them appear how small are the real wants of human nature, which we Europeans have increased to an excess."*

Aboriginal people in the remote areas, live with a harmonious and supportive view of life, with respect of the nature, in a spiritual peace, without any discrimination, nor distrust towards strangers as we were. To illustrate this: we were welcomed and integrated into their families and activities.
We do think that this welcome reflects a high level of hope and mental well-being, that is questionably higher than in our western societies where money, time, competition and environmental pollution become more and more important.

On one hand, in outback communities, we discovered “Tranquillity and Wisdom” with physically unhealthy men; and on the other hand, in towns, we rediscovered our own “physically Healthy Society” with a view of life, based on money and appearance, that leads to racism and no respect of nature.
Two worlds that, sometimes less than 100 km apart, lead us to wonder on which one could finally be more helpful to the other?

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II. Discussions with aboriginal people :

.*from the Gibb River Road :*
-Narelle : the Senior Aboriginal Health Worker (AHW) we were hosted by.

.*from Bidyadanga :*
-Susanne : health reprentative of the community and her mother
-Morven and his Family from the Karhadjary group
-Barbara the Aboriginal Health Worker who speaks 5 aboriginal langages

.*from Djarindjin :*
-Sampi Family : Evelyne, Kassy, Glenis, Oncle Andrew,

.*from Broome :*
-Jennifer and Nevelle Poelina and their children

.*from Perth :*
-Ricky Osborne from the Curtin Indigenous Research Center

III. Discussions with non-aboriginal people

In Australia:

.*Doctors :*
- Katherine
-

. *Nurses :*
- Juliana and Aaron : from Bidydanga
-
-

. *Lawyers :*
- Paul Castley

.*Anthropologist :*
- Patrick Sullivan
-

.*from the University of Geneva:*
-Dr Robert
- Dr Chastonnet

IV.Demography and statistics

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