ABORIGINAL STUDIES – Marr Mooditj: Twenty-five Years of Community Controlled Health Education

Summary of Proposed Research Program for Doctor of Philosophy

Title
Marr Mooditj: Twenty-five Years of Community Controlled Health Education

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

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

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

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

Objectives
My central research question will be:

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

To answer this question I will focus on the following objectives:

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

Background

The Nyungar peoples of the southwest of Western Australia appeared to be healthy when the Europeans came to our shores in 1829, and certainly in better health than the newcomers (Saggers and Gray 1991, 95). In retrospect it was assumed that their good health was due to their hunter and gatherer lifestyle and spiritual beliefs (Abbie 1970; Thompson 1984). '[The] estimated life span of 40 years' [was] certainly better than that of 'the new arrivals' (Cowlishaw 1978, 73). Their diet consisted largely of meat, berries, root vegetables and traditional herbs, which combined to provide a recipe for good health. The diet was devoid of refined sugar and wheat flour, and produced fit physiques in contrast to the current global epidemic of obesity. 'Governor Phillip was so impressed with the physique and presentation of Aborigines he met, he named Manly Bay in the colony of New South Wales after them' (Saggers and Gray 1991, 20). This early observation corresponds with the athletic build seen in the anthropological photographs of the time (Randall 2005; Hughes 1988).

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

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

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

> *When race was the issue, all white men stuck together, boss, worker, bond and free Protestant and Roman…. Nothing the government did called*

> *forth more contempt and greater resistance than to bring white men to justice for murdering blacks* (Reynolds 2000, 133).

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

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

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

With the wiping out of traditional Aboriginal social institutions, it can be argued that a state of 'anomie' set in; an erosion of standards and values, resulting in alienation and purposelessness (see Durkheim 1964, Giddens 1972). Hartman (1958, 24) also acknowledged the "disorganisation of social and personal values during times of catastrophic stress". Hartman estimated that there were 300,000 Aboriginal people living in Australia at the time of European contact, while others have provided higher estimates. Most agree, however, that by the early 1900s only about 70,000 Aboriginal people remained. Since this time, the health of Indigenous people has deteriorated beyond that of any other social or cultural group living in Australia.

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

In 1974 the Perth Aboriginal Medical Service (PAMS) was established through the combined efforts of Indigenous and non-Indigenous health care workers. I graduated

from the inaugural Diploma of Nursing cohort at the Western Australian Institute of Technology (WAIT) in 1979 and started working as a community nurse at PAMS in 1980.

In the 1970s and early 1980s, in Western Australia, the health status of the Indigenous community was abysmal. Alcohol abuse was rife, infant mortality was ten times that of the wider society, and the life expectancy for Indigenous males and females was twenty years less than for their non-Indigenous counterparts. On all measures Indigenous health compared extremely unfavourably with the health of mainstream Australian society (Winch 1980, 451). Many people lived solely on welfare money, drank alcohol and sugar-laden soft drinks, ate fast foods loaded with fats and had little idea about healthy nutrition from either an Indigenous or a western point of view. Obesity and hypertension were common, and the spectre of diabetes was becoming pandemic (Thompson 1984, 943).

The measures introduced by the Federal and State governments and other non-Indigenous organizations combat problems associated with Indigenous health were largely ineffective. Aboriginal people's contact with government institutions had been one based on oppression and subjugation, and there was little expectation of assistance and understanding from government services and figures of authority. The Indigenous community had little respect for and trust in the government and its representatives. In the midst of progress, mayhem was taking over giving the people voice, power but no education. As Aboriginal organizations were developed by the community, there were no ongoing steps to prepare these early-day leaders to manage them. Consequently there were large gaps in developing and managing the newly founded projects. As a result, the progressive steps that were expected to lift us from segregation to self-determination in 1972 were often mouthed words with no action; and Aboriginal people remained unsure of their rights. Although Native Welfare was changed to the Department of Aboriginal Affairs (DAA), the department remained otherwise unchanged, particularly with respect to deeply held prejudices.

In this new policy era many non-Indigenous 'experts', although of good will, did not understand the Nyungar mentality or protocols. Without realising it, health professionals often either offended or frightened their Indigenous patients and, as a result, Nyungar people avoided the clinics and medical posts that were built at great cost to serve them. Those who did seek assistance did not trust non-Indigenous staff, particularly if they were spoken to in a degrading manner, as happened on many occasions.

By 1980, as one of the few Aboriginal people working in the area of health care in Perth, my task of addressing these problems became overwhelming. Some of the living conditions left a lot to be desired. The camps, with little or no running water, led to diseases, such as gastro-enteritis and skin diseases, that were endemic. It was clear that Aboriginal people needed to have education to help them to make decisions about their health, and that this education would need to be responsive and culturally appropriate. From this realisation grew the idea for an Aboriginal Health Worker Education Program. The graduates from the programme would become health advocates for their people; particularly when they spoke to non-Indigenous health professionals when relatives were hospitalised. The wider vision was of equipping Mums and Dads with the language and opportunity to talk to their children about

health and about the importance of reading the labels in the supermarket, as well as understanding hygiene in the home.

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

The Aboriginal Health Worker Program was established in 1983 as a community controlled health education program with financial help from the WA Lotteries Commission and support of key persons in the community including, Aboriginal community leaders and key persons in major hospitals, particularly Royal Perth, King Edward Memorial and Princess Margaret Children's Hospitals. It was initially based at the Perth Aboriginal Medical Service. In 1990 the college was named 'Marr Mooditj' - Nyungar for 'Good Hands'. A new college building was completed in 2000. Since its establishment, Marr Mooditj has sought to enhance and develop the role it plays in Indigenous health care training and in social and cultural life in Australia. The reputation within the state, nationally and internationally has been acknowledged through the many awards the College has received since inception, the latest being at the WA Training Awards in September 2006. Marr Mooditj was named WA Small Training Provider of the Year, which makes the College eligible to participate in the National awards later this year.

In 2008 Marr Mooditj will mark twenty-five years of Indigenous Health Worker Education. My intention is to document from a Nyungar standpoint the history of this organization and its achievements to inform the ongoing attainment of Indigenous health and wellbeing.

Significance

The research will focus on a particular Indigenous organization in a service-delivery context (the south-west of Western Australia) across an era of change. Although this organization has had outstanding success, there is a lack of research on the history and establishment of the program. This project will document the perspectives of those participating in the development of Marr Mooditj. The 'early days' participants, government agencies, non-Aboriginal and Aboriginal, will have a written history which they can own with pride. These participants broke new ground for Aboriginal

health education in Western Australia and cut through the red tape preventing appropriate service provision, despite the struggles of the day and the fact that they were starting out in new directions. These forerunners have achieved the unthinkable; growing from those with a sparse knowledge in health care to highly qualified health workers with university degrees stretching across the health sciences.

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

Research Methods

The method that I propose will construct an Aboriginal standpoint in order to understand the development of Marr Mooditj, a Nyungar organization, from a Nyungar perspective, and to provide a history for Nyungar people to read, reflect on and refer to. This standpoint will inform a qualitative, interpretative autoethnographic inquiry into the contextual and lived experience of the participants, supported and evidenced by organisational records, documents and iconographies. The members of the Advisory Council of Marr Mooditj have agreed to act as a Critical Reference Group for my research project.

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

Qualitative research could be described as using open-ended, in-depth interviewing techniques to provide insight into the way that individuals make meaning of their own attitudes, beliefs, values, feelings and behaviours. Successful qualitative research provides an understanding of the deeper meanings that an individual or group makes of lived experience, thus allowing the reader to understand what is being described (Denzin 1989; Lincoln and Guba 1985). In my project, a selection of past graduates will be interviewed, including Nyungar, Wongatha and Yamatgee peoples, who are now in gainful employment, in order to build a picture of how the Marr Mooditj Health program affected their lives. Other key non-Aboriginal stakeholders will also be invited to share their experiences.

Data will be collected from this series of open-ended personal interviews with participants. Observation, literature and document searches will serve as triangulation. At all times the welfare and rights of the participants will be paramount. Arrangements for meetings will be made well ahead of time, and will be held in a place that is private and comfortable for the participant. Interview transcripts will be returned to the participant for accuracy checking and approval. Data analysis will be carried out in a conventional analytical process whereby a number of major themes within the topic will identified by the researcher from information gleaned from documents or given by the participants in interviews. These themes will then be tested, negated or validated by taking relevant remarks from the interviews and matching them to the topics. This way will allow for a level of reflexivity to develop, as different participants often echo or confirm similar experiences or interpretations. Participants will be selected from the considerable number of people who were involved in Indigenous health activities in the Nyungar community, by way of a sensitive and non-intrusive request for participation, guided by the foreknowledge of my own considerable responsibilities as a member of that community.

I will be drawing upon the organization's formal records as well as retrieving archival material from public sources. I will also review historical documents relating to Indigenous health in local, regional, national and international contexts.

Ethical Issues

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

All participants in this research will be adults. They will be fully informed of their rights as participants, of confidentiality issues, and their rights to withdraw from the study at any time at their own discretion. In the event that a participant wishes to withdraw, no pressure will be applied for continuation, and their previously collected data will be returned in entirety. All participants will be given an information sheet, made aware of a conduct of procedure, and given appropriate contact details. No data will commence without a properly completed consent form.

Pseudonyms may be used for participants if they wish, and any information, which may tend to identify particular people or their families will be disguised at their discretion. The participants will be informed that transcriptions of the data will be available to the Supervisor/ Examiner/s, if needed in order to verify integrity of the study. Transcripts of the data will be checked for accuracy, and confirmed with the participants as soon as possible after the interview.

Facilities and Resources

No special resources or facilities are required to complete the study.

Data Storage
The data storage provisions are outlined in the attached Research Data Management Plan and meet the Curtin University Research Data and Primary Materials Policy.

Time Line
Research Preparation and Logistics *September Year 1 – December Year 1*

- Detailed investigation of existing literature
- Contacting stakeholders and potential interviewees
- Establishing appropriate Indigenous research protocols
- Preparing specific research questionnaires and interview formats
- Research training and orientation in preparation for data collection.

Intensive Research Phase *December Year 1 – September Year 2*

- Auto-ethnographic planning and writing
- Survey of graduates of Marr Mooditj and follow-up interviews.
- Interviews with key stakeholders
- Archival research focusing on the early years of Marr Mooditj.

Data Analysis and Integration *September Year 2 – September Year 3*

- Analysing the information and data collected
- Extending the ongoing research on secondary sources
- Reporting back to key stakeholders via preliminary reports and presentations
- Identifying issues requiring further investigation/clarification

Writing, Presentation and Dissemination *September Year 3 – May Year*

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