Chapter 1
Introduction

Prior to the invasion by the British in 1788, there were five to six hundred different Aboriginal nations in Australia. Each of these nations had its own individual language, its own land area, its own spiritual beliefs, its own oral history (Dreaming), its own laws, regulations, ceremonies and rites (Monticone 1999). Australian Aboriginal culture was predominantly based on hunting and gathering and involved stones, bark, bone, fibre, wood and skins. In the subsequent years, in many parts of the country this was all but destroyed, even by missionaries:

> ... well-meaning church groups with theological rigidity and missionary zeal using the laws to try and win converts, of sadists who beat and punished their young charges, of religious people who blindly refused to believe the stories they were told by the Aboriginals, and, more than anything else, of a deep racism which, by the definition of the 1948 Convention on the prevention and punishment of the crime of genocide, was unambiguously genocidal (Elder 1998:218).

For Aboriginal women, gathering traditional food demanded elaborate knowledge of the ecology of plants, trees and roots, and their properties as food and medicine. These women were described as keepers of the fire, as the creators of medicine, woven vessels and the possessors of secret knowledge.

Women knew how to transform the raw materials and animals into nurturing, healing products (Winsor 2001).

Aboriginal people living communally were separated by boundaries, different languages and belief systems, as if there were many separate small countries on the same continent. Although the separate nations of Aboriginal people traded, and at times came together for specific ceremonies, people did not cross each other's borders or attempt to enter into another's country without permission. This system developed over thousands of years, with rich and ongoing cultures centred on a cherished relationship with land and sea. Aboriginal people, before the

invasion and colonisation, enjoyed healthy lifestyles and, contrary to the early anthropological reports, lived lengthy lives (Flood 1990).

After 1788, life for Aboriginal people became a matter of enduring an adverse and shattering social and political environment, which severely affected the lifestyle, psychological bearing and physical health of all Aboriginal peoples. Aborigines have witnessed the destruction of much of the foundation of their societies through the implacable processes of diffusion and dispossession. Today, many Aboriginal communities and individuals have little or no stake in the 'whole' life of the Nation, other than what the 'Government' may choose to provide and control (Flood: 1990). The health status of Aboriginal people is the poorest of any identifiable sub-population in Australia (Australian Bureau of Statistics 1997). Substantial social and economic disadvantage, histories of cultural dislocation, undervaluing and political oppression and the experience of considerable discrimination have resulted in extremely poor health (Saggers & Gray 1996:180–183).

Despite the disadvantages of two centuries, Aboriginal cultures continue to grow in strength and resilience. The vigour of Aboriginal art in all its forms is based in the pride of people in their culture, heritage and traditions. Nonetheless, the evidence of continuing shortcomings in the actions of governments is stark and pervasive. For the majority of Aboriginal people in this country, the scourge of poverty is a daily reality. The Social Justice Report (1999) profiled disadvantage for Aboriginal people in employment, housing, education, health and justice. By any criteria, the findings are disturbing. Realising that each of these issues impacts on each other in examining society and social change, it is easy to contrast the rhetoric of the Social Justice Report (1999) to the reality of Aboriginal people's health.

The adverse health statistics for Aboriginal communities, the figures for deaths, disease and disability, are well known. Every few years, such figures are reported and attract attention but more and more they appear to be accepted as inevitable. The human element in these figures appears to be lost. Aboriginal people die

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Increasing Aboriginal participation and management in the health services foster Aboriginal control and create opportunities for the development of culturally appropriate health care. Saggers and Grey (1991) found that it is essential that Aboriginal people have an increased input into the design, implementation and evaluation of health services. Strategies aimed at increasing Aboriginal participation must target both local health provision in communities and the broader health system. Moreover, Aboriginal people in different communities have indicated a preference for health services which are specifically tailored to meet their needs and employ more Aboriginal Health Workers with recognised professional status (Winsor 2001).

Research aims

This research explores the similarities and differences between Aboriginal Health Worker experiences in mainstream and community-controlled health services; it informs readers about Aboriginal community ways of life and related cultural obligations; it facilitates the blending of both traditional and western models of management, and it demonstrates the value of recognising the significant professional and cultural roles that Aboriginal Health Workers play in the health arena.

Research objectives

The objectives of this study are to:

- conduct a relevant literature review that describes the tension between Aboriginal and mainstream cultures in which Aboriginal Health Workers work

- compare traditional Aboriginal management models to western management models of health

- identify differences and similarities in Aboriginal Medical Services and mainstream health services in rural and remote areas

- collect information on the above issues from Aboriginal Health Worker participants through interviews.

From the insight of Wayne King (1996:20) in his book *Black Hours*:

> The problems of alcohol, health and education are not the real problems of the Aboriginal community. The real problem is a sickness of spirit. If Aboriginals are to survive, we need to revitalise that spirit and have pride in being Aboriginal.

It is hoped that this project will demonstrate a valuing of what makes Aboriginal societies distinctly different and give voice to that spirit of which Wayne King speaks.

Chapter 2
Background

A brief history of Aboriginal Health Worker training

The role of the Aboriginal Health Worker is considered to have begun when Aboriginal people first cared for their own health (Elkin 1977). Grootjens and Spiers (1997) provide a detailed history of how the Aboriginal Health Worker role has developed in a western context. They note that during the Second World War, workforce shortages resulted in many Aboriginal people on the northern frontiers of Australia working as medical orderlies and sanitation workers. In the 1950s and 1960s Aboriginal people were more frequently employed in the mainstream health system as nursing assistants and orderlies in hospitals and clinics in both urban centres and remote clinics. Other programs also included training of Aboriginal people for the East Arm Leprosarium in the Northern Territory during the 1950s. It was not until the early 1960s that Aboriginal communities were taught to look after members who had leprosy in their own communities.

Grootjans and Spiers (1997:91) note that:

> Prior to this [caring for leprosy sufferers in their own communities] the Welfare Department practised forcible relocation of leprosy patients to the leprosarium where they would have to live out their lives isolated from family and community members.

In conjunction with these developments, the Hospital Assistants Course for Aborigines commenced in 1963 at the Royal Darwin Hospital. This program was discontinued in 1965 when a Northern Territory-wide Health Worker program was established with a 'cultural' approach to health. This program was located in major regional centres in the Northern Territory (Josif & Elderton 1991:11). This was the first time on record that any 'cultural' issues were genuinely addressed in the provision of health services for Aboriginal communities. The Northern Territory Government was the first to initiate this major change in health services to Aboriginal communities.

In New South Wales, the history of Aboriginal people participating in decision-making about their own health began in 1971. The Redfern Aboriginal Medical Service was established, as a landmark of self-empowerment and determination, to provide primary health care services to Aboriginal people in a culturally appropriate manner.

Between 1971 and 1980 the concept of the Aboriginal Health Worker did not exist, and while the role was surrounded with much rhetoric in health policy development, it did not translate into anything tangible for Aboriginal communities (Grootjens & Spears 1997). This situation began to change in New South Wales when a worker from the Redfern Medical Service attended the first National Aboriginal Health Worker Conference in Darwin in 1978. This acted as an impetus to establish some form of a culturally sensitive mediation and brokerage role between mainstream health services and Aboriginal communities. The Redfern Medical Centre finally resolved to establish their own Aboriginal Health Worker Training program in 1984, under the guidance of stalwart, Sister Dulcie Flowers, a professional nurse.

Despite these efforts by single and concerned individuals, the role of the Aboriginal Health Worker did not develop to any great extent through the 1970s and 1980s. In New South Wales, the NSW Department of Health did not recognise a legitimate role for Aboriginal Health Workers until the National Aboriginal Health Strategy Working Party (1989) and the Royal Commission into Aboriginal Deaths in Custody (1991) recommended that the role be formalised. The National Aboriginal Health Strategy Working Party (1989) recommended that hospitals urgently establish an employment strategy to encourage Aboriginal community members to develop and participate in the workforce, at the coalface of mainstream health services, to assist and meet the health needs of the Aboriginal community.

The role of the Aboriginal Health Worker continued to be difficult to define because of the various competing demands on Aboriginal Health Workers from both mainstream health services and from within local Aboriginal communities. Aboriginal communities have attempted to take ownership of defining the role of

the Aboriginal Health Worker in the face of much opposition from other health professionals, including doctors, allied health professionals and administrators (Winsor 2001:10).

It was not until 1985 that the role of the Aboriginal Health Worker finally gained Australia-wide recognition for providing an important contribution to the delivery of health care and services to Aboriginal communities. As the role developed, a number of difficulties in the work environment became apparent and health care providers highlighted these at the time.

Cyril Coaby (1984:3) spoke about some of the different pressures and problems faced by Aboriginal Health Workers in South Australia:

> The work of an Aboriginal Health Worker is subjected to different pressures in their work and community life, which is defined as cultural stress, i.e. living and working in the same community but applying western ways of caring for and going against cultural ways.

Most of the time Aboriginal Health Workers live in the communities where they work and quite often their work and private lives are intertwined in the communities in which they live. They share much the same burdens of illness and crises in the communities they serve. Aboriginal Health Workers are still expected to participate in the life and activities of their local communities or other communities in which their other family members live.

In 1985, accreditation of the first Aboriginal Health Workers Registration Board in the Northern Territory was established in an Act of the Northern Territory Parliament. This board was the first of its kind and remains the only place in Australia where Aboriginal Health Workers have full professional recognition through an Act of Parliament. This Act is enforced under the Health Practitioners and Allied Professional Registration Act (Grootjans & Spiers1996:11–13).

Despite the professional gains occurring in the Northern Territory, the role and the name of the Aboriginal Health Worker has changed somewhat over the years between different states and health jurisdictions. Names have changed from nurse's aide, nurse aid training, camp aide and hospital orderly to those more specific to their duties, for example HIV/AIDS, Sexual Health Worker, Drug and

Alcohol Worker, Diabetes Education Worker and Environmental Health Worker. The workers' duties and responsibilities are often specific to their workplace settings and their working conditions may vary due to the local health requirements of the communities in which they serve. Therefore, the role of the Aboriginal Health Worker continues to be difficult to define precisely, relying on the demands made by local communities and resources provided by employers (Winsor 2001).

The role of the Aboriginal Health Worker in the past twenty years

The uncertainty of the role and the lack of clarification of the Aboriginal Health Worker role began at the first National Aboriginal Health Workers Conference held in Darwin in 1978:

> Will Europeans accept everyone to be trained as one? Don leave Aboriginals low and other high. Will our general training levels be high enough for health workers' training and for other type of training? (Lak Lak inWinsor 2001:36)

This role uncertainty remained unresolved at the second National Aboriginal Health Workers Conference held in Sydney in 1997. Both of these conferences earmarked the role and recognition of Aboriginal Health Workers as a major issue to be addressed for the future of Aboriginal Health. Tregenza and Abbott (1995) and Ah Kit (1991) note that the role definition of the Aboriginal Health Worker has not advanced significantly over this long period of time. These authors also demonstrate the pressures that Aboriginal Health Workers are subjected to, from within and outside their own communities.

These pressures include:

- that they are expected to work using largely non-Aboriginal methods in an Aboriginal community
- that both traditional cultural differences and 'Western made' factions within communities and different Aboriginal organisations increase tensions for Aboriginal Health Workers
- lack of administration and organisational support to tailor positions to evolving work demands.

- Aboriginal Health Workers continue to encounter difficulties in collaborating with mainstream health services.
- they must also socialise and exist in their own community, sharing the community's aspirations, burdens and joys, and act as the go-between for their community with the mainstream health services that employ them.

One of the pivotal skills of the *experienced* Aboriginal Health Worker is to take their systemic knowledge of mainstream health services and blend this knowledge with their own cultural knowledge and community understanding to achieve better health outcomes for their community. Aboriginal Health Workers hope to use this level of knowledge and skills to bridge the cultural divisions that stop community members from fully utilising available health services. The Aboriginal Health Worker can therefore make a tangible, realistic impact on addressing the poor Aboriginal health status when properly trained and supported. Unfortunately, Aboriginal Health Workers are rarely adequately recognised for their capacity to blend the knowledge of two worlds (Reid & Trompf 1991:406). This lack of support means that they often learn in a trial and error fashion and not in a systematic and planned way.

Community influence on the Aboriginal Health Worker role

Aboriginal Health Workers' roles will vary from one area to another. Some communities may expect the Aboriginal Health Worker to have skills in clinical care, while others may prefer Aboriginal Health Workers to adopt a community development role. The role of the Worker therefore will be largely determined by the demands and needs of the local community and the skills and qualifications of the workers (Winsor 2001:22). In New South Wales this is particularly apparent. The present study will explore the similarities and differences that Aboriginal Health Workers experience between mainstream and community-controlled health services. This examination is presented as a realistic reflection of the types of environments in which Aboriginal Health Workers currently exist and function (Sherwood 1999:5).

Communities usually have a say in choosing their health worker but this too can be fraught with difficulties. Sometimes a person is chosen for the role because of

family ties rather than merit. On other occasions, a person may come from a different area and is not socialised into the local community they must serve. On the other hand, some do come from other areas and are highly respected people who can work effectively in the Aboriginal community. The Aboriginal Health Worker selection process may also vary from area to area; however, careful consideration would always be taken to ensure that locally appropriate members are appointed to the selection committee. Non-Aboriginal society can look upon appointments based on formalities as nepotism; however, family obligation and kinship reciprocity is extremely important for Aboriginal communities to function and they can dramatically affect how well the Aboriginal Health Worker is received by the community. Thus, what non-Aboriginal people call nepotic appointments are viewed as familial reciprocity by Aboriginal people. Due to different communities requiring different roles of their Aboriginal Health Workers, it would be hoped that consideration of how these roles are to function and to whom the Aboriginal Health Worker is responsible would be clear before appointing someone to the role (Reid & Trompf 1991:407).

Issues of living in two worlds

Aboriginal Health Workers are often the first point of contact with the health care system for Aboriginal people. Therefore the development of the Aboriginal Health Worker's role is essential for the culturally appropriate delivery of health care to Aboriginal communities. Traditionally, little attention has been paid by the wider health system to the important contribution that Aboriginal Health Workers make to the health and wellbeing of Aboriginal communities (Flick 1997:19–20). This lack of consideration occurs because Government health professionals and the wider community usually do not fully understand the role of the Aboriginal Health Worker, let alone the health problems confronting Aboriginal Australians. Moreover, attempts to define the role have been a source of continuous, ongoing contention.

Reid and Trompf (1991:407) state that:

> In a number of programs, the role of the health worker has been inadequately defined and this has led to problems for workers leaving their employment. In 1989, in an attempt to rectify this situation, the National Aboriginal Health Strategy Working Party

> recommended the development of uniform, accredited courses for Aboriginal Health Workers.

The role definition issues raised by Tragenza and Abbott (1995) were previously supported at the Second National Aboriginal and Torres Strait Islander Health Workers Conference (1977) in Randwick as one of the primary recommendations and imperatives to be addressed under Health Worker professionalisation and representation.

The role of the Aboriginal Health Worker has often been described as a brokerage between Aboriginal and non-Aboriginal cultures. This is seen by many Aboriginal people to facilitate other Aboriginal people through a less stressful passage through the health care system.

> In the role of cultural broker, the Health Worker is the go-between, the link between the health services and the community, the person in the middle of, and participating in, the two cultures (Tregenza & Abbott 1995:23).

The idea of the 'go between role' is clearly specified in the competency standards set out for Aboriginal and Torres Strait Islander Health Workers (National Community Services & Health Industry Board, 1996). The World Health Organization's Alma Ata Declaration of 1978 goes as far as to suggest that this brokerage role for Health Workers is essential in attaining health for all in Aboriginal local communities (World Health Organization 1978). This implies that without Aboriginal people working as cultural brokers, Aboriginal people's health will not improve. This issue has created challenges for many workers who have attempted to remain loyal to their communities while trying to remain employed by government health departments. It has been identified that health departments do not seem to appear to respect the nature of cultural obligations but try to force Aboriginal Health Workers to conform to non-Aboriginal ways of thinking and doing (Winsor 2001:10). This approach calls into question the commitment of the system to the cultural brokerage role, and reveals it to be little more than tokenism.

Western models of managing health care

Twenty years ago, Langford (1978:17) noted that within the New South Wales Health system:

> The Department stated that many Aboriginals do not seek health care because they fear the strange hospitals and doctors surgeries. They are not familiar with non-Aboriginal ideas of illnesses and are sensitive about being misunderstood.

Twenty years later, Ian Anderson (1993:38) continues to reflect the cultural barriers dividing mainstream health services and the Aboriginal community:

> Good outcomes are possible, and this will depend on the relationship between the doctor and patient, the strategy of care from the doctor must be economically, socially possible, and desirable. This can be difficult enough when doctors and patients share a class and cultural background. You can imagine how much more it would be difficult if the advice is being given by a member of a colonizing culture to a member of a colonized one.

The conflict created by this tension between the demands of mainstream management and the needs of the local Aboriginal community will be explored in greater detail in the interviews. Aboriginal Health Workers previously interviewed by Winsor (2001) made it very clear that this is one of the major problems confronting Aboriginal Health Workers in the workplace.

The western model of health care is based on bio-medical practices highlighted by 'new managerialism', which focus on data, income generation and cost recovery. Many managers are interested in how many people they can get in, and then how quickly they can get them out of the hospital system. This causes conflict for Aboriginal Health Workers who try to deal with patients holistically, using traditional methods of healing and management, while attempting to conform to the economic rationalism demanded by the health bureaucracy (Sherwood 1999). A New South Wales task force report, titled *The Last Report* (NSW Task Force on Aboriginal Health, 1990:12–13), adopted a definition of health that supports the Koori[1] perspective of health delivery and healing:

> Not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community.This is a whole-way-of-life view and it also includes the cyclical concept of life-death-life.

The Task Force (1990:12–13) went on to state its objective:

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[1] Koori which means 'person' or 'people'. In the 1960s, it came to be used by Aborigines of these areas to mean 'Aboriginal people' or 'Aboriginal person'. It was a means of identification. *Koori* is currently confined to most of New South Wales and Victoria.

> To work for significant improvement in Aboriginal infant and adult health by encouraging communities to take more responsibility for their own health and to enable and encourage communities to use existing health services.

This further reinforces the notion that Aboriginal people need to be self-determining in the management of their own health. The role of the Aboriginal Health Worker and how the role encourages the Aboriginal community to use services is crucial to this process and will be further explored in the interviews.

The mainstream health system managers have high and unrealistic expectations of the Aboriginal Health Workers and seem quick to censure them when things fail. Ah Kit (1991:53) has suggested:

> The right to make mistakes and the right to learn from these mistakes as being an essential element of self-determination ... How can people learn, how can they develop self-determination except through control and the mistakes it inevitably entails? We should also remember that the non-Aboriginal health care system is in absolutely no position to criticize Aboriginal mistakes.

The impact of Ah Kit's (1991) comments are highly relevant and may well be reflected in the way management fails to adequately prepare Aboriginal Health Workers for their roles.

Aboriginal health training programs

There are a number of professional programs and courses specifically designed to empower Aboriginal people (e.g. the Redfern Aboriginal Medical Service Aboriginal Health Worker Training) in the helping professions. Additionally, there are numerous mainstream courses at a tertiary level undertaken by Aboriginal Health Workers. Tertiary level training can provide generalist education in primary health care, community development, professional practice and/or research. However, despite this preparation and training, the status of the Aboriginal Health Worker remains low in the health care arena because these areas of training are *too generalist.* This generalist position does prepare the Aboriginal Health Worker adequately for the professional demands placed on them in the field. Resulting in Aboriginal Health Workers having little or no voice in any decision-making within the health bureaucracy and not being treated as professional equals (Winsor 2001). This lack of professional recognition of

Aboriginal Health Workers has dramatically impacted on their self-esteem and how they perceive their standing in the health system in New South Wales (Winsor 2001).

Delegates at the Second National Aboriginal Health Workers Conference (1997:86) noted that:

> The overall status of Health Workers has not changed over the years at all. Their career structures and potential for professional development are limited. Delegates expressed their frustration at a lack of clear definition of the role of Aboriginal Health Workers, this causes confusion and high expectations of what is required of the Aboriginal Health Worker by both the community and by employers and colleagues and leads to high levels of stress, issues of miscommunication and poor retention rates.

Community ownership of services

The partnership agreement policy of encouraging mainstream services to give health back to Aboriginal people in a political way was adopted by the New South Wales health system when they began to implement these partnership agreements with Aboriginal Medical Services in 1990s. However these agreements have been slow to produce genuine community ownership because of the bureaucratic demands on their functioning. It may well be that the best results come from partnerships between worker and worker, organisation and organisation, where one form of expertise complements another form of expertise. The interplay between the two requires that 'ownership' is reconciled with 'community control' and 'self-determination' in practice. However, this appears not to have been realised at the grass roots. Aboriginal people in New South Wales need to have significant control over the provision of their health before health indicators will show any improvements. Currently, control exists only as policy rhetoric in state health department annual reports or Federal Productivity Commission reviews. While Aboriginal people may have their own medical services to take control of their own health, limited funds from government departments make the delivery of care in an appropriate way, a slow and painful process: 'Aboriginal people have been disadvantaged in not making decisions about their health and decision making is taken out of their hands by the structural and positional power of the invaders' (Anderson 1993:4). Non-Aboriginal bureaucracies continue to control the purse strings.

Additionally, the New South Wales Health Department continues not to acknowledge the qualifications of Aboriginal Health Workers. New South Wales workers continue to battle for clear role definition and recognition of AHW professional status. While it is hoped recognition would give Aboriginal Health Workers influence in the development and management of their jobs, little has been achieved in terms of implementation (Second National Aboriginal Health Workers Conference 1997:30).

Flick (1997:32) highlights these issues with the following comments:

> Aboriginal Health Workers should receive the same levels of recognition and rewards that are enjoyed by the broader field of health professionals. This includes pay and working conditions commensurate with work and responsibilities.

Anderson and Flick note that these things are seen by non-Aboriginal managers as generous gifts from the system, rather than a matter of the work of the Aboriginal Health Workers.

To register as an Aboriginal Health Worker in the Northern Territory, the only requirement is to have Basic Skills training (eg: taking blood pressure, dressings, temperatures, assessing blood sugar levels) but the Aboriginal Health Worker Registration Board also accepts equivalent certificates. However, New South Wales graduates from universities still do not have any form of an association in place to protect them from potential abuse by health management, nor do they have registration supported by legislation. The underlying issue of what is and what is not legitimate expertise when servicing communities appropriately needs to be addressed. The system can effectively pressure Aboriginal Health Workers because the system will not give them credit for insight and skills without mainstream credentials and qualifications. These structural difficulties will also be explored during the interviews. How Aboriginal Health Workers have or have not adapted to them will also be of primary importance and explored in the interviews.

Current developments in the Aboriginal Health workforce

The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework was drafted in May 2002 for workforce reform and consolidation to

improve the training, supply, recruitment and retention of appropriately skilled Aboriginal health professionals. This framework is currently being implemented nationally and statewide under the auspices of the Australian Health Ministers Advisory Council. The timeframes for completion are to be decided by the various state and territory health forums over the next few years. The current project will act as an adjunct to this framework and highlight some of the framework's strategies in its findings and recommendations. The outcomes of the framework and their implications for this project are discussed in some detail in chapter five.

Chapter 3
Methodology

This chapter describes the reasons for choosing in-depth interviewing as the main strategy for exploring the work experiences of the participants. It also describes the selection of participants and the interview process, techniques for collating the data, and the method of interpreting and analysing the interview material. This study used qualitative research to examine Aboriginal Health Worker experiences and perceptions of living and striving in two worlds. Community consultation, involvement and ownership of the research are important components that needed to be incorporated into the methodology. Bearing this in mind, the methodology chosen took a grounded theory approach with narrative style interviews. Advantages of this methodology are that it provided participants with an opportunity to discuss their perceptions and contextual experiences in an appropriate setting and manner.

It is important to emphasise the integrity of the researcher's investigating experience. Informal discussions with colleagues established that there were Aboriginal people enthusiastic to speak about their experiences with the researcher. It was therefore important to connect the researcher's wanting to know with participants wanting to tell (Marshall 1999). First, it is necessary to make some comment about partiality through a short history about how the researcher's interests and values in this area have developed. As the researcher, my personal

background obviously had some influence on how I viewed the research problem and interpreted the experiences of the participants. The purpose of the following section is to provide the reader with the researcher's reasons for undertaking this project.

Personal background

As the researcher, my interests, values and close acquaintance with the research problem were the main reasons for undertaking this study. My Aboriginality and my previous work experience with health (mainstream and Aboriginal) in the New South Wales health system for several years were central to the research question. I have first-hand knowledge of the problems that Aboriginal Health Workers face each day and have experienced great personal loss through my own family and close friends in the Aboriginal community, but I have also been fortunate enough to experience the politicisation and socialisation of the Aboriginal communities across New South Wales. During this time I also developed many close professional and social relationships with members of the mainstream health and Aboriginal community-controlled health services in New South Wales and worked many long hours to better the circumstances of the communities that I serve. This background gave me the experience to perform this present research.

Through my contact with Aboriginal people who work in the health system, and my own personal experience, I distinguish the need for Aboriginal people to function in two worlds when they work as Aboriginal Health Workers. My experiences highlighted how they are subject to a variety of pressures from both their communities and the health system in which they work. I have a passionate interest in this project's outcomes for Aboriginal workers. I do not wish to presuppose the outcomes of the research, but to explore the working experiences of Aboriginal Health Workers, both good and bad. I do acknowledge that my perceptions and evaluations could be influenced but my exploration has persisted and is fostered by my motivation to make a significant contribution to the development of the Aboriginal Health Worker role. It is recognised that it is not possible to keep this research totally objective and scientifically pure of the researcher's own interests, values and presence using a qualitative design. The

qualitative approach taken here will provide a much deeper and richer response from participants than a quantitative approach would allow. Because I am the Aboriginal researcher and I live in a large Aboriginal community, there is familiarity with all the associated cultural obligations and customs. This plays a major role in the researcher's credibility to be able to navigate across a number of Aboriginal communities in New South Wales and earn their trust and respect.

My participation in this project has forced me to examine my own Aboriginal identity as an Aboriginal Health Worker. The research process has forced me to confront a number of issues. My role of researcher left me with the feeling that I was a usurper of the participants' innermost thoughts and dreams. In Aboriginal society, this is difficult to do and rarely done. Therefore, I found the role and thinking of the researcher confronting, as it forced me to separate my emotional and racial identity from the objective, detached thinking that is required of an effective researcher. This experience has helped me to clarify my role as a researcher and forced me to try to detach myself from the emotionality of the social experiences in the interviews, particularly when participants expressed the hurt that they had experienced during their working career at the time of the interviews.

The importance of telling the participants' stories became increasingly evident as the project developed. As the researcher, I gave the AHW's a voice in a way of honouring what the participants are and what they have experienced. The analysis and evaluation of the data proceeded for four months and a variety of themes and concepts emerged as the project unfolded. These themes are reported in chapter four of this thesis.

Personally, I had a difficult time being the researcher and the confidante to the participants at the one time. For me, there was a huge divide from feeling like a Koori to thinking like an academic. Throughout this whole process I felt unsure and concerned that I was only addressing the small parts of the Aboriginal participants' stories and not presenting the entire picture that came through as I lived and breathed their life spaces. At times, I have felt that I was not doing the Aboriginal Health Workers any justice as I was only producing codes that I

status of participants and their ability to decide as this project does not have a 'natural' community. While Ethics Committees also make decisions about the proposed processes for conducting research, these processes continue to be culturally inappropriate for research acceptable to Aboriginal communities.

Reasons for choosing in-depth interviewing

A quantitative study could not have provided the researcher with the necessary information to explore the topic, especially the experience of Aboriginal Health Workers and how they feel about their social experiences at work and in their communities. A qualitative methodology positions the researcher as close as possible to the participants' actual experiences when they recount their lives as Aboriginal Health Workers. Thus, in-depth interviewing was selected as the main research device. Having participants tell their own stories was a culturally appropriate way for them to share their experiences and to narrate their stories. The issues examined during the interviews were determined largely by prompt questions that the participants explored at their leisure.

The researcher had a nursing background and previous experience as an Aboriginal Health Worker, and was well positioned with considerable skills in listening, asking questions and interpreting the participants' comments. The interview process allowed information to be obtained first hand. It is acknowledged that the researcher's presence undoubtedly influenced the participants' responses; however, not interviewing does not guarantee 'valid data' and places considerable restrictions on information gathering (Denzin & Lincoln 1994:28). The necessary skill is to make the interview safe. The frankness of the responses and the openness of the discussion allowed people to be free to speak their minds. As Hammersley and Atkinson (1983:112) note:

> We should consider what the informant's statements reveal about his or her feelings and perceptions, and what inferences can be made from these about the actual environment or events he or she has experienced. The aim is not to gather 'pure' data that are free from potential bias. There is no such thing. Rather the goal must be to discover the correct manner of interpreting whatever data we have.

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purposes of this research. The total number of interviews was therefore ten (two categories of five participants each). This selection aimed to cover a wide variety of work environments and communities serviced by Aboriginal Health Workers within the state. Efforts were made to access and achieve some balance from each target group.

Within all Aboriginal communities, it is expected that Aboriginal health research initiatives will have the formal approval of a peak body representing the Aboriginal community. For this reason and out of respect for their authority, this project has been designed around the official auspices of the Aboriginal Health and Medical Research Council (AHMRC). At the conclusion of the research, the results will be forwarded to the AHMRC. While AHMRC is the peak body in NSW for Aboriginal health research, some the participants do not accept that the AHMRC represents them. However the researcher consulted with the AHMRC out of respect and to fully inform them on the progress of the project.

Due to the researcher's previous experiences of working as an Aboriginal Health Worker and having had first hand knowledge of what the participants encountered, it was relatively easy to establish good rapport with the participants. The researcher's Aboriginality was a distinct advantage in that it linked the need for specialised knowledge and skills with the requirement for interacting empathetically with the participants, all of whom were also Aboriginal. This also helped to reduce the possibility of misunderstandings in communication due to cultural differences. Presenting this research from an Aboriginal perspective is an indication of the significant importance placed on empowerment and self-management for Aboriginal people. It also alleviates, in part, the lack of control and disadvantage this particular group has endured since the inception of the role of the Aboriginal Health Worker. The researcher acknowledges that there are some limitations with this design. Interviews were restricted to a small number of participants in each chosen location and to only those who were available within the period of the study. However, the small sample ultimately provided a wealth of information that was meaningful and stimulated debate around the professionalisation of the Aboriginal Health Worker role.

Interview process

The in-depth interviews used in this study closely follow the methodology described by Minichiello (1995). The process could be described as open but focused. Interview prompts were used to act as a stimulus for discussion. The procedure involved the participants reviewing what they perceived as difficulties in their work environments and the details of their present community activities. Lastly, they were asked to reflect on their past life and present experience to identify what they had found useful in helping them to work in mainstream and/or community-based services.

The purpose of this method was to determine how each individual constructed living and working in his or her community and the work environment. The interviews also explored their own subjective experiences and identified what they perceived as barriers to functioning effectively in their roles. The researcher's task was to listen as the participants reflected on past and present experiences and then consider these experiences in relation to their role as Aboriginal Health Workers.

The researcher interviewed each participant once, with the duration and discussion topics kept as open as possible to enable sufficient but comfortable exploration of the subject matter. Each participant was interviewed for approximately two hours each. All ten interviews were completed fully with none being discontinued due to participants dropping out or not wanting to continue. All interviews were audiotaped, using a small, fairly inconspicuous tape recorder without a microphone and fitted with batteries in case of difficulty with electrical connections. Spare batteries were also kept at hand. The interviews were held in a place mutually agreeable to the participant and the interviewer, preferably where background noise and interruptions were minimal. Interviews were best held at the participant's home where possible. Sensitivity to the participants' time constraints was also an important consideration. Most of the participants had a variety of community obligations such as funeral preparation and attendance, of which the researcher had to be aware and value.

Before the interview, contact was made by phone and confirmed by letter, and a date was set for the interview. If time permitted, it was more satisfactory to allow

for an initial contact visit before the interview to familiarise the participant with the interviewer and the equipment to be used during the interview. During the initial visit, the purpose and nature of the research was explained and the prospective participant provided with a brief information form (see Participant Information Sheet in Appendix 1), which included data on whether they had worked in a community-based or mainstream health service. The date was set for the interview while the participant and the interviewer discussed the written consent form (essential for discussion clarity, to prevent misunderstanding, and as a courtesy) and both signed indicating mutual agreement (see Participant Consent Form in Appendix 2). This process allowed time to resolve any uncertainties. If participants decided to withdraw from the study, then their decision was respected without any covert pressure from the interviewer to continue. It was very clear during the initial meeting that participants could freely withdraw from the study at any stage. This was particularly necessary for Aboriginal people who may have already faced significant racism or found it difficult to speak of these painful experiences again. The decision to use data from incomplete interviews was determined by the usefulness of that data as a genuine representation of the participant's experience up to the point of the termination of the interview. If there was doubt, the data were discarded. The decision to do this was at the researcher's discretion.

The interview questions were flexible and were rephrased when the meaning of the questions seemed unclear to the participant (see Participant Interview Sheet in Appendix 3). Once the interview began, the researcher usually only asked questions for clarification or made the occasional comment to move the conversation to another level or to clarify the researcher's understanding of what the participant had said. The participant mainly 'drove' the conversation, with the researcher providing minimal input.

The data were assembled from each interview by verbatim transcribing into a transcript file. The transcript file was then attached to a descriptive account of the researcher's personal experience of the setting and the participant (the researcher's personal log). A transcript file and personal log were created for each interview. A detailed examination of the questions asked at each interview and

ideas that emerged as the study progressed were then entered into an analytical file to monitor and summarise the entire project and to develop concepts and extract themes from the data.

Analysis and interpretation

The analysis followed procedures detailed by Minichiello (1995) which entailed mounting codes in the beginning then moving to axial coding as themes began to emerge from the data. Coding continued until theoretical saturation was reached for the present study. Ten interviews were sufficient.

The mechanics of working with the material required the analytical process to be dynamic and ongoing. This involved continual identification of themes from the analytical file, and collating and filing theme material so that data could be easily retrieved. No interview process guarantees that the transcripts will be full of references to, or insights on, the basic topics of primary interest to the researcher. However, the in-depth interview process made this more likely by providing enough time, an atmosphere of trust and a setting which encouraged the free flow of reflection. These discussions provided the best opportunity for a detailed story to emerge and for the participant to reflect on the meaning that their work had for them. It also added clarity to what aspects of their jobs were within their power to control or change and what they could not change. The process of analysis began with the first interview and continued to evolve as the material was collected. The coding and interviewing provided potentially fruitful methods for reducing the narratives and extracting what work and community obligations meant for the participants. This analytic process was a combination of the meaning that the participant made of his or her experience and the meaning that the researcher found in the words of the participant. Presentation of results is in both the words of the participants and through the researcher's interpretation of the thematic material that emerged from the interview transcripts as the project unfolded.

Placement of the project's conclusions and implications

Results of the study will be summarised in chapter five. This commentary will also include reflections on how fully the actual events of the study matched the intentions of the proposal, difficulties encountered conducting the project and

how fruitful the results are in terms of implications for structural and individual work models for Aboriginal Health Workers. The commentary will also include discussion on the limitations of the inquiry and suggestions for further research.

Results from this study provide clarification on the realities that Aboriginal workers face in navigating their way through the current health systems. Implications for the future of Aboriginal Health Workers, participation in constructing their work roles, and for the future of Aboriginal Health Workers within the New South Wales health system become clearer. Most important will be the possibility for new insights and understandings, which will encourage Aboriginal Health Workers to increase their involvement in policy and decision-making about their communities and their workplace environments. A better understanding of how Aboriginal Health Workers survive and thrive in these two worlds was the ultimate goal of this research.