A history of health services for Aboriginal and Torres Strait Islander people

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LEARNING OBJECTIVES

This chapter will help you to understand:

- The defining Indigenous health periods and systems, including the contemporary health policy agenda of 'Closing the Gap'
- The varied history of health service provision to Aboriginal and Torres Strait Islander peoples
- The history of Aboriginal and Torres Strait Islander peoples' health in Australia
- The link between self-determination, community control and improved health outcomes
- How the history of health service provision to Aboriginal and Torres Strait Islander peoples relates to contemporary health outcomes

KEY WORDS

Aboriginal community-controlled health services (ACCHOSs)
Closing the Gap
cultural determinants of health
lock hospitals
self-determination
social determinants of health

Introduction

Social determinants of health The economic, social, political and environmental conditions that influence an individual's health status.

Contemporary understandings of Aboriginal and Torres Strait Islander health are largely framed by an understanding of the **social determinants of health**: the economic, social, political and environmental conditions that influence an individual's health status. These social determinants are 'the conditions in which people are born, grow, live, work and age. [They] are shaped by the distribution of money, power and resources at the global, national and local levels' (WHO, 2025).

Social determinants are the primary cause of health inequities, which are demonstrated through the 'unfair and avoidable differences in health status within and between countries' (Solar & Irwin, 2010; WHO, 2025). The social determinants of health also influence the health outcomes of different groups within a country, as demonstrated by the disparate health outcomes evident across Australia. An historical perspective of the social determinants of health reveals the thinking and actions that influenced Aboriginal and Torres Strait Islander health policies and practices, which have contributed to devastating inequities in health and social outcomes for Indigenous Australians.

This chapter offers an historical examination of Aboriginal and Torres Strait Islander healthcare from a nursing viewpoint. It considers how the current shape of Aboriginal and Torres Strait Islander health has been formed by actions taken since European colonisation. It discusses the status of Aboriginal and Torres Strait Islander health during different historical periods, including what is known about the pre-invasion health system and health service provision during the periods of initial contact, separation and protection. Finally, the chapter discusses the rise of the Aboriginal and Torres Strait Islander community-controlled health system and contemporary choices for Aboriginal and Torres Strait Islander people in the delivery of healthcare and health outcomes. It further discusses the approach taken by all Australian governments to working with Aboriginal and Torres Strait Islander people, communities and organisations in implementing the new National Agreement on **Closing the Gap** at the national, state and territory, and local levels (www.closingthegap.gov.au/national-agreement). Each section of this chapter is, where possible, framed within the prism of nursing, exploring the role of nursing in health systems and the delivery of healthcare.

Closing the Gap A federal government policy that aims to close the gaps that exist between Aboriginal and Torres Strait Islander and other Australians in health, education and employment.

Pre-contact health status and the health system

There are limited recordings of the health status, health practices and care of Aboriginal and Torres Strait Islander people prior to invasion. This section relies on the early accounts of observers and archaeological evidence from bones and tools (Smith, 2011). This evidence offers a glimpse into the health conditions of Indigenous Australians prior to colonisation.

Health status pre-invasion

Accounts of the health status of Aboriginal and Torres Strait Islander people prior to invasion vary greatly. An early explorer of the Australian continent, William Dampier, who landed on the west coast of Australia in 1688, is said to have described Aboriginal people as the 'most miserable people in the world' due to great plagues of flies prevalent for about three-quarters of the year (Bates, 1985). It is likely that the flies, wind, dust and sand caused 'sandy-blight', a condition that results in weeping eyes and trachoma (Bates, 1985).

In contrast, many other early accounts (including pictorial evidence) described how healthy, lean and fit Aboriginal and Torres Strait Islander people were. For example, one account stated that 'they were of a middle stature straight bodied and slender-limb'd the colour of wood soot or of dark chocolate … their features are far from disagreeable' (Clark, 1966, p. 51). Other accounts, such as those of Cleland (1928), Hamilton (1981) and Stone (1974) reached similar conclusions.

While it appears likely that Aboriginal and Torres Strait Islander people were healthy before invasion, some common diseases and conditions were known, including yaws and trachoma (Smith, 2011). Yaws is an infectious disease characterised by skin lesions and is highly transmissible through personal contact. Trachoma is a disease that affects the mucous membrane of the eye and cornea. The symptoms cause pain and weeping from the eye and light sensitivity. It is spread predominantly by flies and is likely to be what Dampier described in 1688 on Australia's west coast.

In addition to documented observation, bone and fossil records have been used to examine health status. Evidence from skeletal remains uncovered in various parts of Australia indicates that congenital abnormalities were present, such as premature fusion of bones in the skull, arms and legs (Smith, 2011). Neural tube defects were also present.

One study of the skeletal remains of over 1000 Aboriginal people from between the lower Murray and the south-east coastal regions found that the right tibial bone showed prevalence of Harris lines in between 8 and 33 per cent of people (the study assumed that all the people had died before the 1788 invasion). Harris lines, or growth arrest lines, are lines of increased bone density that show the position of the growth plate at the time growth stopped. They are only visible by radiograph or in cross-section. The lines are thought to be caused by periods of acute malnutrition in children under the age of five years, with the lines present for the remainder of the person's life. The rate of these lines is indicative of malnutrition occurring among people who have survived periods of food insecurity. It is likely that, due to extreme seasonal variations, many of the young population would have perished during periods of famine (Smith, 2011).

Another major source of morbidity and mortality from this period would have been trauma – either inflicted or accidental. Studies of bones from various regions of Australia show a relatively high incidence of fractures. Among one group in Central Australia, a high rate of fracture of the long bones of the leg suggests that accidents often occurred during travel or hunting excursions (Smith, 2011). Among another group from the Murray River region north of Adelaide, fracture of the left ulna was observed as a common feature, perhaps indicating the blocking or parrying of blows sustained during conflict. A study by D.G. Knuckey (cited in Smith, 2011) revealed a high proportion of skull fractures (around 50 per cent of the 94 skulls examined) among people from the Northern Territory and the south-eastern region of South Australia, most likely inflicted during conflict. (For further discussion about research and study methods, and social and emotional wellbeing, see Chapters 10, 11 and 13.)

Health systems pre-invasion

The pre-invasion Indigenous health practitioners and healthcare delivery systems have been framed by Western observers as 'traditional medicine' delivered by 'clever men and women', 'traditional healers' and 'men of high degree' (Berndt, 1943; Elkin, 1946). The delivery of healthcare and healing was often described as 'magic' and 'sorcery'. This framing of

pre-invasion healthcare most likely occurred because traditional healers placed equal emphasis on the spiritual and the physiological in their explanation and treatment of illness. From the descriptions of several authors, it is clear that traditional healers, medicine men and women, clever men and women, and native doctors looked heavily to the spiritual and supernatural worlds to explain illness and disease (Berndt, 1943; Elkin, 1946). However, it is equally the case that traditional healers were inclined to describe illness and disease as physiological manifestations.

While the clever men and women carried a heavy responsibility for dealing with health issues, they also had a broad range of other responsibilities, such as rainmaking, appeasing spirits and deciding on punishments. Within their communities, they represented what we today describe as 'the health system'. Just as contemporary health professionals use physical and medicinal treatments, so did traditional healers. A wide variety of records exist concerning the traditional use of plants for medicinal purposes (Bates, 1985; Berndt, 1943; Elkin, 1946; Locher, Semple & Simpson, 2013; Packer et al., 2012; Pearn, 1993; Smith, 2011; Walton et al., 2004). There is also evidence that injuries such as broken bones were treated in the pre-contact period. The 'healers' and 'native doctors' were predominantly male and their knowledge was passed through the patrilineal line from father to son (Elkin, 1946). However, this might also be as a result of patriarchal Western systems where anthropologists and earlier teams would only deal with men; according to Berndt (1943), there are some documented accounts of women being responsible for these roles.

CASE STUDY 1.1

Pre-invasion pharmacopoeia and treatment of injury

Prior to invasion, Aboriginal and Torres Strait Islander people had a substantial knowledge of drug-making for curative and treatment purposes. There are substantial accounts of different tribal groups' knowledge of how to use plants and animal extracts for treatment. This summary of pre-invasion treatments is drawn from Locher, Semple and Simpson (2013), Packer et al. (2012) and Pearn (1993, 2005).

The most common treatments were used across many different tribal groups. This knowledge was usually the domain of the 'native doctor'. For example, a universal treatment for rheumatism involved crushing eucalyptus leaves and rubbing them over the affected area. A common treatment for headache also involved eucalyptus leaves, which were either crushed and steamed (with the steam inhaled) or boiled (with the resin ingested). There are accounts of infected wounds being treated with leeches to remove the infection. Wounds were treated (and infections prevented) through the application of an antiseptic rub from eucalyptus leaves mixed with mud or ochre.

Treatment of fractures appears to have been common and diverse. Accounts from Western Australia describe wrapping leg bones in possum or kangaroo skin, then applying straight tree branches to either side of the leg as a brace. Twine made from possum fur was used to hold the brace together. Other accounts from New South Wales and Queensland describe the use of possum fur mixed with clay to form a cast around a fractured limb. For compound fractures, eucalyptus leaf extracts in the form of paste would be applied to the wound before a clay cast was applied – a method similar to contemporary practices.

A guide to traditional bush medicines was published by the Northern Territory Health Department in 1988. In it, many treatments were identified as having recognised therapeutic properties (ACNT, 1988).

Examination and application of traditional medicines continue today. For example, one substance obtained from a type of tree found in Central Australia and already identified as an antiseptic is also an effective treatment for rheumatism (Saggers & Gray, 1991). Scabies can be treated with tea tree oil (Walton et al., 2004), and antibiotics and antifungals with low toxicity are being developed from the Currant Bush (also known as the Maroon Bush) (Pearn, 1993). Plants and extracts that make up traditional pharmacopoeia continue to represent an area of research interest in an age of antibiotic resistance and advances in medical technology.

QUESTIONS FOR REFLECTION

- Who 'owns' this traditional knowledge of healing? Who should benefit when traditional pharmacopoeias are incorporated into current treatment approaches?
- If an Aboriginal and Torres Strait Islander client has a strong spiritual illness or wants to be treated by a traditional healer, how might traditional approaches be received by nursing staff in the hospital system today?
- How can traditional healing practices be incorporated into the care of Aboriginal and Torres Strait Islander clients in combination with Western medicine?

There are many accounts of other roles played by women in traditional healthcare. The most prominent was in the birthing process, in the role of midwife (discussed in detail in Chapter 6). While the care of women during birthing varied according to region, some similarities did exist (Bates, 1985; Hamilton, 1981). In many communities, when it was time to give birth, the pregnant woman would leave the main camp and be attended by female relatives (often her mother or mother-in-law). Typically, men's attendance was forbidden during birthing. Another common feature was the seclusion of the mother for a period after the birth.

Aboriginal and Torres Strait Islander preventative healthcare pre-invasion

Treatment of disease and illness was common in pre-colonial Australia. There is also some evidence that preventative healthcare measures were practised by Aboriginal and Torres Strait Islander people in this era. For Aboriginal and Torres Strait Islander people, preventative healthcare does not just stop diseases or illnesses, but also enables holistic care and results in living a good life.

There is a lack of a comprehensive knowledge base about Aboriginal and Torres Strait Islander healthcare that can be attributed to the 'inherent deficiency caused by the omission of Indigenous knowledge' from the onset of colonisation (Blyton, 2009, p. 119). However, despite limited literature on preventative healthcare measures in the pre-colonial era, two examples show how Aboriginal and Torres Strait Islander people stayed healthy: caring for Elders and eating native bush foods.

Caring for Elders and old people is an integral part of Aboriginal and Torres Strait Islander cultures. Many early reports of Aboriginal and Torres Strait Islander people falsely claimed that the population only lived until the age of around 40 years. Instead, impressionist observations are of Elders and old people who were very healthy and likely living into their

eighties, with the First Fleet's surgeon Worgan recounting numerous run-ins with old people and stating, 'They seemingly enjoy uninterrupted Health, and live to a great Age' (Worgan, 1788). Cultural concepts of caring for old people, providing social support and delivering medicinal remedies are all aspects of a preventative healthcare system that helped Aboriginal and Torres Strait Islander Elders and old people counter illness and live long, healthy lives (Blyton, 2009).

Another way in which Aboriginal and Torres Strait Islander people maintained their health and prevented illness was through their diets. Aboriginal and Torres Strait Islander people traditionally ate 'native bush foods': seasonally and geographically dependent meat, fruits, vegetables, nuts, seeds and insects (Watarrka Foundation Limited, 2019). Native bush foods varied between differing Aboriginal nations and clans, depending on their geographic location. In the area that is now Brisbane, Queensland, for example, coastal mobs undertook hunting and marine harvesting of dugong, turtle, fish and crustaceans, while mobs living inland traditionally ate kangaroo, emu, witchetty grubs and plants like yams, wild fig and grapes (Stuart-Fox, 2000).

Hunting, gathering, preparing and eating native bush foods were a communal feat (Blyton, 2009). This helped with knowledge-sharing and a holistic approach to diets and health that is intrinsically linked to culture and caring for Country (Watarrka Foundation Limited, 2019). Varied and well-balanced diets, and the shared role of food preparation in communities, contributed to pre-colonial preventative healthcare of Aboriginal and Torres Strait Islander peoples.

The period of initial contact, separation and protection (1788–1940s)

Health status and health provision

This devastating era of health decline for Aboriginal and Torres Strait Islander people began immediately after the invasion commenced. Between 1788 and the 1940s, the health of Aboriginal and Torres Strait Islander people fundamentally changed. People moved from the pre-invasion era of mostly good health to the very poor health status that we recognise today.

When New South Wales was established as a convict colony in 1788 by the British, their first interactions with the Aboriginal and Torres Strait Islander population were meant to be peaceful (Saggers & Gray, 1991; Smith, 1980). However, from the outset, Aboriginal and later Torres Strait Islander people were excluded from the economy and society (only convict labour was used in the early years), and other exclusionary practices ensured that conflicts arose. Most notably, land was taken through pastoral expansion (grants of land to colonists) from the early 1800s. Aboriginal and Torres Strait Islander people were physically pushed to the margins in the new society and were separated from their traditional lands. Pastoral expansion began at a rapid rate, initiating a period of conflict between pastoralists and local Aboriginal peoples. The result was often the massacre of entire family groups or the movement of people to separate camps, reserves, settlements and stations on the fringes of towns and cities. The decline in Aboriginal and Torres Strait Islander health and the decline in population numbers both stem from this time. Policy decisions and societal factors from this period continue to have a lasting legacy.

During the early colonial period, many fundamental changes occurred in the lives of most Aboriginal and Torres Strait Islander people. Dietary habits were transformed. Tobacco was introduced, as were white flour, white sugar and high-fat meats. People encountered introduced infectious diseases to which they had no or limited immunity. And they were forcibly moved: instead of living as small, highly mobile groups, they began to live in large, sedentary and mixed (tribal and family) groups. Together, these factors had a significant effect on morbidity and mortality (Sherwood, 2013).

The population figures presented in Table 1.1 illustrate the story of the destruction of Aboriginal and Torres Strait Islander communities. While the pre-contact population shown is contested (Butlin, 1982), there is no doubt that the health and wellbeing of Aboriginal and Torres Strait Islander people were significantly and negatively affected by colonisation, with estimates that two-thirds of the population did not survive.

Table 1.1 Estimated population, pre-invasion, and lowest estimated population

State	Estimated pre-contact population	Estimated lowest population	Year	% of pre-contact population
NSW	48,000	7,434	1901	15.5
Vic	15,000	850	1901	5.7
Qld	120,000	22,500	1927	18.8
SA	15,000	4,598	1921	30.7
WA	62,000	17,500	1933	28.2
Tas	4,500	18	1861	0.4
NT	50,000	15,386	1933	30.8

Sources: Saggers & Gray (1991); Smith (1980).

The large-scale movement of Aboriginal and Torres Strait Islander people into reserves and settlements had a profound effect on their health, particularly in terms of infectious diseases. While records are scant, Abbie (1969) compiled a list of the most common diseases introduced at the time: malaria, hookworm, filariasis, leprosy, smallpox, influenza, pneumonia, typhoid, measles, chickenpox, whooping cough, mumps, scarlet fever, diphtheria, tuberculosis, gonorrhoea and syphilis. Aboriginal and Torres Strait Islander people did not have immunity to these diseases, as they did not exist in Australia prior to colonisation (Abbie, 1969). The severe impact of what was probably smallpox is evident from accounts of Governor Phillip about the Port Jackson area. He noted that the disease had killed half of the Aboriginal population and appeared to spread inland and along the coast (Saggers & Gray, 1991; Stone, 1974). The explorer Charles Sturt also noticed the results of smallpox: on an inland journey into the Bourke region of New South Wales, he noted evidence of smallpox scars prevalent among the local Aboriginal population (Saggers & Gray, 1991).

Sexually transmissible diseases and infections, then known as 'venereal disease', also became a common cause of mortality, with reports of between half to two-thirds of the Aboriginal population in Port Phillip dying due to syphilis (Saggers & Gray, 1991). Venereal

Lock hospitals Remote hospitals where supposedly ill Aboriginal and Torres Strait Islander people were locked away, given little health treatment and left to die.

diseases were introduced by the English and were often transmitted as result of sexual abuse of Aboriginal women. Similar accounts were reported in parts of Western Australia and Queensland (Parsons, 2008). The concern about venereal diseases became so great that authorities soon devised measures of isolation for those suspected of having venereal disease, leading to the creation of the infamous **lock hospital** systems.

CASE STUDY 1.2

Lock hospitals in Queensland

In the early twentieth century, Queensland had two different systems for the control of venereal disease: one for the non-Indigenous population and another for the Aboriginal and Torres Strait Islander population.

The Department of Public Health was responsible for the non-Indigenous population, and focused on the reporting of venereal disease by general practitioners (GPs). This involved provision of free medical treatment and public health awareness and education programs. Sex workers who were infected could be detained forcibly at the Brisbane Venereal Disease Hospital. Once clear of infection, they were free to leave the hospital and return to the community (Parsons, 2008).

For Aboriginal and Torres Strait Islander people, the responsibility fell to the Chief Protector of Aborigines, whose primary approach involved quarantine. Almost no attention was given to developing awareness and education. The Chief Protector established quarantine stations, such as the Fantome Island lock hospital. Similar quarantine stations were established across the country (Saggers & Gray, 1991).

In Queensland from 1928 until 1945, Aboriginal and Torres Strait Islander people suspected of having venereal disease were removed from communities and transported to the Fantome Island lock hospital. The island is 70 kilometres from Townsville and part of the Palm Islands group. The lock hospital was established on the (contested) basis that venereal disease was rampant among the Aboriginal population and that the only solution was to separate those who were infected from the rest of the population (Parsons, 2008).

Aboriginal people from Palm Island were sent to build the Fantome Island lock hospital in 1926. The hospital had an operating theatre, dispensary, treatment room and hospital ward. It also had an obstetric room, irrigation blocks, office, communal kitchen and barrack wards. Men and boys lived in the barrack wards – open-aired huts with a roof but no walls, which could accommodate up to 30 patients. Women were housed closer to the hospital in ward accommodation. The hospital was staffed by up to six Aboriginal and Torres Strait Islander people, a charge attendant and a visiting medical officer, who was supposed to attend twice weekly.

When transported to the hospital, men were placed in neck chains, while women and children were placed in handcuffs. Once on the island, their treatment regimen, while consistent with medical knowledge of the day, was risky and often led to side-effects such as swelling, unconsciousness and toxic poisoning. The treatment included injections of arsenic, bismuth and occasionally mercury.

The system for diagnosing disease differed for Aboriginal and non-Indigenous people. From 1930 onwards, bacteriological testing was available and incorporated into the clinical diagnosis for non-Indigenous people. This testing was not available to the patients at Fantome Island.

During the two years from 1940, five separate reports by inspectors at both Palm Island and Fantome Island described the widespread mismanagement of the lock hospital system. The inspectors recommended that the facility at Fantome Island be removed to Palm Island and reorganised, along with a significant improvement in facilities and treatment. When the patient profiles were reviewed, the inspectors discovered to their surprise that 146 of the 192 people at the facility were disease-free. In addition, there were no signs of infection – old or new. Despite these findings, the Department of Native Affairs was reluctant to release any disease-free patients and ensured that discharged people were relocated to reserves at Palm Island, Woorabinda or Cherbourg.

Source: Parsons (2008).

QUESTIONS FOR REFLECTION

- What do you think was behind the decision to create places like Fantome Island?
- If you were asked to administer medication that is not recommended for a specific treatment (and is not best practice), how would you manage this?

Health systems

In 1837, largely as a result of an inquiry by the British House of Commons that highlighted the appalling state of Aboriginal and Torres Strait Islander health, a new system of separation and 'protection' from the excesses of the European settlers was advocated. The colonial office was to retain responsibility for Aboriginal and Torres Strait Islander people, and the states were required to finance protection. Each state had a 'Protector of Aborigines' who would look after the interests of Aboriginal and Torres Strait Islander people.

This policy change saw the establishment of reserves and missions for Aboriginal and Torres Strait Islander people. Some people moved voluntarily, though many were forcibly relocated. At the time, there was a crude health system in the colony solely for the treatment of illness (Smith, 2011); minimal public health and primary healthcare were available. Only those Aboriginal and Torres Strait Islander people who were employed under contract or those retained under the *Aborigines Protection Act* were eligible to receive treatment. Fees were applied for treatment and had to be paid to the hospital from the Protector's office.

Magistrates had the power to dispense medication or send impoverished Aboriginal and Torres Strait Islander people to hospital. When people were referred to hospital, their treatment left much to be desired. After the 1890s, nurses were the primary caregivers where the standard protocol for treating Aboriginal and Torres Strait Islander people was for treatment to be given outside in the yard or on the verandah, not in the hospital itself (Saggers & Gray, 1991). In some hospitals (for example, at Kempsey Hospital), Aboriginal and Torres Strait Islander people were admitted to separate wards. In some areas, this practice of separation continued into the 1950s (Smith, 2011). Anecdotal reports indicate that segregation wards and treatment of Aboriginal and Torres Strait Islander people on the verandahs of hospitals continued into the 1970s (Forsyth, 2007).

One purpose of the reserve and mission system was to 'civilise' Aboriginal and Torres Strait Islander people and bring them into accordance with modern education, employment,

religion and living standards (Pollard, 1988). From 1880, many Aboriginal and Torres Strait Islander children were forcibly removed from their communities without their parents' consent. Although not a violation of Australian law at the time, this practice was a violation of human rights and international law. The ways in which children were removed varied greatly. Sometimes it was achieved by deception, with parents being tricked into letting their children go with the government officials. Sometimes brutal force was used. It was not uncommon for Aboriginal and Torres Strait Islander mothers to be forced to sign forms giving consent for their children to be taken by the authorities without understanding the implications of the document being signed. It has been estimated that 13 per cent of the Aboriginal and Torres Strait Islander population was removed from families (the Stolen Generations). In addition, 31 per cent of the population had relatives who were part of the Stolen Generations, amounting to an estimated 44 per cent of the Aboriginal and Torres Strait Islander population being exposed to familial removal. People belonging to the Stolen Generations are significantly more likely to experience poorer health and socioeconomic outcomes compared with Aboriginal and Torres Strait Islander people who were not removed from their families. These impacts include increased contact with the justice system (including incarceration), higher levels of violence, poorer self-assessed health and lower household income. The effects of the Stolen Generations are also intergenerational: descendants of the Stolen Generations are more likely to experience adverse health, cultural and socioeconomic outcomes (AIHW, 2018).

Most of the children who were removed from their homes were between the ages of two and four years. There are accounts of newborn infants being taken from their mothers while at the hospital, with nurses and midwives sometimes involved in this process (HREOC, 1997). The justification for removing a child could be vague. Between 1915 and 1939, a reserve manager or police officer could remove a child on moral or spiritual welfare grounds, due to 'negligence' or even on the vague belief that it was 'necessary'.

From about 1900, health services slowly began to be established on the reserves and missions in an attempt to deal with the pressing health issues of the time. In Cherbourg (Queensland), a hospital was built eight years after the Barambah Aboriginal settlement was established (under the *Aboriginals Protection and Restriction of the Sale of Opium Act 1897)* (Cox, 2007). Similar arrangements were seen at reserves and missions across the country. The hospitals (sometimes called dormitories) were usually staffed by a non-Indigenous matron. Medical treatment was normally undertaken by visiting doctors on a rotational and sometimes irregular basis (Cox, 2007).

Although Aboriginal and Torres Strait Islander people were not allowed to participate in formal nursing education programs until much later, many (mainly females) were trained in basic nursing skills to look after patients in the reserve hospitals. They worked alongside the hospital matrons as nursing assistants. However, some Aboriginal and Torres Strait Islander women did undertake formal nursing training in the early 1900s, including May Yarrowick (Best & Bunda, 2020, 2025). A letter dated 28 May 1906 from the Matron of Crown Street Women's Hospital to the board, accepting May Yarrowick, stated that 'the fact of her being a half caste was not a valid ground in refusing her to train as a nurse. A separate room would, however, be provided for her.' In the 1940s, Woorabinda mission began to offer a two-year nursing training program for 'native girls'. Cherbourg and Palm Island missions introduced similar training programs, with mixed success (Best, 2015).