Empowerment in Aboriginal health

Objectives

After working through this chapter you should be able to:

- critically analyse the concept of ‘empowerment’
- explore Aboriginal community-controlled health services as an example of empowerment in Aboriginal communities
- analyse structural obstacles to empowerment
- reflect on existing practice.

Introduction

This chapter is divided into four parts. In Part A we discuss the concept of ‘empowerment’ and its relationship to Primary Health Care and cultural safety. Part B highlights examples of Primary Health Care, cultural safety and, consequently, empowerment in Aboriginal communities. Part C explores factors that inhibit empowerment and, in Part D, case studies are presented to ensure that our discussions clearly reflect back on practice.

PART A: EMPOWERMENT

There are as many definitions of ‘empowerment’ as there are of ‘power’; indeed the term has become a catchcry in academic and political discourse. Yet, as Wallenstein (2006) and Chamberlin (2009) have pointed out, there are no clear definitions of the term and no common understanding of the concept. As a consequence, ‘the word had become political rhetoric, with a flexibility of meaning so broad that it seems to be in danger of losing any inherent meaning at all’ (Chamberlin 2009, p 1). To address this deficit Chamberlin worked with a group of leading US consumer/survivor, self-help practitioners to develop the qualities associated with empowerment. The group identified many such qualities including:

- the power to make decisions
- access to information and resources
- a range of options from which to make a free choice
- assertiveness
- believing in the individual’s ability to make a difference
- thinking and acting on the basis of critical reflection

- managing anger
- identifying with others, acknowledging the rights of others
- effecting change in one's own life and that of one's community
- learning skills identified by the individual as important
- increasing one's self-esteem and
- embracing growth and change.

Tsey et al (2009, p1) also focus on growth and change in their definition of empowerment as:

> … both processes and outcomes, generating change at multiple levels (individual, organizational and community) and strengthening the capacity for collective action to positively influence social situations.

Further, Chamberlin (2009) indicated that empowerment was an individual as well as a group phenomenon, while McEwan and Tsey (2009) extend this further by including structural empowerment. They explain:

> Indicators of personal empowerment include improved perceptions of self-worth, empathy and perceived ability to help others, the ability to analyse problems, a belief in one's ability to exert control over life circumstances and a sense of coherence about one's place in the world. Group empowerment manifests in strong social networks and community participation in organisational decision making, perceptions of support, community connectedness and the ability to reach consensus on goal-oriented strategies. Structural empowerment refers to actual improvements in environmental or health conditions, evidenced by changes in systems, public policy and the community's ability to acquire resources to create healthier environments.
>
> (McEwan & Tsey 2009, p 7)

Most writers, then, believe that empowerment occurs when people take control of their lives, when they are in a position to influence decision making, when they have the ability and the opportunity to set themselves goals, when they have a vision about what they want to do and how they can achieve it. However, to make decisions, we have to be aware of the range of alternatives from which we can choose. To be aware of the available alternatives, we need information. To get information, we need access to the sources of information … and so it goes on. Consequently, Spindler (1994, p 7) maintains that empowerment really consists of effective participatory decision making and:

> depends both on the will to make decisions and the capacity to do so. The former includes a felt need and the expectation that the decision will be implemented. 'Capacity' includes a degree of expertise or knowledge of the subject matter as well as skill or experience in the organisational process.

Wallenstein (2006) considers participatory decision making as central to participatory empowering strategies in effective public health care interventions. Other strategies include focusing on the cultural and local appropriateness of programs, facilitating rather than directing change, and utilising community stakeholders in the identification, design and delivery of programs. As a result, 'empowerment is recognised both as an outcome in itself, and as an intermediate step to long-term health status and disparity outcomes' (Wallenstein 2006, p 4).

Activity

Brainstorm the concept of 'empowerment'. List all the elements that you believe contribute to your empowerment. Explain why you believe these elements to be important.

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However you have defined the construct, if empowerment is to generate change on an individual, organisational or community level, it must, as a minimum, be based on:

- self-awareness/self-confidence
- skills to develop understanding and action solutions
- sharing in decision making
- access to resources.

Now we've got this far, here comes the rub! When we consider the elements that we believe constitute 'empowerment', we tend to forget that empowerment is not a 'thing' but a *process*. As such, no individual can empower another! We can only create the environment to facilitate the opportunity for people to empower themselves. Shearer and Reed (2004, p 257) cited by Florczak (2009, p 89) describe such empowerment as 'a health patterning of wellbeing in which the client optimises the ability to transform self through the relational process of nursing'. The importance of relationships and 'relatedness', previously emphasised, emerges once again.

Consequently, we cannot 'empower people to participate effectively' as Spindler (1994, p 4) would have us do. We can only create opportunities for people to want to participate and to want to gain the skills necessary for effective participation. In the process, both parties involved (professional and client) should be strengthened.

Florczak (2009, p 290) agrees with us that 'this differs considerably from the perspective that the nurse gives power to the patient and in so doing the nurse's authority becomes diminished as the patient's knowledge increases'.

Historically, Aboriginal communities have had few opportunities to trust that mainstream interventions will indeed provide them with the opportunities to empower themselves. The current Northern Territory Emergency Response (NTER) is a glaring example of a public health intervention, which completely bypassed participatory empowering strategies. It says a lot about the mainstream mindset that the Intervention employed quite draconian measures such as the suspension of the *Racial Discrimination Act* (RDA), compulsory income management, compulsory five-year leases to the Commonwealth of designated communities and repeal of the permit system for entering Aboriginal lands. As Yu et al (2008, p 2 of 3) point out:

> The crisis that prompted the NTER in June 2007 is real. … But the way forward must be based on a fresh relationship.
>
> … It requires the building of effective social and civil institutions that express the values and beliefs of the community. It requires investment in local skills and capacities and leadership … If it is to work, community development must be led by the community. That is the basis for a new relationship.
>
> *It is a relationship governed by principles of informed consent, participation and partnership.* (our emphasis)

Although empowerment can relate to organisations and communities, we do believe that it has to start with the individual. Roy Gray points out that he feels empowered when he has the freedom and resources to aspire to achieving a good, healthy life—with no strings attached. 'The strings attached', the hidden agendas that prevent aspirations—that is, *systemic frustration of aspirations*—are soul destroying; they sap motivation, create self-doubt and lead to a mentality of 'we want' rather than 'we are strong and can contribute'.

It is clear from these discussions that the philosophies, processes and practices of Primary Health Care (PHC) and cultural safety contain the prerequisites for creating the circumstances in which people are able to empower themselves.

Activity

List the features that empowerment, cultural safety and PHC have in common.

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The fact that 'empowerment' has become the catchcry of government should worry all of us, because unless empowerment arises from within communities, the process can lead directly to *disempowerment*. We will keep this caution in mind in our discussion when we consider examples of empowerment in Aboriginal health.

A very important example of empowerment is the Aboriginal community-controlled health services.

PART B: AN EXAMPLE OF EMPOWERMENT: ABORIGINAL COMMUNITY-CONTROLLED HEALTH SERVICES

Aboriginal community-controlled health services (in some States referred to as Aboriginal Medical Services) crystallised the determination of Aboriginal groups to assert independence and community control by and for Aboriginal people. They emerged in response to appalling Aboriginal health statistics and the government's promised policies of self-determination and self-management. The founding in 1971 of the first Aboriginal Medical Service (AMS) in Redfern, an inner-city suburb of Sydney, was the result of a community movement. Aboriginal people felt that the existing health services discriminated against them and did not provide appropriate services. Consequently, 'Aboriginals just did not use them' (Redfern AMS, Naomi Mayers 1981).

The services, which are Aboriginal by inception, organisation, management and control, provide a unique concept in health service delivery. As Foley (1982) points out, these services are designed to be run by the people, for the people, according to their needs, and in harmony with their holistic view of health. Consequently, the decision-making base is shifted from the medical professions to community-elected boards of directors. As one doctor working in such a service explains:

> Rather than being set up by the Government of the day, the Aboriginal Medical Service (AMS) was born of the Aboriginal community's consciousness of the need for the provision of more accessible and appropriate health care to the people … its establishment and initial survival was achieved by local people and depended on the active support of the community. From the beginning it was a Medical Service operating along lines dictated by Aboriginal people.
>
> (Fagan 1984, p 19)

DEFINITION

For us, *community control* means a service where:

- the client of that service has a large say in how the service operates
- the community identifies its needs and then works together to address these needs
- the community has ownership and is wholly involved in the planning and decision making
- there is strong influence from the grassroots up
- the community does things in its own time and at its own pace
- accountability to the community is the guiding principle.

Community-controlled health services, then, are a major example of the principles underlying empowerment, PHC and cultural safety—accessibility, acceptability, participation, a shift in the power base, and a redefining of services to:

> provide scope for activities which are intended to directly strengthen the communities' social and cultural identity and advance community empowerment. These activities, in Aboriginal Health Services, have been characterised by the mass involvement of clients. Health services have recognised that such involvement can have a dual benefit. Firstly by improving the quality and attesting to the validity of a service or

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> program—this benefit is recognised in existing philosophies of community control/participation. Secondly, the involvement of clients in the programming and delivery of services has brought about a heightening of personal and community awareness. Lastly, it addresses the conundrum created by poverty, powerlessness, dispossession, oppression and discrimination.
>
> In this light, such activities are not just simply an adjunct to the quality of management or planning, they constitute a valuable and intentional act to meet a health need, and in this, they constitute a service.
>
> (Houston 1991, pp 13–14)

Regardless of where Aboriginal people live, it cannot be emphasised too strongly that the combination of historical, cultural and economic factors (including poverty) as well as the attitudes of health professionals often cause Aboriginal people to avoid existing health services. This has been known for several decades. Indeed, there is ample evidence that the treatment they received in some of these mainstream institutions diminished and demeaned them. The National Aboriginal and Islander Health Organisation (1982), the first umbrella body for the community-controlled health services, for example, made this very clear, as have Dwyer et al (2004).

A nurse working at the Redfern AMS in 1974 has provided the following case study from her experiences.

Case study

Diminished and demeaned

I knew of ten unnecessary deaths in a six months period. I believe that if these Aboriginal people had been able to access appropriate hospital care at that time they probably would not have died.

It was a powerful lesson in how the mainstream hospitals are dangerous places for a lot of Indigenous people—dangerous psychologically, spiritually, emotionally, historically, culturally etc.

Even as a non-Aboriginal nurse I felt some of this fear, frustration and anger as I sat with Aboriginal people as they waited in outpatients. The diminishing confidence and disempowerment was palpable as they were offended by words and actions of the hospital staff. Some of them, because of their experiences, were ready to be treated poorly and they seemed to pick up on the slightest misdemeanour. Most knew they had to be there so gritted their teeth and kept their head low. The next day or a few days later I would sometimes hear that they had taken themselves out of hospital.

One person I was sitting with summed her experience up—'What's the good of them saving my leg if I come out of here small and shrivelled as a person?'

State health services, with all their goodwill, are still seen as part of the white bureaucratic system, which in the past has been one of oppression and imposition. Such perceptions are not peculiar to Aboriginal people. Ramsden (1990) highlighted similar issues when she wrote about the inappropriate health services provided for Maori people in New Zealand/Aotearoa.

> As long as people perceive the health service as alien and not meeting needs in service, treatment, or attitude, it is culturally unsafe. A dangerous place to be.
>
> (Ramsden 1990, p 3)

Community-controlled health services provide an important alternative—affordable, accessible and appropriate services—which allows choice based on cultural difference. Consequently, these services have proved extremely popular and in 2009 there were 140,

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ranging from small clinics to major multifunction health centres, and accessible to at least 50 per cent of the Aboriginal population (NACCHO 2009).

However, despite three major independent studies (including the Commission of Enquiry into Poverty, *Third Main Report*, 1976; the *Report of The National Trachoma and Eye Health Program* (Royal Australian College of Ophthalmologists 1979); and the joint Parliamentary *Report on Aboriginal Health* (House of Representatives Standing Committee on Aboriginal Affairs 1979)), which demonstrated that Aboriginal/Islander-controlled health services provided more effective primary and preventative health care to Aboriginal people, and although the Federal Government's stated policy and philosophy was self-determination, community-controlled services were critically short of funds between 1971 and 1989 (Nathan 1980; Eckermann & Dowd 1988).

Most community-controlled health services were incorporated under the *Aboriginal Councils and Associations Act 1976* as well as the Commonwealth Department of Aboriginal Affair's (DAA) by-laws. We (Eckermann & Dowd 1988) have argued that this was a formula for *systemic frustration*. Organisations were expected to apply for annual funding, which was conditional on quarterly acquittals; governance of such organisations was largely hierarchical, via boards elected by the community; and there was little understanding of the nature of Aboriginal communities within the Act or the by-laws that implemented it. Further, most Aboriginal health funding continued to be allocated to State departments and their Aboriginal health units.

The reasons for these constraints appear to be twofold: first, Australia was fearful of relinquishing 'control' of a population that for so long it had considered in need of protection and direction; and second, 'assimilation' continued to play a major role in Aboriginal affairs. Thus the National Aboriginal Health Strategy (NAHS 1989) warned that although mainstream systems were aware of the need to encourage Aboriginal participation, they were unwilling to hand over control to Aboriginal people because they were 'too far entrenched in the current health system, based on the medical model, to promote or contemplate an alternative' (NAHS 1989, p vi).

Anderson (2004) argues that this trend persists and that on average the government spends only 20 cents more per capita on Aboriginal health care, which is woefully little, given the state of Aboriginal health. Further, Dwyer et al (2004, p xxiv) argue that:

> Recent expert analyses of total spending and Indigenous health care needs relative to non-Indigenous Australians … show clearly that less than half of the required funding is currently available. Within this total level of spending, there is also a mismatch of type of investment, with low spending on primary health care offset by higher use of hospital (at approximately twice the rate of non-Indigenous Australians), which is neither good for health nor an efficient use of health resources.

This discrepancy continues to exist. Indeed, Professor Ian Ring has warned that, unless Aboriginal health funds are boosted by $400–450 million a year and ad hoc and piecemeal programs reformed, Aboriginal health will not improve (O'Dwyer 2005). At the end of the first decade of the twenty-first century, nothing much has changed. Reviewers of Aboriginal health spending point out that, although budgets appeared to commit quite large sums of money to Aboriginal health, these were rarely ever spent. Thus, in relation to one of the most urgent issues in remote Aboriginal communities—family violence—COAG allocated $37.3 million over four years to Family Violence Partnerships; in 2004–05, only $858,000 was spent, in 2005–06 just $4.4 million was spent—as well as $800,000 for administration costs (*Sydney Morning Herald*, 30 May 2006).

The 2009–10 Budget firmly addressed Aboriginal health issues, and Dr Mick Adams, the chair of NACCHO, welcomed the government's commitments. Yet he was forced to highlight that:

> … NACCHO is concerned over aspects of the COAG package where
>
> Aboriginal community-controlled health services are being marginalised in favour of Aboriginal health funding going to mainstream GP services most of which never see Aboriginal clients.
>
> Aboriginal community controlled health services have over thirty years experience providing frontline primary health care in urban, regional and remote areas.
>
> If the Government is committed to the Close the Gap Statement of Intent it signed in March 2008 it is imperative to establish a partnership with NACCHO in setting Aboriginal health priorities.
>
> International examples show the greatest advances in closing the gap will be made when Aboriginal peoples have genuine control of their lives and over the design and delivery of their health services.
>
> (NACCHO 2009)

Activity

Review the influence of power and control on our current health system. In what ways are they challenged by Aboriginal community-controlled services?

PART C: FACTORS THAT INHIBIT EMPOWERMENT

In the mid-1990s, the Commonwealth Government changed its approach to Aboriginal health. In the spirit of rationalising the health dollar and in order to ensure intersectoral collaboration between mainstream and community-controlled services, regional health authorities had to negotiate partnerships with community-controlled services. If such partnerships could not be negotiated, both services lost funding.

Activity

1. Consider the term ‘partnership’. What does it mean to you?
2. Go back to Houston’s four major components of partnership (in Chapter 6) and keep these in mind as you explore this concept.

We will follow our discussion of ‘partnership’ through to the present by exploring policy developments in Queensland as a case study.

In 1994, the Queensland Department of Health launched its Queensland Aboriginal and Torres Strait Islander Health Policy. Dowd (1996) analysed this policy and pointed out that it appeared to strongly support a holistic approach to Aboriginal health. Indeed, the policy stated that:

> The philosophy of Aboriginal and Torres Strait Islander health is embodied in the key community principles that are expressed in the policy. The principles are an integral part of ensuring ownership and commitment …
>
> (Queensland Department of Health 1994, p 4)

Ownership was to be ensured through the Department’s commitment to community-controlled health services. As such, the Department and its new policy claimed that it would:

> empower Aboriginal and Torres Strait Islander people to determine their own primary health care priorities … empower Aboriginal and Torres Strait Islander people to develop and manage their own health service … extend the existing network

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> of community-controlled PHC services to provide access to primary health care for the Aboriginal and Torres Strait Islander population throughout the state.
>
> (Queensland Department of Health 1994, p 11)

As Dowd (1996) pointed out, the Queensland Department of Health proposed to empower Aboriginal communities by ensuring their *participation* in the planning, in *contributing* to staff selection and in *advice* to the Minister.

Note the words *participation*, *contributing* and *advice*. Are they really related to decision making? How would they be structurally supported?

The same rhetoric characterised other policies of the time at State and federal level. As a consequence, a number of Indigenous writers criticised such government policies as assimilationistic. Bin-Sallik et al (1994, p 18), for example, commenting on education policy, point out that 'government policies have failed to distinguish between Aboriginal and Torres Strait Islander control … versus Aboriginal and Torres Strait Islander people being involved in educational decision making'.

For many Aboriginal people, participation means equitable access to decision making, not simply consultation, or contributing to discussion.

Remember

Empowerment cannot be 'given'; power can only be taken when the powerless have recognised their situation and have themselves taken action for change (see Freire 1990). Similarly, empowerment implies that people make choices—no one can 'give' people choices; it is only possible to raise awareness of the choices available and their consequences. Within this process, participants must have access to the resources necessary to fulfil their plans.

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In the case of the Queensland Aboriginal and Torres Strait Islander Health Policy, the Department promised to negotiate with the Commonwealth to ensure:

> equitable funding of Aboriginal and Torres Strait Islander health services in Queensland, including general practitioners services, community-controlled services, nursing homes and hospital services and infrastructure.
>
> (Queensland Department of Health 1994, p 15)

This basically means that community-controlled Aboriginal and Torres Strait Islander health services would be competing with mainstream institutions for funding support. The whole process of *participation, contributing* and *advising* then becomes constrained by established power structures. This danger is clearly recognised by many writers of community initiatives. Grace (1994, p 279) argues that within the 'health machine' the consumer has become:

> a manipulated component of a marketing enterprise … as a 'consumer' the individual is 'programmed' in accordance with a model, the provider of the service no less than the consumer.

Similarly, the Council for Aboriginal Reconciliation (1994) warns that we often use words such as *consultation* and *participation* when we really mean informing people about what has already been decided.

Activity

Record the obstacles inherent in 'consultation' when powerful interest groups whose agendas are different from those of the community dominate this process. In your experience, what effect has this had on community initiatives?

Clearly this brings our discussion back to the importance of power.

Remember

Political power is evident in formal policy, informal control and influence in the political process, and influence over public opinion.

Economic power rests on income, wealth, access to credit, control of employment, control of wages and prices.

Social power or *social status* is evident in access to political/economic power and how this is evaluated by the community.

The power we give others, such as the government, over us (i.e. political power) is sometimes called *external authority* (Rees 1991, p 13). But psychologists believe that there are two further kinds of authority: *internal authority* and *anonymous authority*. Internal authority is a personal sense of integrity and conviction, and anonymous authority arises from 'tradition'—'things have always been done this way'—we do not challenge the process because it is part of our world view.

Rees (1991) believes that we are easily overawed, particularly by external and anonymous authority:

> so that individuals use these reference points [traditions] as their philosophy, providing justification for their actions. It is as though they have been submerged by the organisation in which they work … that submerging and absorption constrains the freedom of individuals and groups …
>
> (Rees 1991, p 14 our brackets)

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What relevance does this have for our discussion of factors that may inhibit empowerment in Aboriginal health?

First, internal authority, our own sense of integrity and conviction, is something that grows as we grow and mature into self-confident adults. A range of factors, such as unemployment, family disruption or poor health can challenge our own sense of integrity, that is, our internal authority. Many Aboriginal people suffer from poverty, educational underachievement, unemployment and poor health and they have experienced prejudice, family separation and trauma. All of these will chip away at their sense of worth and belief in themselves. We have made you aware of a range of reports since the 1990s that have highlighted the levels of alienation, gross environmental stress and social–emotional dis-ease within Aboriginal communities. These include the *Reports from the Royal Commission into Aboriginal Deaths in Custody* (1991), the *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (1997), *The Aboriginal and Torres Strait Islander Women's Task Force on Violence* (2000), the *Gordon Report* (2002) and the *Little Children Are Sacred Report* (Wild & Anderson 2007) among others. Note that Cawte (1972) already identified the enervating levels of gross environmental stress, which were debilitating Aboriginal people's levels of social and emotional wellbeing in the early 1970s.

Activity

1. Review the major findings from one of the reports listed above.
2. What have been the main forces, which have undermined internal authority among Aboriginal people?

Second, external authority is clearly evident in the departments, bureaucracies and organisations that direct and control Aboriginal communities. Their authority is enshrined

in legislation, in their power to distribute funding, and in the rules and regulations that legalise Aboriginal organisations. In Chapters 1 and 2 we have referred to the levels of past institutional racism and current structural violence, including systemic frustration, which have characterised the impact of external authority on Aboriginal communities.

Activity

Review definitions for institutional racism, structural violence and systemic frustration—explore how these forces have impacted on Aboriginal health, past and present.

Third, anonymous authority is apparent in the unspoken rules and assumptions that govern Aboriginal communities and government policies, as well as the interactions of professionals and clients. For example, all official communication between government organisations and Aboriginal organisations is in writing—that is how the system operates, and has operated for a long time (anonymous authority). If you don't respond in the same way, you are disadvantaged in the system. Similarly, interactions between professionals and clients have been 'established' by many decades of anonymous authority. This is why Moodie (1973) argues that the only way to understand the health system is to be part of it, or to have a relative who is a health professional. Think about it—if the system (which has power) has expectations about which you are unaware or unable to understand (English might not be your first language) or which are contrary to your cultural expectations/values/norms—what effect will that have on your ability to work the system? Are you not frequently subjected to systemic bias?

It is clear that such anonymous authority is also evident in some major mainstream policy changes over the past 20 years. In tertiary education, for example, increasing emphasis is being placed on 'fees for service', cutting back on government funding, relying on 'soft money' to fund teaching and research. When this trend began in the late 1980s, most academics were appalled—now they accept it. Rees (1991) helps us to understand what is happening here. He maintains that we have come to apply 'a certain recycled form of economics [which] … usually crops up in reference to goals of efficiency, productivity and accountability' (Rees 1991, p 14) in relation to achieving social justice and welfare goals. He argues that we accept, without questioning, the usefulness or appropriateness of economic/business goals for managing human affairs because we are persuaded that this is the only way to achieve efficiency. Indeed, it could be argued that *efficiency, productivity and accountability* have become major political platforms. The same principles and associated values have been applied to mainstream health services and we have all grown to accept them, even though this may well be doing structural violence to clients. There is no doubt that such changes in the health system's operations, fostered by the established power system, are at the very core of what Galtung (1990) calls cultural violence, because they become incorporated into the dominant value system.

Activity

1. Consider the health system—identify some of the economic/business goals that have affected health care.
2. Did you think about the reduction in Medicare, the government's support for private insurance, the 'rationalisation' of hospitals and hospital beds, the rise in private hospitals and the reduction in public services to the aged?

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A combination of extensive external and anonymous authority leads to domination. Domination leads to dependency and oppression. Freire (1990, p 24) would argue that, as a result of domination and oppression, people:

> who have adapted to the structure of domination in which they are immersed, and have become resigned to it, are inhibited from waging the struggle for freedom so long as they feel incapable of running the risks it requires.

Such people, then, experience structural violence. We see the effects of such resignation in the intergenerational dependence on income support among many unemployed Aboriginal families and communities, and the growth of internal/intergenerational violence.

Bureaucracies and institutions are, however, not the only obstacles to the process of empowerment and self-determination. Those of us who are working in Aboriginal health may be disempowering our own organisations/communities in a number of ways. We may:

- uncritically accept external authority
- uncritically accept anonymous authority
- develop our own agenda for promoting ourselves, our profession(s) and/or our families rather than the people with whom we are working.

In fact, we can become instruments of oppression. Let us give you an example.

Case study

Internal disempowerment

An Aboriginal organisation, committed to improving the life chances of local Aboriginal groups in relation to housing, health and employment, is participating in the local CDEP (Community Development Employment Program). Two CDEP workers turn up fairly regularly. When you visit the Centre, they generally hang about the main office, chat, have cups of coffee. After a month a training position becomes available. Both CDEP workers apply and both are unsuccessful. Their families are angry; Centre staff retaliate by pointing out that the two CDEP workers were 'only just wasting time, hanging about …'.

Activity

What do you think is happening here? Were the CDEP workers just plain lazy? Think about it. From our perspective, we would ask:

- What expectations did the Centre have of the workers?
- What kind of induction did the Centre provide for the workers?
- What kind of training/support did the Centre offer the workers?
- What kind of involvement did the workers feel with the Centre?
- Did the Centre simply 'take on' the CDEP workers without really thinking about the implications? Did the Centre just 'do what we have always done'? Did the Centre think that giving someone a job, that is a wage, whether there was actual meaningful work to be done or not, was all that was required? Isn't that what non-Aboriginal organisations have been accused of doing to Aboriginal 'trainees'?
- Have the local workers been encouraged to empower themselves, or has the community organisation become an agent of disempowerment?

In this context we need to speak openly and frankly about factionalism in Aboriginal communities.

Factions can be a source of strength, or they can destroy community development efforts. Their strengths are obvious—factions are made up of family groupings, which provide

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support, warmth, encouragement and resources. In fact, they provide their members with what Friedmann (1992) calls social, political and psychological power.

DEFINITIONS

Social power is concerned with access to certain 'bases' of household production, such as information, knowledge and skills, participation in social organisations, and financial resources.

… *Political power* concerns the access of individual household members to the process by which decisions, particularly those that affect their own future, are made. Political power is thus not only the power to vote; it is as well the power of voice and of collective action.

… *Psychological power*, finally, is best described as an individual sense of potency. Where present it is demonstrated by self-confident behaviour …

(Friedmann 1992, p 33)

However, the competition between factions can cripple communities. Indeed, we (Eckermann & Dowd 1988) have argued that community factions can become totally absorbed in gaining and maintaining power for themselves, and in the rules and regulations of external authority that disempower them. This then becomes a vicious cycle of scheming to exclude others in the community from participating in decision making, in case they threaten the power base that currently exists. When the power base changes, the whole cycle starts again.

Such a process provides agents of external authority (such as government departments) with the opportunity to close down community organisations or to appoint an administrator. Both of these reactions reinforce non-Aboriginal perceptions that Aboriginal people 'waste' money and that they need to be controlled and held accountable.

Consequently, the internal forces that can disempower communities can be as destructive as the external forces. The following case study illustrates how one community, unable to unite, worked with factionalism in order to retain family exclusivity while presenting a united front to the outside world.

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Case study

Finding common ground

There are eight housing companies in this NSW community—they revolve around eight large family groups, which argue that they can't rely on anyone in another family to represent them or to look after their interests. The regional housing authority has stated that it will not fund any of the housing companies until the eight groups join and become one company.

The eight groups are persuaded to come together with the support of an external facilitator. They are adamant that they are unable to work together. Instead, they agree that, as their strength is their family base, they will continue to promote their family interests. They do, however, agree that they will meet and work out between themselves which family-based housing company(ies) will be prioritised so that every family will get 'something' when they meet with the regional authority.

They choose to call themselves The Roundtable and they present a united front to the regional authority, even though they often argue and fight among themselves.

A shift in policy and practice?

In the twenty-first century, government policy has moved away from claiming to 'empower' Aboriginal communities to developing whole-of-government approaches to Aboriginal community capacity advocated by the Council of Australian Governments (COAG).

A whole-of-government approach, which incorporates partnerships between State, Local and Commonwealth governments as well as business and Aboriginal communities, has a lot of merit. It could overcome the fragmentation that has characterised policy and service delivery in the past.

Remember

Myrdal (1971) warned us that it is impossible to break the cycle of poverty unless *all* aspects of the circle are attacked simultaneously in a coordinated manner.

COAG has set up a number of Indigenous trial sites across Australia. In New South Wales, one of these is the Murdi Paaki ATSIC Region, which spans most of north-western New South Wales from Lightning Ridge to Dareton; in Queensland the Indigenous trial site is focused on the Cape York communities. Again such a process has merit—it sets out to trial strategies before applying them nationally.

We will stay with our Queensland case study to analyse policies that have grown from the trial sites. Drawing on the Cape York partnership, the Queensland Government prepared the discussion paper, *Partnerships Queensland: The way forward for Aboriginal and Torres Strait Islander Queenslanders* (2004, p 2). It:

> draws together the key themes of existing Queensland Government policies and programs for Aboriginal and Torres Strait Islander Queenslanders into four goals:
> - strong families, strong cultures
> - safe places
> - healthy living
> - skilled and prosperous people and communities.
>
> These goals are consistent with agreed national strategic directions of COAG and the Ministerial Council for Aboriginal and Torres Strait Islander Affairs (MCATSIA).
>
> **Mechanisms for change**
>
> Partnerships Queensland introduces a new way of doing business in Aboriginal and Torres Strait Islander communities. This 'new way' is based on partnership and governance mechanisms that have proven successful in individual Queensland communities. These mechanisms are:
> - community engagement
> - improved governance
> - better performing and more accountable service providers
> - shared responsibility.
>
> Communities in the Cape York region are leaders in the successful use of some of these mechanisms. These communities may provide the lead and the learning for other Aboriginal and Torres Strait Islander communities as these mechanisms are applied across the state.

This commitment to partnership is admirable, as is the focus on community engagement and shared responsibility. Further, the document (Partnerships Queensland 2004, p 17) details the following priorities under the four major goals:

- 'Strong families, strong cultures'—these include alcohol and substance abuse, children, youth and families, and access to land and sea
- 'Safe places'—alcohol and substance abuse, and crime and justice
- 'Healthy living'—social, cultural and environmental factors, and health services
- 'Skilled and prosperous people and communities'—education and training, as well as sustainable economic development using cultural and natural resources.

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Communities are encouraged to develop community development plans and via 'negotiation tables' have the opportunity to develop a 'shared responsibility agreement and community action plan' with government. Negotiation tables are composed of community leaders and senior public servants. Who the community leaders might be, or how they are to be chosen, is not specified and has become doubly problematic since the demise of ATSIC. However:

> The process is based on the principles of reciprocity, mutual responsibility and accountability for resolving issues. Negotiation tables are most effective when communities drive the agenda and the government responds by coordinating resources for improving services and service delivery.
>
> (Partnerships Queensland 2004, p 18)

The above quote is the closest the document comes to actually defining partnership. Note the emphasis on reciprocity, mutual responsibility and accountability—but in the process, communities drive the agenda, while government coordinates resources. What does that mean in terms of power?

We have come up with the following definition of partnership.

DEFINITION

A healthy partnership is based on trust and respect. It is not only talked about but practised. It is a two-way street—it is two or more people walking together, side by side, for a common purpose. It means backing each other up, acknowledging mutual boundaries, and taking the time to grow and learn together.

This definition finds reflection in the NTER Review. Yu et al (2008) entreat the government to initiate new relationships with Aboriginal communities—relationships, which are based on respect and trust, in order to:

> … redefine Indigenous people, not as problems, but positively and distinctly. It needs to focus on Indigenous people as capable and adaptive people. It needs to support the development of Indigenous people's capacity to be independent, self-managing and self-supporting. There needs to be much greater understanding of the different world views of Indigenous, cultural and regional richness …
>
> (Yu et al 2008, p 4 of 13)

Much of what applies to such a partnership, then, also applies to cultural safety. Having said this, it is important to note that these sentiments are not incorporated into the partnership agreements we have analysed.

The Partnerships Queensland proposal does refer consistently to the Cape York partnership as the model for other communities, and that presents some difficulties. Cape York communities are largely Deeds of Grant in Trust communities, set up in 1984 under the Bjelke-Petersen Government to forestall any return of reserve lands in anticipation of national land rights legislation. They are run along the lines of local government areas and directed by local, elected councils. Some 20 per cent of Aboriginal and Torres Strait Islander Queenslanders[1] live on these communities; their organisations can hardly be thought to reflect the diversity of cultures and decision-making processes that characterise other Aboriginal communities.

Concepts such as reciprocity, mutual responsibility and accountability are fully explored in the Cape York Trial—indeed, Pearson (2000), arguing for major change in Cape York, maintains that they are the foundations of Aboriginal culture. They *are* important concepts, which, we believe, find expression in many Aboriginal communities throughout Australia. How they translate into negotiating priorities and funding, however, will vary between communities. Consider the following case study, which shows how easily negotiations for partnership can go wrong.

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Case study

External disempowerment

They called this community meeting for us to talk about the issues and concerns we have about health—with some Aboriginal people from Queensland Health. Quite a few people turned up because we are having all these problems with young people and drugs and getting into fights and stealing. Well this young Murri woman stood out the front and told us that we had to agree on some terms of reference for this partnership—and then she trotted out the terms of reference! I got a bit hot under the collar and asked her if the meeting was supposed to work out the terms of reference—or if everything was already set. She put me down—I couldn't believe it—this young woman had the cheek to put me down. Anyway—she didn't get anywhere—the people all wanted to talk about their problems, not her terms of reference.

In relation to health:

> The Queensland Government is committed to implementing the National Strategic Framework for Aboriginal and Torres Strait Islander Health … The Queensland Implementation Plan identifies key result areas around access to integrated services, environmental health, workforce development and planning, evidence-based health care and information management. It plans for delivery of effective primary health-care services essential to health protection, early detection and treatment of illnesses, referrals and disease management, and conceptualises health in its broadest social, cultural and spiritual context.
>
> (Queensland Government 2004, p 13)

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The document makes no reference to community-controlled services, and lists a range of *Selective Primary Health Care* targets, such as alcohol and drug programs, programs to enhance child nutrition, guidelines and protocols for mental health and emergency departments, as well as diabetes, cancer and cardiovascular disease interventions in selected communities. This does not bode well for a holistic approach to health or, indeed, provision of comprehensive PHC.

Since 2007, the Queensland Government has committed itself to the national Closing the Gap targets, that is to close the gap in life expectancy within a generation; halve the gap in mortality rates for Queensland Indigenous children under five within a decade; halve the gap in employment outcomes between Indigenous and non-Indigenous Queenslanders within a decade; ensure all Queensland Indigenous four year olds in remote communities have access to early childhood education within five years; and halve the gap for Queensland Indigenous students in Year 12 attainment or equivalent attainment rates by 2020. The government has also created an 'Aboriginal and Torres Strait Islander Partnership' within the Department of Communities, and Queensland Health has set up the Queensland Aboriginal and Torres Strait Islander Health Partnership as an official forum (Queensland Aboriginal and Torres Strait Islander Partnership—Indigenous Health). Its mission (2007) is to:

> maximise the health system response to ensure that Aboriginal and Torres Strait Islander people determine their health and wellbeing; and facilitate community engagement and participation.

The documentation available from the Queensland Government and Queensland Health websites stresses the importance of partnerships, sets out a number of priorities which such partnerships need to address, supports, in the case of Queensland Health, the notion that community control is important in intervening positively in Aboriginal health; yet it does not define what is meant by partnership, community engagement or participation. We would argue that a clear understanding of the principles underpinning such concepts should be the very first step BEFORE any forum or planning group is set up.

It is important to acknowledge that all States have similar emphases on partnership, community engagement and participation.

Activity

Consider the partnership agreement in your Area Health Region.

1 Who initiated the partnership?
2 Who set the terms of reference?
3 Who has financial control?
4 How is the partnership reflected in the services' strategic plans?

The latest Commonwealth policies expressed in the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NATSIHC 2003, p 17) maintained that Comprehensive Primary Health Care (CPHC) must include clinical services, educational/disease-prevention programs, programs for health improvement, access to doctors, hospitals and allied services, as well as assistance and advocacy for communities and clients. Indeed, as Dwyer et al (2004, p 9) pointed out, the government, in its reply to the *Commonwealth Grants Commission Report on Indigenous Funding 2001*, committed itself to partnership and shared responsibilities, secure, long-term funding, equitable access, mainstream programs that take their share of responsibility for Aboriginal health, providing resources commensurate with the problems in Aboriginal health, providing additional Indigenous services when mainstream services are inadequate, ensuring outcomes, coordination of services and developing an appropriate data base. Despite the rhetoric, however, this commitment was not put into some realistic framework until the Labor Government acknowledged the need to address all aspects of PHC in its proposed National PHC Strategy. Indeed, its call for submissions to define PHC and its process is a major step in meeting some of the prerequisites for an approach based in partnership, community engagement and participation. However, as we have pointed out, the process for gaining community engagement is based in written submissions—a tool of the powerful.

Remember

Remember our emphasis in Chapter 6 — in People Centred Care, it's not so much *what* you do but *how* you do it.

Whenever we critically reflect on such documents, we should ask ourselves: who within the whole of the health system has established power and all the infrastructure, knowledge and skills to secure their power base? The answer, we would argue, is: those who already have access to some power. Isn't this what systemic bias is all about? When both parties do not have access to the same resources, systemic frustration and disempowerment can result. Consequently, when you critically analyse partnerships in your region, ask yourself:

- Who defines the problem?
- Who proposes the solution?
- Who has the resources to make decisions?
- Are these decisions in line with PHC, cultural safety and empowerment?

In order to succeed, health strategies—including COAG's whole-of-government approach and regional partnerships—must investigate the assets in local Aboriginal communities, liaise with all Aboriginal organisations, and support local self-help initiatives. Solutions can be

found from within Aboriginal strategies; those that are imposed by outsiders frequently fail. This is what community participation in health is all about.

As the WHO (1981) maintains, through participation people and their communities, in collaboration with health care providers, make decisions about their own health and plans to improve it. Such participation involves shared responsibility and accountability, not only in terms of identifying issues but also in relation to obtaining resources and implementing programs.

Primary health care, community participation and community development are not compatible with the existing hierarchies of authority and decision making in health. Community participation that re-affirms existing structures and patterns of decision making is unlikely to challenge established, socially and legally sanctioned professional and administrative hierarchies.

So, when you explore the kinds of PHC approaches advocated, consider the following questions carefully:

- What are the principles underlying PHC /cultural safety, rather than those which characterise primary care or Selective Primary Health Care?
- What are the structures in which it is envisaged that communities will be able to empower themselves?
- What mechanisms are proposed to facilitate community empowerment?

Keeping these questions in mind, we will now explore some case studies in empowerment.

PART D: CASE STUDIES IN EMPOWERMENT

We have argued throughout this, and previous editions of *Binaŋ Goonj* that we are all affected by our shared history of colonisation. This history has grown out of cultural violence and has led to decades of scientific and institutional racism, which have supported the level of structural violence inherent in our social fabric today. The past, and indeed the present, have led to some bitterness, which needs to be acknowledged. Ena Chong, for example, points out that:

> They're trying to get organisations and departments to do partnership agreements and these are attempts at reconciliation, and all the time I've had a look at it, the school or the hospital has all the funding; the Aboriginal organisation doesn't have any funding—it's not a fair and equitable agreement—the Aboriginal people don't have the control or power or respect. All the things that make for a good agreement aren't there. The Aboriginal people fall out of it, stop coming to meetings because there's nothing in it for them. It's the people in power—that's their agenda—that's not us. Like with Palm Island [a death in custody in 2004]—things like that open old wounds and scars upon scars. And John Howard's talking about the need to curb alcohol abuse as the biggest issue. That's not the biggest issue for them people—the biggest issue is that there's no natural justice—not even going to be seen to be just …

We believe that many Aboriginal people share Ena Chong's concerns. Nevertheless, things have changed in Aboriginal affairs. As Roy Gray argues:

> I think in the past we've been trying to jump from where we were to major autonomy. I think that could still happen in the future—but we have to take small steps. Even the Deeds of Grant in Trust[2] were a small step towards self-determination. I think we are taking these small steps and we need to celebrate them. We don't do that—we don't celebrate our achievements—like Bonner [the first Aboriginal Senator]—we've forgotten that. When we look back at where we've come from—on the outskirts of town and dispossessed—we've moved a long way from that. There's actually a lot of achievement, but it's quiet, convincing and insistent, and we need to acknowledge and reflect on it.

Examples of these quiet and insistent achievements include such innovations as Circle Sentencing, which has operated in New South Wales communities since 2002:

> is an alternative sentencing process for adult Aboriginal offenders in New South Wales [for offenders who plead guilty to certain offences]. It takes the sentencing process out of the traditional court setting and allows the involvement of the offender's community. In a circle sentence, the offender, magistrate, community elders and (on occasion) the victim and support people for the offender and/or victim sit in a circle to discuss the circumstances and impact of the offence and determine a sentence tailored to the offender. Circle sentencing has the full sentencing powers of the court.
>
> (Fitzgerald 2008, p 1 [our brackets])

At the same time, similar courts were established throughout Australia. They were called the Murri Court in Queensland, the Koori Court in Victoria, the Nunga Court in SA and the Ngambra Circle Sentencing in the ACT (Gamble 2005). While evaluations of the schemes have not indicated a change in the number of offences committed or re-offences after circle sentencing, Aboriginal communities and most Magistrates support their continuance and maintain that it takes time before such innovations have an impact (Fitzgerald 2008).

Clearly circle sentencing is an example of individual as well as community empowerment. Similar examples are found in the way people are coming to terms with their experiences as members of the Stolen Generations. Many individuals and families at Yarrabah, for example, contributed to the oral history 'Reflections in Yarrabah' (Denigan 2008). Yarrabah was established as an Anglican mission on the coast of Cape York Peninsula in 1892. In 1960, the State of Queensland took over its management and in 1984 Yarrabah gained its Deed of Grant in Trust (facilitated by Roy Gray as Chair of the Yarrabah Council), which made the reserve a self-managing local government area. Many of the current residents are the descendants of people who were forcibly removed to the mission/reserve (Denigan 2008, McEwan & Tsey 2009). By confronting and articulating the pain and trauma, as well as some of the humour of their lives, the people have recorded their history and genealogies for themselves, their children and grandchildren. Again Roy Gray played a major part in supporting these developments as curator of the Yarrabah Museum.

Lynette Nixon was engaged in a similar process when she researched the Gunggari language and the fate of those Gunggari who were removed from Mitchell and the Yumba after 1900. Today, the Gunggari have an audio-visual resource of oral history and language which is used to teach Aboriginal as well as non-Aboriginal children about the history of the south-west of Queensland. The Yarrabah and Mitchell examples affirm people's resilience and insistence in creating a better social and emotional environment for themselves and their communities.

The *Overcoming Indigenous Disadvantage Report* (Commonwealth of Australia 2009) reports on progress in addressing COAG's key indicators of disadvantage—life expectancy, young child mortality, early childhood education, reading, writing and numeracy, Year 12 attainment and employment. Such evaluations are always followed by examples of 'things that work', that is, projects and initiatives throughout the country that have been identified as 'successful' by their participants.

Activity

Consider the *Overcoming Indigenous Disadvantage Report* (2009) www.pc.gov.au/gsp/reports/indigenous/keyindicators2009 and explore the types of projects, programs and initiatives, which have been identified as 'things that work' in relation to health.

In the following case studies we will try to capture some other 'small steps' towards empowerment that are happening in the communities in which we live and/or work. You will see that all of these relate to a holistic approach to health.

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Case study

We are taking charge

The community is experiencing a number of difficulties, which include:

- the level of violence and substance abuse among the youth in the district
- the level of educational underachievement among their children
- the number of children suspended or excluded from school
- the number of grandparents who are having to take responsibility for the rearing of their grandchildren because mothers are too young or too dysfunctional to care for their children properly.

About thirty Aboriginal women have held a series of meetings, in collaboration with the local Aboriginal school, at which they have decided that they want to develop their own intervention program—designed and delivered by them. In order to do this effectively, they have identified the skills they require. These include behaviour and anger management, assertiveness training and familiarisation with the education and legal systems. On the basis of these decisions, the women have approached the school, the Aboriginal medical service and some staff at the university to provide them with training programs to develop their skills, design their own intervention and help them to monitor and evaluate the interventions. A series of successful funding proposals will provide the resources to support the Women's Group. Participants belong to a loose federation of local families who have worked together successfully in the past; and the partnership with the school, medical service and university is informal.

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These are small steps but they have come from the women themselves, they provide an opportunity for them to make choices about what is needed in their community and for their children, and they provide access to resources *they have chosen* to support their initiative.

A different and much larger example of empowerment in health is contained in the following case study.

Case study

The Yarrabah Family Wellbeing Empowerment Program

In the mid-1990s the Yarrabah people were traumatised by the number of suicides in their community. Deaths occurred almost on a weekly basis and the Yarrabah Health Services (Gurriny Yealamucka) turned to the community to identify the causes and to develop some social and emotional intervention strategies such as a crisis intervention group and a Family Life Promotion Program (see Hunter 2001). In 2001, Gurriny Yealamucka went into partnership with the Family Wellbeing (FWB) Empowerment Program to train local facilitators and to deliver a series of community workshops designed by Indigenous people to:

> … focus on social and emotional wellbeing and the development of self-worth, communication and problem-solving skills, conflict resolution, and other personal qualities that enable the individual to take greater control and responsibility for themselves and their family, work and community life.
>
> (McEwan & Tsey 2009, p 1)

The Yarrabah project is sited in a number of reports, e.g. *Overcoming Indigenous Disadvantage* (2009) as a 'thing that works', and this is borne out by McEwan and Tsey's (2009) evaluation. Between 2001 and 2002, facilitators from James Cook University and the University

of Queensland trained ten Yarrabah community members to become facilitators of the FWB Program. Between 2003 and 2005, 122 Yarrabah residents participated in the program; almost one-third of them were interviewed in the evaluation. The findings clearly indicated that:

> Participants thought FWB was relevant to the challenges facing Indigenous communities, to the local workforce, relationships and to suicide prevention. FWB's approach to life skills made it relevant to participants' current circumstances … Participants also referred to personal healing, an improved ability to control destructive emotions, prevention or management of domestic conflict and more positive family relationships …
>
> (McEwan & Tsey 2009, p 7)

Importantly, the evaluation highlighted the significance of spirituality—in all of its forms—in the process of participants' healing.

Why is the FWB Program in Yarrabah a 'thing that works'? We would argue that its success is due to a number of factors, which preceded its implementation, some of which are outlined in the case study below.

Case study

PHC in Action

First of all, many Yarrabah people are 'descendants of the freedom fighters' of the twentieth century. Until about 1960 Yarrabah was a penal settlement where 'troublemakers' from other settlements were sent by 'the manager' as a form of punishment. Invariably these 'troublemakers' were those who refused to submit to an oppressive regime, people with spirit.

Into this mix Sally Johnson, a nurse who worked with PHC principles, arrived in the early 1980s. Even though she had been appointed by the government, she sought an interview with the elected leaders, told them about herself, asked if this was the type of nurse they wanted and if so what did they want her to do. This set the scene for a productive and long lasting relationship.

Not long after this the then Chairman of the Yarrabah Council, Roy Gray, came to the health team with concerns about AIDS. As a result of actions by the health team, Yarrabah was described as 'the most informed community in Queensland' on this issue years before the general health system was mobilised.

The next elected Council, a few years later, raised its concerns about rheumatic fever and how it was affecting young people. Once again the health team WITH the community tackled this issue. The Papago First Nations People from Arizona had written up their successful project on tackling rheumatic fever, which had been eradicated over a ten-year period. After learning about the program, the Yarrabah Health Workers claimed that they would reach this goal in five years. In fact they reached it in three years and together with the cardiologist advisor wrote up their program in the *Medical Journal of Australia* (Neilson et al 1993). In the following issue of the MJA there were letters from sceptical doctors saying it wasn't possible.

This community went on to organise their own child health screening, Diabetic Club (Sugar Babies), SCAN (Suspected Child Abuse and Neglect) Team and their Community Controlled Health Service—Gurriny Yealamucka.

Working in a way that did not disempower, this nurse and others tried not to get in the way of community initiatives but rather to support them, a simple approach really. First do no harm.

Continued

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This gave the community a very positive experience in PHC and reinforced their belief that they were capable of running their own intervention programs. As part of this confidence, Yarrabah supported the Life Promotion Program, which was developed in collaboration with Colleen Gray, Roy Gray's partner. The Life Promotion Program was expanded to other Cape communities and trained Community Life Officers to maintain a suicide watch in communities, run workshops and, if necessary, refer individuals to medical intervention.

It is not surprising, then, that the people of Yarrabah, who had some experience in self-determination and empowerment in health, would embrace the FWB program.

The program was also adapted to meet the specific needs of the Cape York communities of Hope Vale and Wujal Wujal; during 2007 the program was incorporated into primary school curricula.

According to the *Overcoming Indigenous Disadvantage Report* (Commonwealth of Australia 2009, p 8), 'things that work' are based on:

- cooperative approaches between Indigenous people and government—often with the non-profit and private sectors as well
- community involvement in program design and decision making—a 'bottom-up' rather than 'top-down' approach
- good governance—at organisation, community and government levels
- ongoing government support—including human, financial and physical resources.

Activity

Consider the two case studies on Yarrabah and identify how they met the criteria of 'things that work'.

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Remember

We are talking about PHC—that includes all aspects of the physical, social, emotional, spiritual, economic and psychological wellbeing of the individual as well as the group to which she/he belongs.

In out next case study we will focus on how Aboriginal people in south-west Queensland empowered themselves, and strengthened their resilience, through knowledge of their past to develop a better future for themselves and their children.

Case study

Our past is our future

I grew up in small towns in south-western Queensland. I was born in the late forties. Going to school was a bit of a struggle, mainly because I travelled around the area a lot and didn't spend much time in one place. I was way behind in all my grades. The other reason was, you never

felt as if you belonged at the school. You were often called names and told you were dumb, and that you would not need to finish school.

By the time I was fourteen I was in grade six and ready to leave school. It was not expected that I would go on. The norm at that time was that a young Aboriginal girl would leave school and go to work on a station doing domestic duties.

I left school at fourteen and went to work on stations throughout my local area. It used to hurt me to hear other people talking and saying bad things about my family. You would be called 'mongrel bred', and 'you're not the real Aborigines'. These remarks justified being last to be served in a shop, or not being allowed to go to the pool, and being sent to one side of the picture theatre. Even after I was married and had children we were not allowed in some of the hotels in the town. These kinds of actions would hurt you and make you feel inferior. There was little you could do because the law was not on your side.

I really loved my family, who worked very hard, and were the most honest people you could find. I found it very difficult to believe that these people were 'mongrel bred' and worthless.

We were taught at a very early age to be proud of who you were and never let other people put you down. We were told to 'show them you are as good as them if not better', 'always do the best you can, and feel good about it', 'always be honest and live up to your good family name'.

You belonged to a family and you always felt protected and wanted. Your responsibilities were made clear to you at an early age as well. Being in a large family had its problems, but you had values, beliefs and a sense of belonging and a very distinct role in life. These family values were the base to being a responsible adult, and gave you that sense that you were worthy of praise and deserved to be treated better.

It was such a thought that began the research into our local Aboriginal community. The urge to tell our stories.

We always knew we deserved to be recognised as worthwhile citizens of our community. We thought it was time to let people know the contributions our old people made to the development of the town we all call home today.

In 1983 we had a lot of trouble with the kids not wanting to go to school. The headmaster was willing to get together with us and we had a couple of workshops and got to know the teachers, and they got to know us. We set up some work groups and, because we wanted the kids to learn about our history, we and the teachers put together a book about our people. Then we decided that we wanted all our people to share in the book, so we arranged a reunion of all the Aboriginal people who lived in that town over the years and launched the book in 1985.

It turned out to be one of the biggest events of the century, people returned from all over Australia, even Perth and the Northern Territory. This festival became a regular event. Connecting people to their home country.

A lot of things have grown out of that—we worked to get our old Yumba [camp] back under a cultural lease; we got hold of the old Yumba school building from the 1940s and relocated it on the Yumba as part of our plan to develop a cultural centre; we worked on our oral histories and genealogies and language to put in our Native Title claim and out of that we worked on a culture and language program which won a prize for reconciliation in 2004. Well, the school got the credit—but we own it!

The case study above illustrates how 'small steps' can lead to startling developments, which enhance the social, emotional and physical wellbeing of not only the people in that town but also their extended families across Australia. As such this case study exemplifies a community doing for itself, a community taking control rather than being passive participants or recipients.

Listen

I look at you and say
'Yeah it'll be fine'
But you're not listening
to what's in my mind
Me, in my ethnocentric way
Don't want to be exactly
like you one day.
I hurt deep down inside
You have damaged my dignity and pride.
Take away your money, welfare
and guilt and give me back my land
That's where my survival is built.
But you won't listen
You won't hear
That's why we live in frustration and fear.
I hope and pray
That one day, we won't always be Manga Dithibai.[3]

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CHAPTER SUMMARY

- Empowerment cannot be 'given'. Individuals and groups can only empower themselves when they make informed choices, determine their own fates and acquire resources to support their decisions.
- Empowerment, then, is part and parcel of self-determination. It underlies the process of Primary Health Care and self-determination.
- Government policy or individual action can facilitate empowerment. It is consequently imperative to critically examine such policies and actions in order to identify forces that can impede empowerment.
- Forces, which may impede empowerment include: external and anonymous power; an emphasis on structures rather than processes; and external control of resources and opportunities.
- Forces which facilitate empowerment include: positive self-esteem, empathy, belief in one's ability, problem-solving skills, community participation and strong networks as well as community connectedness and the ability to reach consensus on agreed upon goals.
- There is a symbiotic relationship between PHC, cultural safety and empowerment—they all require reciprocal trust, respect, collaboration, participatory decision making and a shift in the power base and control.

NOTES

1 The document clearly states that separate agreements will be made with the Torres Strait Island Authority; consequently the proportion of Aboriginal people who live on Deeds of Grant in Trust communities is even smaller than 20 per cent.

2 Deeds of Grant in Trust (DOGIT), initiated by the Bjelke-Petersen Government in 1984, extinguished the existing Aboriginal reserves in Queensland and converted these reserve lands into local government areas. It could be argued that the move was the conservative Queensland Government's response to the possibility of national land rights legislation, which would have returned reserve lands to the residents. In many ways the DOGIT communities were exposed to extreme systemic frustration—the new deeds encouraged them to believe that they would now have control over decision making in their communities, but in reality they remained dependent on the State because local revenues were unable to sustain needed infrastructure and employment.

3 *Manga Dithibai* is a Gunggari phrase which means the same as *Binaŋ Goonj*, and refers to blocked ears.

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