

Learning the Tiwi Way to Community Control:

“What is community control for the Tiwi people, and how do they wish to implement a community controlled health service?”

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Declaration

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Ethics Approval: Menzies School of Health Research and Department of Health and Community Services, Human Research Ethic Committee, 06/52, 4 April 2007.

I hereby declare that this thesis, now submitted for the degree of Professional Doctorate of Charles Darwin University, is the result of my own investigations, and all references to ideas and work of other researchers have been specifically acknowledged. I hereby certify that the work embodied in this thesis has not already been accepted in substance for any degree, is not being currently submitted in candidature for any other degree, and that this thesis is less than 50,000 words in length excluding Figures, Tables and Appendices.

Greg Rickard
Darwin, NT Australia
November 2009

Abstract

Learning the Tiwi way to community control: “What is community control for the Tiwi people, and how do they wish to implement a community controlled health service?”

Providing access to appropriate services for Indigenous people delivered by the Aboriginal Community Control Health sector has been the argument and rhetoric in Australia for the past four decades, but over this period the health inequalities between Indigenous and non-Indigenous Australians have increased. The causes of this health inequality have been cited as policy failure in addition to the continuing structural disadvantage of Indigenous people.

I used anthropological and organisational analysis methodologies to analyse and gain a greater understanding of the cultural and social elements that enabled or prevented the Tiwi Health Advisory Committee (THAC) from moving towards the community control of their health service.

What is evident from this research is that a structured and supportive framework of health development is needed over the long-term, a framework that fully engages with the THAC and the Tiwi people. I identified six areas for development within this supportive framework: the integration of contemporary Tiwi culture into the emerging health organisation; the role of Indigenous governance in community control; the function of Tiwi leadership in self-determination; the role of mentoring in building capacity; the stewardship of governments and stakeholders as key enablers to community control; and the facilitation of an “enabling framework” that is focussed on individual and community self-determination.

From this research, I also found that interventions that did not adequately engage with the Tiwi people or address local needs had the potential for greater individual and community dysfunction and social break down. I concluded that there was a need for significant change in the way governments and stakeholders work with the THAC and the Tiwi people, with a focus on the development of dual capacities and competencies.

Acknowledgements

Acknowledgement of the Traditional Owners

I acknowledge the Tiwi ancestors, as well as my own ancestors in this “meeting ground”: this journey of inquiry and learning. This acknowledgement of the Traditional Owners is my declaration of reconciliation and cultural security.

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In taking this time to give respect to these groups of people and through these acknowledgements, is not out of cursory politeness and definitely not out of political correctness, but serves as an anchoring point from which this acknowledgement is composed, delivered and hopefully received by readers and other researchers.

This acknowledgement to the traditional owners has been adopted from one developed by Karen Atkinson, an Aboriginal woman from the Quandamooopah and Bidjara nations (2005) and member of CATSIN: the Congress of Aboriginal and Torres Strait Islander Nurses.

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Dedication

I dedicate my research, as one but a significant building block in my “life’s work”, to my father Albert (1915-1964) and mother Joan (1920-2001), who inspired me from an early age with the potential of education and life long learning.

Contents

Declaration	ii
Abstract	iv
Acknowledgements	vi
Dedication	vii
Contents	viii
Introduction	1
Chapter One: Research Problem	
Introduction	5
Tiwi Community Control	6
Traditional Tiwi Culture	8
Tiwi Health Board: 2000 to 2003	11
Tiwi Health Service: 2003 to 2009	13
Problem Identification	14
Summary and Conclusion	15
Chapter Two: Literature Review	
Introduction	17
Defining Community Control, Community and Community Participation	17
The Development of the Community Controlled Health Sector	
Best Practice in Indigenous Primary Health Care	
Lay Knowledge	
NT Aboriginal Health Forum, “Enabling Framework”	
Major Issues Emerging from the Literature	26
Community Control Definitions and Models	
Capacity for Engagement and Participation	
Risk Management	
Problem Representation: Who has the Problem?	
Indigenous Health: A Contemporary Public Health Matter	30
Australian Government Intervention A Unique Research Context	
‘Noble Savage’ or ‘Wounded Warrior’?	
Summary and Conclusion	37
Chapter Three: Research Methods	
Introduction	39
Researching with Indigenous People	39
The Research Initiation	41

Aim and Objectives	42
Methodology	42
Revised Research Approach and Methodology	45
Response to the Research Initiation	49
Social and Political Context for the Tiwi People	
Meaning and the Future Directions for Community Control	
Summary and Conclusion	53
Chapter Four: Research Findings	
Introduction	55
Tiwi Culture and Governance	
Introduction	57
Contemporary Tiwi Culture	57
Impact of Tiwi Culture on Governance	58
Summary and Conclusion	61
Tiwi Governance	
Introduction	62
Defining Tiwi Governance	62
The “How” of Tiwi Governance	66
Determining Future Health Needs	
Implementing Tiwi Governance	
Achieving Community Control	68
Tiwi Ways to Achieving Community Control	
“Yoy”: Dancing to the Same Goals	
Risks to Achieving Tiwi Governance	71
Summary and Conclusion	74
Leadership	
Introduction	75
Defining Tiwi Leadership	75
Contemporary Tiwi Leadership	77
Transition to New Leadership	79
Summary and Conclusion	79
Capacity Building	
Introduction	81
Defining Capacity Building and Social Capital	81
Building Capacity and Social Capital to Improve Health Outcomes	83
Learning is about Community Control	
Building Capacity and Social Capital	
Tiwi Secondary Education	
Understanding the Value of Traditional Foods	
Collaboration in Capacity Building	
Tiwi Football	
“Capacity Building” Tainted?	88

Summary and Conclusion	89
Governmentality	
Introduction	91
Defining Governmentality and the Predicament of Governments	92
A “History” with Governments	94
Rules of Engagement with External Agencies	96
Capacity: Who’s Capacity?	98
Summary and Conclusion	99
Enabling Framework: Pathways to Community Control	
Introduction	101
Defining the Indigenous Governance Enabling Framework	101
Tiwi Governance and the Enabling Framework	104
Summary and Conclusion	106
Chapter Five: Discussion	
Introduction: The Five Research Questions	107
What is Community Control for the THAC?	108
How is Community Control to be implemented by the THAC?	109
Culture	
Leadership	
Capacity Building	
Governmentality	
What is the Pathway to Community Control?	113
What are the Key Implementation Issues and Risks for the THAC?	113
Is there a Common Framework for Community Control?	114
Summary and Conclusions	115
Chapter Six: Conclusion	
Introduction	117
Research in the Indigenous Context	117
Defining Community Control	118
Creating a Tiwi Road to Community Control	118
Role of Governments	119
Role of the Researcher	119
Recommendations	120
Postscript	121
References	123
Appendices	133

List of Figures

Figure 1: Project Design

Figure 2: THAC Community Control Conceptual Framework and Key Themes

Figure 3: “Hub and Spoke” Governance option based on geographical locations

List of Tables

- Table 1: The timeframe to Community Control Health Service (Robinson and Bailie, 2000, p 10)
- Table 2: Key Insights for Successful Indigenous Governance (Hunt and Smith, 2005; Hunt and Smith, 2006)
- Table 3: Alternative Forms of Native Community Planning, (Boothroyd, 1986, p19)
- Table 4: Problem Identification, Two Positions – “the left and the right” (Martin, 2007)
- Table 5: Key Research Informants
- Table 6: THAC Meetings
- Table 7: Comparing “enabling frameworks”, 2006 and 2008

List of Appendices

Appendix A:	Aboriginal Community Controlled “Enabling Framework”, (Pathway to Community Control)
Appendix B:	Commonwealth Laws Impacting on Indigenous People
Appendix C:	Personal Statement of Research Values
Appendix D:	Research Agreement
Appendix E:	Project Plan and Timeframe
Appendix F:	Information Sheet
Appendix G:	Consent Form
Appendix H:	Data Collection Template and Example
Appendix I:	Standard letter to Politicians and Government Agencies
Appendix J:	Project Officer, Job Description
Appendix K:	Project Officer, Expression of Interest

List of Acronyms

ACCCHS	Aboriginal Community Controlled Health Service
AGI	Australian Government Intervention
AMS	Aboriginal Medical Services
AMSANT	Aboriginal Medical Service Alliance Northern Territory
ASIC	Australian Securities and Investments Commission
ATSI	Aboriginal and Torres Strait Islander
BIITE	Batchelor Institute of Indigenous Tertiary Education
CAEPR	Centre for Aboriginal Economic Policy Research, The Australian National University
CAR	Collaborative Action Research
CCT	Coordinated Care Trial
CDEP	Community Development Employment Project
CDU	Charles Darwin University
COAG	Council of Australian Governments
DHCS	Department of Health and Community Services, Northern Territory (restructured July 2008, to become the Department of Health and Families)
DHF	Department of Health and Families, Northern Territory (from 1 July 2008)
DoHA	Department of Health and Ageing, Commonwealth
FaCSIA	Commonwealth Department of Families, Community Services and Indigenous Affairs
HRSCAA	House of Representatives Standing Committee on Aboriginal Affairs
ICGP	Indigenous Community Governance Project (refer CAEPR)
IHS	Indian Health Service
IMC	Indicators of Management Capacity
KWHB	Katherine West Health Board
NACCHO	National Aboriginal Community Controlled Health Organisation
NHMRC	National Health and Medical Research Council

NT	Northern Territory
NTAHF	Northern Territory Aboriginal Health Forum
NTER	Northern Territory Emergency Response
NTG	Northern Territory Government
PHC	Primary Health Care
TFL	Tiwi For Life
THAC	Tiwi Health Advisory Committee
THB	Tiwi Health Board
THS	Tiwi Health Service
TITEB	Tiwi Island Training and Education Board
TLC	Tiwi Land Council
WHO	World Health Organisation

Qualification: “Indigenous” is used throughout the thesis to represent all Australian Aboriginal and Torres Strait Islander (ATSI) people.

Introduction

The Tiwi Health Board (THB) was foreclosed in September 2003. This occurred despite the initial, so called “significant successes” of the Tiwi Coordinated Care Trial (CCT) from 1996 - 1999 and the establishment of the THB in 2000 which were funded and promoted by the Commonwealth and Territory Governments. The Federal Minister for Health and Family Services, Dr Michael Wooldridge announced the Tiwi CCT on the 22 November 1996 (Australian Government, 1996). Agreements were to be signed between the Northern Territory Government (NTG) and the newly incorporated Tiwi Islands Health Board to develop the CCT as a means of providing better health care for Australian’s with complex care needs. Minister Wooldridge stated that the trial would have a whole of community approach with public health, health promotion and education programs playing an important role in improving health outcomes for the Tiwi people. The trial, it was stated, would also help break down the barriers between Federal and State programs to provide appropriate, quality and cost effective services to those who need to utilise a number of health and community services.

Over 12 months later, on the 4 December 1997 (Australian Government, 1997) the NT Minister of Health, Mr Denis Burke, pronounced the historic agreement between the Tiwi people, the NTG and the Commonwealth as providing greater autonomy for the community to decide its health needs. The Tiwi CCT Legal Agreement stated Mr Burke, gave the “green light” to Medical Benefits Schedule and Pharmaceutical Benefits Schedule cashing out arrangements, the pooling of health funding and the coordination of care in the Tiwi community health centres. The Agreement was to inject an additional \$2.5 million of Commonwealth funds into Tiwi Health Services. The evaluation of the Tiwi CCT, along with the other nine general CCTs and three Aboriginal and Torres Strait (ATSI) CCTs in 2002 revealed evidence of improved patient well-being and significant changes in service mix coordination and community participation, but did not produce convincing quantitative evidence of health gains (Beilby and Pekarsky, 2002, p321).

Five and a half years after the commencement of the Tiwi CCTs, the Tiwi Land Council Annual Report 2001/2002 (2002, p 42 - 43) stated:

The (Tiwi Health) Board has had another successful year, but has operated under extreme financial difficulty as the result of inordinate delays experienced in the negotiation of new funding arrangements with what was then the Commonwealth Department of Health and Ageing, that were meant to be completed during the Transition year following the two year Coordinated Care Trial ending in December 1999.

The Board struggled to meet the budgetary requirements imposed on it through this impasse and most of its long overdue and effective programs had to be cut back to match available funding, and to cope with the inevitable increase in costs.

Council observes that the Tiwi Health Board is not the only organisation in this position, and strongly urges Government to reconsider its priorities in this regard. This does not require further reviews, commissions, reports or committees. It simply requires a commitment by Government to allocate more resources particularly in areas where effective and proven programs have already been put in place, and to resist the temptation to avoid action through overstating the need for good governance and accountability. These two terms have recently been overworked to the point of meaninglessness, and are far too often used to justify overweening and

excessive interference by agencies far removed from the reality of Aboriginal health as experienced in communities throughout the nation.

The Tiwi Land Council Annual Report 2002/2003 (2003, p 38 - 39) repeated these claims 12 months later, of the bureaucratic inhibited approached when stating:

They (the Tiwi Health Board) are (and have been) historically funded on the basis of delivering services to 2000 people. They in fact deliver services to 2731 Tiwi clients (NT Government figures at 30 June 2003). The money has never caught up with the population being served. The impossible moral decision to deny services has now caught by the legal imperatives of the Companies Act; a conflict predicted years ago. Negotiations with the Commonwealth have been unsuccessful. After seven years of it, our leaders and their resources are exhausted. They are meeting through September 2003 with a view to placing the Tiwi Health Board into voluntary liquidation.

How did the collapse of the Tiwi Health Board occur within four years of its transition from a coordinated care trial to a Charitable Trust, managed by a Trustee Company and wholly reliant on Government funding to deliver emergency and primary health care (PHC) services to the Tiwi people? How did this collapse occur despite there having been supposedly considerable initial “significant successes”, with warnings highlighted in the Tiwi Land Council Annual Reports (2002 and 2003) and risks identified in the Commonwealth funded evaluations (Commonwealth of Australia, 2001, Beilby and Pekarsky, 2002)? Why was the funding for the THB based on a Tiwi population of only 2,000 when the population in 2003, was over 2,700 people? What caused the delays in Legal and Funding Agreements being finalised and signed, taking over six years? Was there misinterpretation or misrepresentation of the initial successes, risks and failings by both Governments and the Tiwi people? Was the overall strategy for Tiwi community control ill considered or misguided by Governments and the Tiwi people?

In 2006, three years after the collapse of the THB, the Tiwi Health Advisory Committee (THAC) expressed the aspiration to return to a community controlled health service. This became the focus of my research after an exploratory meeting with the management of Remote Health, of the Department of Health and Community Services (DHCS) in early 2006. In late 2007, as part of this research project, the THAC agreed to establish a new health Board, planned for November 2008. Little did I comprehend the journey and the impact that this would have on the THAC, the staff of the Tiwi Health Service (THS) and myself.

My contribution to this research is based on over three decades working as a health professional and administrator in four jurisdictions in Australia and working with Indigenous people to improve health outcomes. My role as a researcher is multiple: participant-observer, role model, mentor, educator and facilitator. This will impact on what and how the data will be collected and what access I will have to data and has the potential to conflict with my current employment in the Northern Territory, Department of Health and Families.

Chapter One explores the research context and the key motivations for this research: Why has community control failed to achieve the health gains for the Tiwi people? Why has the community control of Aboriginal health services been so difficult for the Tiwi people and the THAC to implement? Why has the community control of the Tiwi Health Services been so difficult for governments, their agencies and stakeholders? And, What needs to happen to

make community control and the community control sector work? To establish the purpose of the research and the justification for the research questions, this chapter charts the early history, impact of traditional culture, successes and failures in community controlled health services on the Tiwi Islands along with the identified risks. Based on this history of community control on the Tiwi Islands, this Chapter describes the complexity of the research questions, how the research plans to gain a greater understanding of health systems research, and explores “how” the systems and processes can be improved to reduce the health inequalities for Indigenous people and to improve the health outcomes for the Tiwi people.

Chapter Two, presents an exploration of the community controlled health approach from the literature, with an examination of the definitions, models and concepts of community control, community and community participation with recent developments in the community controlled health sector. Community control has been used as the dominant and prevailing answer to address the health inequalities and the provision of appropriate health services to Indigenous people, so an in depth awareness of what is meant by community control is presented. Best practice in the Indigenous PHC sector is also examined with an analysis of lay or traditional knowledge and its impact on health outcomes for Indigenous communities. An introduction to the pathway to community control, the “*enabling framework*” model is provided. Chapter Two also includes an examination of the unique context and environment in which this research was undertaken due to the extraordinary circumstances and challenges that confronted the Tiwi people whose communities were part of the Northern Territory Emergency Response (NTER). The literature review also highlights the continuing stereotyping of Indigenous people and how again this impacts on their health outcomes.

Chapter Three describes the research methodology and approach to undertaking research with Indigenous people with key strategies identified and explored. The research aim and objectives of community controlled health services for the Tiwi people are described with the research methodology and research activities outlined, including a description of the data collection and analysis and the proposed research outcomes. Changes to the research design and methods in response to the changing Tiwi context and demands are also described and justified. The research limitations are also examined.

Chapter Four, the Research Findings are presented using the “*Kurlama*”, the most central of all Tiwi cultural beliefs as the conceptual framework for the findings. The six research findings assist to define community control for the Tiwi people and include:

- Tiwi culture and governance;
- Indigenous governance principles;
- Indigenous leadership;
- capacity building and mentoring;
- the elements associated with the development of stakeholder partnerships, in particular with governments; and finally
- the underpinning mechanism for Indigenous development, the “*enabling framework*”.

Chapter Five discusses the research findings related to each of the five research questions.

Chapter Six, highlights the key research findings within the culturally dense, complex and dynamic environment of the Tiwi Islands and Indigenous health. The conclusion also reflects on the impact that governments and stakeholders have had on the THB and the Tiwi people and the change in the research methodology as a consequence of the research journey with the Tiwi people. The process of stakeholders engaging with the Tiwi people long-term, based on respect and trust, and providing an “enabling framework” for development of community capacity, establishes the primacy of “... *the how...*” when working towards Aboriginal community control. Key recommendations from the research are proposed, as this project of Aboriginal and Torres Strait Island community control or governance is incomplete and remains a “work in progress”, without the many ongoing, alternative and local solutions required.

Chapter One: Research Problem

A 'wicked problem' is a term used in the planning literature to characterise a complex multi-dimensional problem (Hunter, 2007, p35).

Introduction

The first Aboriginal Community Controlled Health Service (ACCHS, also called Aboriginal Medical Services) was established in 1972 in Redfern to improve the access to culturally appropriate health services for Indigenous people. In 2008, there were more than 130 ACCHS established throughout Australia, yet there remains a significant gap or health inequality between Indigenous and non-Indigenous people in Australia, and one which continues to increase. The failure of the community controlled sector was highlighted by Jenny Macklin, Minister for Families, Housing, Community Services and Indigenous Affairs, in her speech to the National Press Club in Canberra on the 27 February 2008 (Macklin, 2008) which emphasised both the gap in health outcomes and impact of failed successive government's policies; Commonwealth, State and Territory. Macklin (*ibid*, 2008) argued these points by recounting the recent Western Australia (WA) coroners' report, describing 22 deaths and suicides, the despair and hopelessness in the Kimberley's in 2006. The WA coroner described the health gap as a "... *vast and worsening gulf*". Macklin spoke of the resulting poor health status as a "... *complicated matter...*" that stemmed from decades of deep-rooted pre-conceptions, entrenched vested interests, and of decades of failure and neglect. Macklin concluded her speech by arguing the need for, "... *finding new ways of doing things because the old ways have so comprehensively failed*".

Much has been achieved since the 1967 Referendum which granted the legislative powers for Indigenous Australians to the Commonwealth Government, and that included Indigenous Australians for the first time in the national census. From 1967, successive Commonwealth Governments have struggled with Indigenous policies ranging from Integration, Self-determination, Self-management (Phases 1 and 2) and Shared Responsibility (Smith, 2007, pp 27 – 29). Whilst acknowledging the local innovation and capacity building, commentators and researchers universally criticize the state of health and wellbeing in Australian ATSI communities, whether they be urban, regional, rural or remote (Carson, *et al.*, 2007; Hughes 2007; Smith 2007; Thomas, *et al.*, 2006; and Trudgen, 2000). This poor level of health status and outcome is compounded by: poor education achievement, with poor literacy and numeracy rates; poor housing and overcrowding; high levels of unemployment and poverty; and high levels of community dysfunction, alcohol and substance use, violence, gambling and child abuse and neglect.

The prevailing and dominant solution to address the health gap or inequalities, and the provision of appropriate health services to ATSI people has been through the development and implementation of community controlled health services. This approach is based on the full array of local health planning, governance and management, service delivery and organisational support: financial; information technology; human resource management; clinical quality improvement; and infrastructure management. The underpinning values and aspirations of Aboriginal community control includes self-determination, empowerment and the devolution of responsibility and accountability that emerged in the late 1960s and early 1970s, after nearly 180 years of protectionism and assimilation. After 40 years of the community control approach, and more recently shared responsibility (also termed mutual obligation) significant gaps in health outcomes remain for Indigenous Australians when

compared with non-Indigenous Australians. These gaps and inequalities are dominated by increased mortality, morbidity and disability rates, increased levels of the burden of disease and poor indicators related to the social determinants of health.

This chapter explores the context in which the research was undertaken; the Tiwi Islands and provides the background to the key motivations for this research: what is community control for the Tiwi Health Service and the impact of the Tiwi Coordinated Care Trials in the late 1990s. This chapter also charts the early history, impact of traditional culture, successes and failures in community controlled health services on the Tiwi Islands along with the identified risks. Based on this context and history the underpinning questions related to the research problem are explored: “how” the systems and processes can be improved to reduce the health inequalities for Indigenous people and to improve the health outcomes for the Tiwi people.

Tiwi Community Control

Tiwi is comprised of the Bathurst and Melville Islands located 60 kilometres north of Darwin and covers 7,900 km². The population of the Tiwi islands is approximately 2,127 people, of which 89 per cent are Aboriginal (Australian Bureau of Statistics, 2006). The major communities are Milikapiti, Nguiu and Pirlangimpi and there are a number of small outstations: Ranku, Pickertaramoor, Paru, Taracumbi and Wurankuwu. Nguiu is the largest community of 1,300 people and located on the most south-eastern tip of Bathurst Island. Approximately 550 people live at Milikapiti and another 350 at Pirlangimpi on the northern coast of Melville Island. The Tiwi identify themselves as one people consisting of sixteen different tribal groups with one language. The Tiwi population also includes members of the “Stolen Generation”, most of who were relocated to Melville Island. English is the second language (Tiwi Health Board, 2001, p 7, Tiwi Land Council, 2004, p 21).

In April 1995, the Council of Australian Governments (COAG) launched a major reform of the health and community services and initiated a series of CCT throughout Australia aimed at service providers having both the incentive and the capacity to respond more effectively to people’s needs (Fine, *et al.*, 2001, p 4). The Territory Health Services submitted proposals for two NT Aboriginal trials that included the Tiwi Islands (Scrimgeour, 1997, p49-50). The timeframe to Community Control Health Service is outlined in Table 4 (Robinson and Bailie, 2000, p 10) and describes the key events leading up to the establishment of the THB.

The Tiwi CCT ran from December 1997 up until December 1999 and was established to achieve four broad objectives (Robinson and Bailie, 2000, p v):

1. to achieve Tiwi community control of health services through [the] establishment of an area health board administering pooled health sector funds;
2. to improve the effectiveness of prevention measures based on Tiwi participation in community programs in public health and other services;
3. to improve the quality and effectiveness of health services delivered to Tiwi people through application of increased resources to a mix of coordinated care and population based health services; and

4. to improve the standard of delivery of health services to Tiwi people according to best practice guidelines and protocols as the basis for care coordination.

Table 1: The timeframe to Community Controlled Health Service (Robinson and Bailie, 2000, p 10)

Year	Events
1976-77	Establishment of Land Rights Act (1976) with Tiwi Land Council (TLC) instituted.
1992-93	TLC increasingly concerned about the high and increasing rates of renal disease amongst the Tiwi population.
January 1995	TLC forms a Health Sub-Committee.
June – August 1995	Meeting between Commonwealth Government, NT Government and TLC representatives concerning health service delivery. THB established by resolution of TLC.
September 1996	First meeting of the THB Executive.
January 1998	Live Phase of the Tiwi CCT commences with THB staff employed.
May 1998	THB accepts Commonwealth offer to extend CCT to end of 1999.
April 1999	THB takes over the running of health centres at Milikapiti and Pirlangimpi.

The THB evaluation (*ibid*, 2000, vi - vii) analysed the policy and implementation of community control on the Tiwi Islands and stated that over the period of the CCT (1997-1999) community awareness of the health service had substantially increased, as had the participation of the Tiwi people in the delivery of community services. Substantial progress had also been achieved in management and policy formation at a number of levels. The evaluation stated however, that ongoing commitment was required to identify processes that support stronger Tiwi input. The training of the THB members, managers and administrative staff was needed to continue to assure input into program management and delivery. Funding was directed to and increased in the areas of community-based prevention programs in public health with a strong emphasis on the extension of a number of health initiatives; including for example men’s health clinics running in all three health centres in response to expressed community need.

The Tiwi CCT transition year evaluation report was published in May 2001 (Robinson *et al.*, 2001). This evaluation (*ibid*, p 4) identified two general kinds of community control based on the relationship between the Aboriginal and non-Aboriginal players. One kind of community control is an ideologically *closed* model that “... masks the nature of the relationship between Aboriginal and non-Aboriginal members of the organisation.” The other model of community control is less forceful or *open*, “... in which the interdependence between Aboriginal and non-Aboriginal members and their roles is open and differentiated within a generally non-ideological disciplinary or occupational structure”. This transition evaluation report found that the THB was characterised

by the more open and less ideological model of community control.

The transition year evaluation (*ibid*, 2001) was also more explicit about the areas of risk for the THB including the: constraints of the trial framework itself; the short timeframe to achieve outcomes in an environment of large scale development where costs and liabilities were unknown except through “trial and error” (*ibid*, p xi); concerns about the development of the THB, that “... *there was limited anticipation by the Board and other partners of the need to explicitly develop the Board's financial and planning capacity in advance of major developments, and difficulty in achieving this within the two-year spending frame*” (*ibid*, p xi); and the responsibility of government stakeholders to identify and introduce controls to stronger safeguard initial establishment procedures, specifically recruitment and the key executive functions.

Robinson *et al.*, (2001, p xi) made a significant statement about the lack of process involving different organisations and levels of government by stating:

“Stakeholders did not specify a clear collaborative framework to analyse and develop positions concerning key issues arising from the trial, with the result, ... that there consequently have not been the timeliness of conceptual and analytical input into the identification and resolution of key future funding issues which one might have expected. There appears to have been a readiness on the part of governments (Commonwealth and Northern Territory) to treat the Board as separate service providers in a closed process of funding negotiation, and less recognition of the distinctive circumstances of the CCT as a TRIAL, and of the need for adjustments to be made during the transition from a trial. These continue to require collaborative effort on the part of all stakeholders”

Thirteen recommendations were documented as part of the future directions for the THB (*ibid*, 2001, pp xxiv - xxv). A number of the recommendations stressed the need for: business planning and estimation of liabilities (Recommendation 2); capacity development of the THB and the development of specific instruments and external supports for the Board by governments to draw upon in order to manage significant growth in programs (Recommendation 4); that any response to Recommendations 2 and 4 will need to consider that externally provided resources and controls tend to undermine the internal development of equivalent resources and controls by the THB and consequently may impede organisational learning and self-sufficiency (Recommendation 5); and that the THB will need to continue to redevelop management and work practices in conjunction with training and other support (Recommendation 12).

The on-going management of the community controlled health service thus required significant adaptability and flexibility to accommodate local circumstances and need, in addition to a commitment from government(s) for support and stewardship. Clearly, the capacity of the local community and health board to manage complex funding models and service needs was going to place significant stress and risk on the THB and the Tiwi community.

Traditional Tiwi Culture

The early descriptions of culture are provided by Hart *et al.*, (1988, p33) who studied the Tiwi people in episodic accounts over nearly 60 years; Hart from 1928 – 1929, Pilling from 1953 – 1954 and Goodale in 1954 and 1962, from 1980 – 1981 and again from 1986 – 1987. Hart, *et al.*, (*ibid*, p 16) viewed the household structure as the focal point of Tiwi culture, one that linked kinship and food gathering, the political and prestige structure, the totemic and seniority systems, the sexual, and the legal, moral and religious organisation of the tribe.

The descriptions of the Tiwi household with the compulsory marriage of all females, either through infant bestowal and widow re-marriage resulted in the older men having as many as 20 wives each, whilst men under 30 years of age having no wives at all. The authors (*ibid*, p 29) argued that having several wives enabled the older men to have increased time away from food production allowing them the resources to spend on activities that created family or bands and ceremony. This enabled and maintained the status of the elder men, a male dominated seniority system within the Tiwi band.

Hart, *et al.*, (1988, pp 35 - 40) highlighted the, "... fluidity of band affiliation" with the dominance of the, "... 'big man', with a large household ...", and the impact that this had on the lives of the family. Households comprised of up to 50 people camping in the same spot and remaining together for up to ten days at a time. Where the father or "big man" originated or grew up further emphasised the central connection to country, with households constantly changing due to food collecting and hunting demands, moving camp, living and sleeping together. When the "big man" died, the household broke up with the surviving members joining other households, based on the re-marriage of the widows. Family members under this system could be relocated in the same country or in some other band's country. Adult males "attached" themselves to a household and assisted with the food production of the household. The "big man" established the daily, weekly and monthly work and travel schedules for the women, younger men and children. Most of the "work" occurred customarily, as all members of the household knew their roles and duties.

The daily activities of food collecting and hunting, food preparation, living and sleeping, the making ceremonial artefacts and participating in ceremony dominated the lives of the Tiwi people. Travelling and moving in country or between clans and country occurred in the dry season from April to November. Large groups were required to witness ceremony and festivals, naming ceremonies, funerals, grass burning, or especially to make "law" as witnessed in fights, feuds and dispute resolution. Band and family affiliation and cohesion were important considerations for the "big man" in dispute settlement. He had to take into consideration the future of his household, the relationships between wives and the offender (usually a young man challenging household norms), food production and status across bands.

Prestige and influence resided with the small number of "big men" that dominated the bands and households across the Tiwi islands. These older men chose their own successors, usually men, 20 or more years younger than themselves, as they posed no threat (Hart *et al.*, *ibid*, p 82).

Thus the Tiwi system actually deserves to be called a primitive oligarchy, ... It was run by a few old men who ruled it not so much because they were old but because as young men they had been clever and then lived long enough to reap the rewards of their cleverness. These rewards made up Tiwi wealth – many wives, much leisure, many daughters to bestow, many satellites (households) and henchmen, and much power and influence over other people and tribal affairs.

The impact on Tiwi traditional life, prior to 1911, when the Catholic missionaries arrived at Nguui was that (*ibid*, p 85):

young men did not elope with young wives because there was no place to elope. ... an eloping Tiwi couple could only take refuge with other more remote Tiwi bands where the system was the same as that which they had rebelled against back home,

and the people with whom they sought shelter were interrelated with those whom they had defied back home.

Thus, traditional law, authority and conformity were maintained on the Tiwi islands due to the “closed” nature of Tiwi bands, and the public displays of outrage and its associated punitive sanctions, usually fights and duels. The display of public outrage, by the ‘big man’ included listing all actions of family and band support for the accused, past present and future, emphasising the favours, debt and reciprocal obligations to his band, and, “... *that social life needed mutual aid and trust between all its members*” (*ibid*, p 87).

The duel between the “big man” and the charged young man or offender, is today named “*payback*”, where the accused is physically wounded. The old man was painted in ochres carrying spears for the duel. Once *payback* is achieved with the crowd yelling approval, the dual was over. If the offender was defiant, male members of the “old man’s” band would also challenge the accused until “*payback*” occurred. I found that *payback* is an example where “traditional law” is still used today, to settle disputes acknowledging Tiwi culture. Hart, *et al.*, (*ibid*, 1988) found little evidence of large scale warfare between bands, but where they are documented (*ibid*, pp 89 – 93), the authority of the “old men” was asserted frequently, “... *by finding a bachelor scapegoat upon which whom to unload all their mutual suspicions and aggressions*”.

Hart, *et al.*, (1988, pp 95 - 104) described the Tiwi as, “... *magic free, but ... taboo ridden*”, identifying three dominant communal and cultural activities: day-to-day debt and obligation taboos, beliefs and rituals pertaining to death, and initiation ceremonies for young men. The interplay of taboos related to favours, debt and reciprocal obligation, the beliefs and rituals of death and the prolonged initiation ceremonies of young man, provided the means for social control and maintaining the status of the “old men” in their families and bands. “*Pukimani*” (also spelt *Pukumani*) refers to anything sacred, forbidden or untouchable, “... *a state of special being in which a person or thing temporarily was*” (*ibid*, p 96).

Pukimani included the period of time from: the one to two weeks after giving birth for women; youth undergoing initiation; or the period of mourning until the burial of the clan member. During *Pukimani* the names of the deceased and all involved in the ceremonies and rituals including the performers, adornments and objects and specific Tiwi places (*ibid* pp 96 – 97) cannot be used. *Pukimani* thus represents the time when people, objects and places are in a “temporary suspended state” of ceremony and ritual, where avoidance and abstinence from everyday actions, including food and sex are rigidly adhered. The authors (*ibid*, p 97) found the attitude of Tiwi people to *Pukimani* as one of passive acceptance; “... *a state that people did not actively seek to enter ...*”, but, “...*just happened...*” and that *Pukimani* behaviour was, “... *something that one accepted and conformed with when required*”.

Pukimani became the central means of achieving communal debt and obligation. The authors (*ibid*, p 100) described how death created two groups in a band: the immediate relatives who entered into the state of strict taboo and could not do anything except mourn; and the other group, the non-mourners, who provided all services and help and who, “... *take advantage of their (mourners) incapacity. ... The Tiwi were always ‘helping’ each other, but the man who was ‘helped’ therefore ‘owed’ something to his helper*”. Violation of *Pukimani* and the associated taboos resulted in shame, loss of reputation and influence, provided the explanation of unsuccessful ventures, or the early death of wives and daughters. Observance of *Pukimani* thus maintained the relationships between men, between bands and families, and the equilibrium with nature (*ibid*, p 98).

The roles of favours, debt and obligation were again observed in the initiation of young men that was marked by successive stages from the age of 14 (*Marukumarni*) with young men forcibly removed from their families until around 24-26 years of age (*Mikingula*) (*ibid*, pp 102 - 103). During this prolonged period of austerity, of up to 12 years living in seclusion in the bush or in *Pukimani* at home, the young men were indebted and by necessity under the obligation to the men who provided initiation sponsorship, themselves fully initiated. *Pukimani* was again, woven into the kinship and influence systems throughout the lives of Tiwi men. Small collective rituals were held each January and February to coincide with the *Kurlama* ceremony to note the passage from one initiation stage to another.

Not until he had finished as Mikingula could he step out into the world and life of men. How he spent the years immediately after finishing initiation decided how soon some senior man would think sufficiently highly of him to aid him in acquiring his first ancient widow. (ibid, p 104)

Goodale's visit to the islands in 1986 (Hart *et al.*, 1988, pp 139 – 145) summarised the significant changes underway in the local Tiwi culture, and related them to the many forms of local employment, adults receiving pensions, and purchasing food from the local store supplemented by hunting and gathering, particularly at weekends. Permanent housing based on western standards had also become the norm.

Goodale (Hart *et al.*, p 143) cited no infant bestowal and widow re-marriage, this having diminished significantly with the influence of the Catholic mission at Nguuiu and Milikapiti from the beginning of the 20th century and almost completely eliminated after the Second World War. The Tiwi households, traditionally dominated by the "big man" had become more influenced by women, with the increased influence of "elder" women, who were outliving the men, due to high levels of disease. Most young men and women had now adopted the, "... *European marriage ritual ...*" cited Goodale (*ibid*, p 143). Goodale also stated that the traditional initiation of young males from their teenage years to their mid-twenties had also diminished, but with, "... *'short-cut' route to full initiation status ...*", and some participants commencing, "...*their training in their mid to late thirties*" (*ibid*, p 143).

Continuity and change were the two leading features of contemporary Tiwi culture described by Goodale (*ibid*, pp 143 - 144). Goodale viewed continuity and changes within the context of the then, recent Australian government passage of Aboriginal land rights [*Aboriginal Land Rights (Northern Territory) Act 1976 (Cwth)*], that reinforced the concept of "self-development", with individual and collective control over their lives and land.

The Tiwi Health Board: 2000 to 2003

The initial successes of the Tiwi CCT and THB were heralded by Commonwealth and Territory politicians with the THB cited as the flagship for all future Aboriginal Community Controlled Health Services developments through Australia (Tiwi Health Board, 2001). Board reports were produced highlighting successes and achievements acknowledging that the fledgling organisation still required significant capacity building, consolidation, risk management and ongoing commitment and support from governments. The complexity of the funding mechanisms and doubts of the adequacy of the funding quantum, were identified in 2001 by the Tiwi Land Council

(2002) without agreement reached between the THB and governments on a formula to meet the population and health needs of the Tiwi people.

The period from the end of the CCT to 2003 is highlighted in two key and disturbing documents: Tiwi Health Board, Internal Discussion Document (Ernst & Young, 2003a) and Investigating Accountant's Report, Tiwi Health Pty Ltd as trustee for Tiwi Health Board Trust, September 2003 (Ernst & Young, 2003b). The Internal Discussion Document, July (*ibid*, 2003a, p 2) identified that:

- the THB is in serious financial difficulty and has significant ongoing concern issues as advised in the audit reports;
- the THB will require significant and immediate changes to their operational efficiencies, services provided or funding levels to enable them to continue to provide a quality service within their budgetary constraints;
- consideration must be given to mounting issues that have been compounding over the past few years, i.e. previous deficits and liabilities incurred; and
- all functions and funding should be reviewed.

The Investigating Accountant's Report, September (*ibid*, 2003b, p 3) highlighted that the THB:

- consisted of 20 permanent members, was cumbersome and inefficient and that it was difficult to obtain consensus amongst such a large number of directors;
- had difficulty in reaching resolutions, that resulted in an over reliance on the Management Committee and/or CEO;
- had incorrect accounting procedures with debts accumulating to approximately \$1M at the end of July 2003; and
- had investment in a new, unproven and potentially high risk business in remote Aboriginal community.

In summary, the Accountant's report (*ibid*, 2003b, p 27) stated that:

"... the Board will be unable to pass a resolution declaring that Tiwi Health is solvent and able to pay its debts. It is clear that the current position of the THB is financially and operationally unsustainable and considered and immediate remedial action must be taken to resolve this issue".

The Australian Securities and Investments Commission (ASIC) operational and financial principles were used to guide the THB, the Commonwealth Department of Health and Ageing (DoHA) and the DHCS in the decision to foreclose the Board.

In summary, the transition from government to Tiwi community control was poorly managed. The true value of transferred assets from the DHCS to the THB for the provision of emergency and PHC services were overlooked and placed great financial pressure on the THB. The ongoing support for capacity development from governments was also lacking and the transition timeframe for community control was also very short. THB also remained politically isolated throughout this

time and avoided participating with a key advocacy group (for example AMSANT) and other potentially advantageous networking opportunities, or other community controlled health Boards facing similar issues and problems.

The Tiwi Health Service: 2003 to 2009

From September 2003 the Remote Branch of the NT, DHCS has managed the THS. Remote Health appointed the THAC members along with a manager responsible for the THS. The THAC consists of a group of Tiwi people, comprising eight to 12 members at any one time and selected by nomination from within the Tiwi communities. The committee members are representative of skin groups, the different communities, the “strong men and women” as well as age specific groups. Attendance at committees is voluntary. Monthly to six weekly meetings of the Advisory Committee are planned and held with key health strategies and issues discussed and future programs developed. It is from this committee that the future of community control is being discussed and possible transfer of accountability back to a THB developed.

The Department has maintained most of the core health services developed and implemented under the THB and has completed a number of service improvements, including capital works and service delivery. The current Tiwi Health, Health Services Delivery Plan 2009-2010 (Department Health and Families, 2009). Currently the THS employs over 50 Full Time Equivalent staff including; Health Centre Managers (3) for each of the three major clinics; Aboriginal Health Workers (AHWs) (12); Remote Area Nurses (RANs) (7); Resident Medical Officers (1.4); Aboriginal Community Workers (13); clerical staff (6); drivers/gardeners (5.5); cleaners (2.25) and pharmacy aid/health support officer (2).

The range of health and wellbeing services currently provided include acute medical and emergency care; medical specialist outreach including a remote outreach midwife; maternal, child and youth health, including a midwife and child health nurse; chronic disease program including public health and a chronic disease nurses and women’s health educator; adolescent and adult mental health, including a community mental health worker; environment and health promotion, including a Aboriginal Health promotion officer; Allied Health outreach; oral health; and nutrition. Only the RANs and AHWs are accommodated within the three major communities and provide services on a daily basis and for after hour emergencies.

The THS at a planning workshop in May 2009 identified a number of gaps in service provision, including: adolescent sexual health program, mammography services for Tiwi women, dental services and oral hygiene education, chronic disease prevention especially for rheumatic heart, skin and ear health, medication management especially for those with chronic disease, re-establishment of the “Tiwi for Life” programs, over 55 year old health checks and feedback from Royal Darwin Hospital on investigations, including radiological examinations (ibid, p 13).

The THS is critical of its own structure and performance (Department Health and Families, 2009 p10):

The current linkages between service providers (are) somewhat ad hoc resulting in perhaps minimal outcomes being achieved during regular visits. Currently all services contact the Health centre and identify the date of their visit to the community. No formal Memorandum of Understanding exists where resources are discussed and outcomes to be achieved are identified.

The failure of the THB has brought significant shame and distress to the Tiwi people, the members of the previous THB and current members of the THAC. Failure in the eyes of their community, the inability to lead the THB as community elders increased shame, with feelings of distrust of governments and bureaucrats, lack of commitment for community control, "... *blamed for the failure of the THB*", and "... *being set up to fail*", still emerge in discussions. This lack of trust of governments by the THAC continues today.

Problem Identification

A meeting with the Director of Remote Health, the THS manager and myself was held in late March 2006 to discuss the future of community control for the Tiwi people. The DHCS had managed the THS since 2003, with the key objective to transfer the health services back to full community control by the THB by the end of 2007. At this meeting, the discussion of community control led to a number of questions being raised and explored:

- what does community control mean for the Tiwi Health Service and the Tiwi people?
- when is a community "ready" for community control and what are the indicators of "readiness"?
- how do you engage with a community in moving towards community control?
- how can the THS move towards community control?
- what are the key stages in the transition towards community control?
- what are the roles of the Tiwi people, governments and stakeholders in initiating, developing, transferring and sustaining community control?
- what timeframe should be adopted for community control? and
- what risks need to be identified and managed?

The key question raised during this meeting was not whether the THS and the Tiwi people wanted to achieve community control, but how. Chopra and Sanders (2000, p 832) argued that over recent years the focus of much health research and policy questions has addressed the: "*what, why, where, and who*". The authors (*ibid*, 2000) recommended that increased resources should be spent on developing health systems research and asking "*how*" the systems, structures and processes can be improved to achieve increased health gain and improved health outcomes. The purpose of this research is to gain a greater understanding of what is meant by community control for the Tiwi people and to determine how the Tiwi Health Service can develop and implement policy and move towards community control.

Summary and Conclusion

The motivation for this research is to explore how to improve the health outcomes for Indigenous people, with a focus on the THAC and the Tiwi communities. After decades of poor mortality and morbidity measures with a widening gap in health outcomes, the ‘wicked problem’ (*sensu*, Hunter, 2007), between Indigenous and non-Indigenous Australians, a commitment to understanding of what is meant by community control and how community control can be implemented to improve health outcomes, is needed. The ACCHS is one such commitment and approach, but one the evidence has shown has underachieved.

The key research questions emerged from the analysis of the history of the Tiwi CCT, the outcomes of the THB and the current context of the THAC. Two major questions resulted: what is community for the Tiwi people, and how do they wish to implement a community controlled health service? It was from this beginning that the project materialised; one based on the principles of community development and self determination.

Whilst there are many examples of achieving “real” outcomes and improvements by the ACCHS sector, there remains for many Indigenous people, especially in rural and remote communities, a number of barriers and significant gaps between the rhetoric and aspiration in achieving improved health outcomes; increased longevity, reduced mortality and morbidity, reduced burden of disease and disability. “How” to realise the aspirations of Indigenous people respectively and how to achieve community control, is the focus of this research with the ‘wicked problem’ remaining until this is achieved. The answers to these research questions must be sought both inside and outside the community controlled sector.

Chapter Two: Literature Review

The solution to address the ill health of Aboriginal people can only be achieved by local Aboriginal people controlling the process of health care delivery. Local Aboriginal community control in health is essential to the definition of Aboriginal holistic health and allows Aboriginal communities to determine their own affairs, protocols and procedures. (National Aboriginal Community Controlled Health Organisation, website accessed 21 October 2006).

Out of decades of fear and desperation came initiative and hope.
(Katherine West Health Board, 2003, p 28)

Introduction

Since the late 1960s, the dominant and prevailing solution to address the health inequalities and the provision of appropriate health services to Aboriginal and Torres Strait Islander (ATSI) people has been the development and implementation of the community controlled sector and approach. Central to the development of Aboriginal Community Controlled Health Services (ACCHS) are the principles of “local” control or self-determination with the ability for Aboriginal Community Controlled Health Boards to identify local health need, decide policy and determine priorities and resource allocation.

This examination of the literature will cover a range of perspectives: defining the concepts of community control, community and community participation; recent developments in the community controlled health sector; best practice in PHC in Indigenous health; lay knowledge with the impact on health outcomes; and an examination of a proposed developmental model or Indigenous “enabling framework”, to achieve community control.

The context in which this research was undertaken was extremely dynamic, political and highly controversial and this section was developed to acknowledge the challenges that confronted both the Tiwi people and myself, in undertaking this research. This chapter provides a summary of the current health status of Indigenous people in the NT and a detailed description of the NTER from the surfacing of the issues in May 2006 up until June 2008, the first anniversary of “the Intervention”. The detail of the NTER is provided as the Tiwi Islands, THS and the THAC were directly affected as a consequence of the Australian Government Intervention (AGI). A review of the impact of dispossession and imposed interventions on the “noble savage” are also provided.

Defining Community Control, Community and Community Participation

The National Aboriginal Community Controlled Health Organisation (NACCHO, website accessed 21 October 2006) has defined community control as; “... a process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the Community”. The term Aboriginal Community Control has its

genesis in Aboriginal peoples' right to self-determination.

An ACCHS is defined as (*ibid*, 2006): an incorporated Aboriginal organisation, initiated by a local Aboriginal community, based in a local Aboriginal community, governed by an Aboriginal body which is elected by the local Aboriginal community, and delivering a holistic and culturally appropriate health service to the Community which controls it. By definition, organisations controlled or managed by governments to any extent, and organisations that adopt a vertical approach to health (segment out primary, secondary and tertiary care) are inconsistent with the Aboriginal holistic definition of health, as defined by the *National Aboriginal Health Strategy* (1992).

Shannon and Longbottom (2004, p 5) stated that the establishment of an ACCHS provided the mechanism for increasing Indigenous control over the management of primary care services and represented a major source of education, training and capacity building for Aboriginal communities through partnerships in policy and planning with governments using Framework Agreements. Scrimgeour (1997, pp 14 - 17) and Smith (2007, pp 30 - 44) have documented many of the policies and concepts of community control that cover "self-determination", "self-management" and "shared responsibility" the Commonwealth Government policies that encompassed the decades from 1970 to today. In the decade commencing 1996, with the then Australian Liberal Coalition government in power, there was a further shift towards the "mainstreaming" (Altman, 2004) of Indigenous policy and the introduction of "mutual obligation" (Collard *et al.*, 2005) which became the dominant political ideology driving community control and Indigenous participation.

When I commenced the analysis of the literature in early 2006, there was very limited documentation on what was meant by community control, other than the NACCHO (2006) definition as previously stated. The major principles of PHC of access, equity, appropriateness, affordability and community participation (World Health Organisation, 1978) underpinned the ACCHS movement and became the foremost arguments to support self-determination and self-management. Most definitions identified the structure and functions of the Aboriginal community controlled health services, but lacked detail on "how" to achieve community control, specifically community governance, decision-making and community participation.

Kunitz and Brady (1995) challenged the entire foundation of the ACCHS movement suggesting that these organisations are derived from external doctrines and were not found within Aboriginal culture. Kunitz and Brady (*ibid*) argued that Aboriginal Medical Services (AMSs) are misnomers and confusing as they were and have been very much dependent on the contribution of non-Indigenous health professionals, administrators and also government funding. An international perspective is provided by Cornell (2008) when highlighting the contribution of the United States of America (USA) federal legislation (1976) to the community controlled sector; legislation based on self-determination and supporting Indigenous communities to achieve community control themselves. This USA legislation was sustained and supported over three decades and has reduced significantly the gap in health status between the American Indians and the non-Indigenous population.

The definition of an Indigenous community, as a homogenous and distinct entity is also problematic and open to question and debate. This lack of homogeneity can be seen throughout the NT across many of the remote communities that may be traditional lands or the result of the "outstations" movement of the late 1970s, or the result of settlements on or near missions, tourist centres, mines, or pastoral leases. The Queensland Government, 2003 Green Paper on community governance, *Making Choices about Indigenous Community Governance* (Shannon

and Longbottom, 2004, p 6) highlighted that Aboriginal communities are:

“... relative recent and artificial creations in Aboriginal history, a legacy of the protectionist policies that brought widely dispersed groups of Aboriginal people together onto reserves and missions”.

In conflict with the Indigenous definition of community and community control are the assumptions of the western, “rational” administrative organisations (Fuszard, 1983, pp 14 - 19). Western bureaucratic definitions of “community control” and “self-determination” are advanced in the House of Representatives Standing Committee on Aboriginal Affairs’ (HRSCAA, 1990, para 1.47) report *Our Future Ourselves*. The Report defined self-determination to be:

“the devolution of political and economic power to Aboriginal and Torres Strait Islander communities, with Aboriginal control over the ultimate decisions about a wide range of matters”.

Again from this parliamentary document (HRSCAA, 1990, para 1.48) “self-management” is defined as being:

“concerned with the efficient management and administration of Aboriginal communities and organisations, and ... about effectively implementing those decisions and priorities that have already been determined by Aboriginal people”.

The HRSCAA (1990, para 1.40) recognized this conflict and the likely failure of policies of self-determination and self-management when stating that:

“... conflict potentially exists between the objective of promoting Aboriginal control over their own affairs, or self-determination, and the bureaucratic requirement placed on Aboriginal communities to be self-managing”.

The analysis of the literature and the concept of community participation also raised many questions and challenges. O’Neil (1995), Jewkes and Murcott (1998), and Dudley, (1993, p 7) openly challenge this concept of community participation, as a means of understanding local concerns and needs. O’Neil (1995) argued that participation hardly ever resulted in self-determination and community control, but more frequently led to the, *“... entrenchment of the power of professionals and bureaucrats”*. The rationale for this lack of community participation and control stated O’Neil (*ibid*), was due to a number of major misconceptions about community participation: the community as a whole not participating, as only certain individuals or subgroups participate; participation rarely occurring spontaneously, requiring “external” motivation and support; participation requiring time, resources and is frequently unwieldy; and the existing potential conflict of values and desired outcomes between the “community” and the professionals, bureaucrats or administrators employed to encourage and support their participation.

These arguments were further developed by Scrimgeour, 2000 (cited in Baum, 2002, p 353) in his submission to the *Health for Life Inquiry* to the House of Representatives when he noted that for “community control” to be real and effective there needs to be significant capacity building in Indigenous communities and sufficient resources committed to the service. To do otherwise, it could be argued that an ACCHS was, *“... set up to fail”*.

Shannon and Longbottom (2004, p 6) again citing the Queensland Government, 2003 Green Paper discuss Aboriginal community governance as being about power, relationships and

accountability and a process of how individuals, groups (families) and communities are able to:

“... interact with, contribute to and draw from, the formal and informal institutions of the dominant society in a considered and informed manner that provides them with real choices as to where to go and how to get there ... a process rather than an outcome”.

Central to the debate of defining community control and understanding the concepts of community and community participation is; who has the mandate for decision making and how is this control achieved and maintained? Robinson and Kearney (2008) quoting the former Australian Labor Party president Warren Mundine, himself Indigenous suggest that community control has been hijacked by the; “... *Indigenous service provider industry that profits from entrenched Aboriginal disadvantage*”. The other key community control arguments are about the level of individual and community participation; the capacity and maturity or readiness of a community to address their health needs and issues; and the resources needed for Indigenous people to engage effectively in the processes of governance and community control, not only to address the significant health burden, but other at time conflicting needs, as health is just one of many priorities in Aboriginal and Torres Strait Islander communities.

Thus, the fundamental question continues to be asked: is community control the solution to address the health inequalities experienced by Aboriginal and Torres Strait Islander peoples?

The Development of the Community Controlled Health Sector

The development of ACCHS throughout Australia (Bartlett and Boffa 2005, Baum 2002, Scrimgeour 1997, Shannon and Longbottom 2004, Smith 2007, and Wakerman *et al.*, 2000) paralleled that of the AMS at Redfern in NSW in the early 1970s. Shannon and Longbottom (2004, p 5) stated that by 2001, 129 Aboriginal community-controlled health services funded by Governments had been established throughout Australia. The distribution of ACCHS contrasted greatly between states and territories, between urban, regional, rural and remote, with significant variation in health services provided, staff numbers and operating budgets.

The Central Australia Aboriginal Congress was established in Alice Springs in 1975 with leadership provided by the local Aboriginal community and medical staff. Local communities in urban and remote communities in the NT initiated several more ACCHS over the next three decades, based on a model of comprehensive PHC to address the social determinants of health and in collaboration with community members. The model of community control for remote health services in the NT continues to be challenging for both the local community members and the funding and support organisations as community populations change and consolidate, relocate or disperse and establish small decentralised communities or “outstations”. Aboriginal communities in central Australia also cross state and territory boundaries, where joint, multi-party jurisdictional agreements are needed.

Katherine West Health Board (KWHB) also participated in the CCTs in the late 1990s and provided an important case study for the community controlled sector. In 2003, the KWHB with the assistance of the Australian Institute of Aboriginal and Torres Strait Islander Studies published “*Something Special: the inside story of the Katherine West Health Board*”, (Katherine West Health Board, 2003). This study highlighted the processes and achievements of a community controlled health service over a vast region covering 162,000 km² and 15 remote communities on the western side of the NT. The key processes to achieve a sustained community control involved thorough and sensitive community consultations (*ibid*, p 42). The consultation phase took over

eight months, with a specific aim of not raising community's expectations (*ibid*, p 45). Discussions involved "old way, new way" thinking; how things would happen differently once community control was achieved (*ibid*, p 50) and how issues of "conflict of interest" would be addressed in the new way (*ibid*, p 70). Pictures and posters were used extensively in this developmental phase (early days of the Board) to draw on the local people's understandings of health and the road to improving the health of all the communities involved. The drawings represented a form of cultural mediation (*ibid*, p 68) that enabled a constant process of negotiation between the two knowledge systems.

This "inside story" also highlighted the key phases of implementation of community control: organising committees; negotiating roles between governments and Aboriginal people; ensuring funding was adequate to address the health needs in the communities; and how the KWHB related to other local organisations. Implementation of community control of the health service was undertaken in a purposeful and planned approach with specific goals identified, worked towards and outcomes evaluated (*ibid* pp 96 – 104). These implementation phases involved initially the introduction of PHC service provision based on local identified health priorities; secondly the introduction of non-clinical public health services; and thirdly the employment of community based Aboriginal Health Workers for clinical and non-clinical service provision.

This case study of the development and implementation of the KWHB identified a range of essential preconditions for Indigenous Community Control and governance: the need to ensure adequate funding from governments to cover all costs; the need for legal agreements between the Board and the funders; and the need for high skill levels of management and administrative staff (*ibid*, pp 105 – 110). The Australian Medical Association (2007) supported this claim of community participation and capacity building and provided examples of not only increased levels of service provision, but improved health outcomes: high rates of screening and early intervention in chronic disease; exceeding national averages for primary care service indicators; and a dramatic decrease in the prevalence of trachoma.

If Indigenous "communities" are to move towards a sustained "community control", the set of preconditions and processes required need to be defined, agreed and resourced to enable this transition to occur. Any definition of community control will need to contain the elements of what community control is and how community control can be achieved. An examination of "best practice" in PHC could substantiate the pre-conditions for and processes necessary for the transition to a sustainable community control.

Best Practice in Indigenous Primary Health Care

Over the past decade a number of research projects have been commissioned to evaluate the effectiveness of Indigenous PHC initiatives as well as Indigenous governance projects. The literature has assisted in the development of a core set of characteristics that underpin and support successful and sustainable PHC projects and organisations.

An analysis of the achievements in ATSI Health (Shannon *et al.*, 2003, pp 9 - 16) provides key evidence of what makes for a successful community controlled health service and establishes a policy framework for thriving Indigenous health organisations. The five lessons resulting from the evaluation project involve the implementation of: a comprehensive PHC model, with specific health interventions working across the secondary and tertiary health care sectors, based on inter-sectoral collaboration; community control and community participation; funding and evaluation processors, including resourcing, workforce and capacity building and sustainability, partnerships, and accountability; and a group of other factors, including a leadership and policy niche.

Community control thus does not occur in isolation to a number of strategic and operational issues. For community control to be successful, Indigenous governance needs to be supported through the establishment of business aims and objectives, rules, team roles and accountabilities, training and measurement of outcomes involving internal and external stakeholders, including funders.

A number of these areas of achievement are reinforced in the NT, DHCS, Aboriginal Health and Families, A Five Year Framework for Action (Department Health and Community Services, 2005). The section titled "Partnerships and Engagement" (*ibid*, p 29), states that:

"We will support pathways to community control through the engagement of local Aboriginal communities in the setting of strategic priorities, agreeing non core services and monitoring of performance of all community health centres in the Northern Territory".

The commitment to community control is highlighted in the Framework by the Department's declaration to engage in an honest "two-way" relationship with Aboriginal communities through consistency in service design and protocols, the sharing of information and collaborative action, complementary workforce structures, and shared access to relevant, quality health and wellbeing resources outside the sector.

While arguing that there was a "dearth of literature" on the sustainability of PHC innovation Sibthorpe *et al.*, (2005, pp S77-S80) identified three key themes that are important to sustaining PHC innovation. The first theme was about the importance of collaboration, achieved through social relationships or networks and local champions. The second theme was in reference to the effect of external forces: political, financial and societal. Lastly, and probably most important, is the motivation and capacity of people within the system, both Indigenous and non-Indigenous. Adding to these themes, Corbett (2005, p 254) stated that the imperatives for PHC and disease prevention are not found within the highly medicalised health care system, but in health policy implementation where there exists trust between agencies, individuals and communities; innovative approaches to managing performance across government; and fostering and the development of government networks and partnerships. In terms of the significant achievements by many ACCHS over the past decade, many Indigenous populations still have not matched the improvements in their health outcomes as evidenced by the high levels of chronic disease within populations. A key challenge, hence for government policy makers, health practitioners and community members is the difficulty to demonstrate change or improvements in health outcomes, "... a foot on the brake, a foot on the accelerator" (Thomas, *et al.*, 2006) whilst reconciling increased reporting, awareness and effective screening moderated with education so community and staff are not demoralised.

More recent research defining community control or Indigenous Governance and of the preconditions required for the successful implementation, outside the health sector has been research undertaken by the Centre for Aboriginal Economic Policy Research (CAEPR). The CAEPR, Indigenous Community Governance Project (ICGP) is supported under the Australian Research Council's Linkage funding scheme. The Australian Government through FaCSIA, (formerly the Department of Immigration, Multicultural and Indigenous Affairs) and the NT and West Australian governments, also collaborated on the research and funded the ICGP.

The ICGP project is also a partnership between the CAEPR and Reconciliation Australia, to undertake research on Indigenous community governance with 13 participating Indigenous communities, regional Indigenous organisations, and leaders across Australia. Smith (2002,

p27) of the CAEPR, again highlighted the lack of definition and clarity of self-determination when citing the Royal Commission into Aboriginal Deaths in Custody in 1991:

“It is remarkable how a concept [i.e. self-determination] which is so widely recognised as being central to the achievement of the profound changes which is required in the area of Aboriginal affairs remains so ephemeral and so difficult to define”.

The Centre for Aboriginal Economic Policy Research has produced many significant reports in the last few years that have highlighted the central issues and concerns for Indigenous community control, or as termed in their research, Indigenous Governance. Documented in the research progress reports of Hunt and Smith (2005; 2006a & b) and the outcomes of “Sharing the Success” governance workshops (Reconciliation Australia, 2007, a & b) a number of key insights have emerged that helped define this area of investigation of community control and are presented in Table 1.

Table 2: Key Insights for Successful Indigenous Governance, (Hunt and Smith, 2005; 2006a)

Ten key messages (Hunt and Smith, 2005)	Further insights (Hunt and Smith, 2006a)
1. Relationships and representation are key	The complexity of “community governance” for community members and stakeholders
2. No ‘one size fits all’, but not all sizes are equal to the task	The importance of Leaders and ‘nodal’ leadership
3. Cultural match is about legitimacy	Networked governance – Indigenous principles and institutions
4. The cultural geography of regions forms a basis of governance	Cultural match, legitimacy and contestation
5. Institutions of governance matter	Capacity development and institution building
6. Leadership, leadership, leadership and succession	The “governance capacity” of government
7. Governance matters for sustained socioeconomic development	
8. The governance environment can enable or disable	
9. Enhancing governance capacity requires a systems and developmental approach	
10. Governments and Indigenous people have different criteria for evaluating governance effectiveness	

The “*Sharing the Success*” governance workshops facilitated by Reconciliation Australia (2007a & b) highlighted the need for a developmental approach to achieving Indigenous governance and community control outcomes; and that specific and tailored programs are required to move from inspirational visions to operational goals. Throughout this literature the importance of the cultural aspects and the process of Indigenous governance are also emphasised.

Lay Knowledge

The area of lay knowledge is relatively new to the development of “ways of working” with individuals, groups and communities, who interpret their experience from their everyday life. A key argument is that lay knowledge is something that we all have, at some time, in some situations (Popay 2006), and that by imposing a set of western scientific or “external” values and beliefs onto a community in relation to health and illness, the impact can be to disconnect individuals and communities from their complex social, physical and economic environment in which they live.

Popay (*ibid*, 2006) explored lay knowledge and the impact of professional dominance, western organisation structures and processes, and theories on communities, specifically in the area of public health and argued that discrediting lay knowledge as subjective could essentially reinforce health inequalities. Researchers and practitioners could improve health’s theoretical base by conducting research that attributes greater validation to lay knowledge where the drivers of health focus on environment, place, social relationships and ontological resources argued Popay (*ibid*, 2006).

Related to this emerging area of lay or traditional knowledge in health is the development of ATSI learning, with their involvement and from their perspectives. The development of lay or traditional knowledge involves a “both ways” philosophy that draws on both the Indigenous knowledge systems and western scientific paradigms (Batchelor Institute of Indigenous Tertiary Education, 2006). The “both ways” philosophy of BIITE (*ibid*) relates to: individuals as researchers; the research practice domain; and the research community through engagement with both Indigenous and western knowledge systems.

This initial analysis of lay knowledge, including Indigenous knowledge systems, has highlighted its potential for acknowledging the diversity of individuals and groups in communities that share the same experience; identifying the different understanding and perspectives in the knowledge system or systems; identifying the potential for disengagement between knowledge systems; encouraging engagement between conflicting or overlapping perspectives in the knowledge systems; assisting to reframe the power relationships between community members, including the researchers; and identifying new ways for policy and practice development through collaborative research, in response to the growing health inequalities. Senior’s (2003) study of youth behaviours and health in Ngukurr, a remote community on the Roper River in the NT highlighted the lack of understanding of local beliefs as potential barriers to the implementation of new health strategies.

NT Aboriginal Health Forum, “Enabling Framework”

“*Enabling Frameworks*” are used to describe the core structures and processes for the advancement and empowerment of traditionally disenfranchised individuals, groups and communities. Gill (2002) articulated a developmental and systemic conceptualisation to the implementation of “enabling frameworks” when describing policy approaches to achieving the advancement and empowerment of women at a United Nations, Division for the

Advancement of Women Expert Group meeting in Beirut, Lebanon. Gill (*ibid*, p1) identified the four core elements to an “enabling framework” as: clear and practical defined policy objectives; identified actions and decisions that may compromise the particular policy [risks]; minimum standards defined to be met by all participants in the policy process; and the provision of procedures for assessing progress towards the policy objectives and added to the debate when arguing that,

“... for the technique of using policy approaches as enabling frameworks to succeed all concerned will have to begin ‘on the ground’.

Gill (*ibid*, pp 1-6) argued that greater community participation and interaction between local people and governments are required along with ensuring the contribution of all community groups, in particular women and youth, and not just relying on the traditional elders or dominant spokespersons. Added to these participation strategies are the inclusion and integration of community concerns into governance and organisation policies based on strengthening community capacity.

In 2006, Northern Territory Aboriginal Health Forum (NTAHF) that comprised the Aboriginal Medical Service Alliance, Northern Territory (AMSANT), DHCS and DoHA developed an “enabling framework” (Department Health and Community Services, 2006) for the establishment of ACCHS throughout the NT. Four key principles guide this framework:

- a shared commitment to community control as the most effective basis for Aboriginal health and community care service delivery;
- planned and sequential movements towards community control through attainment of agreed milestones;
- the development of certainty regarding capacity for Aboriginal community control; and
- sustainability of Aboriginal community controlled health and community services through the planned development of governance and management capacity.

The NTAHF “enabling framework” for the development of Aboriginal community controlled health and community services reinforced Gill’s (*ibid*, 2002) pragmatic developmental approach and is based on three enhancement phases (refer Appendix A): an engagement phase with the sharing of information with the community related to health need and service provision, along with the development of a formal advisory committee, funding for governance training and the employment of a facilitator; the consolidation phase with the development of committee capacity, a community health plan with indicators of management capacity (IMC), funding allocated based on auspicing agreement and establishment of formal stakeholder/advocacy networks; and finally the independence phase where full community and/or regional control is achieved.

To my knowledge, the “enabling framework” developed was based on the experience of members of the NTAHF, such as the KWHB and has not been subsequently implemented or evaluated. The use of this “enabling framework” that guided the early work for the THAC, towards community control is comprehensively analysed in the research findings (refer Chapter Five).

Major Issues Emerging from the Literature

Community control definitions and models

My appraisal of the literature identified a lack of analysis and definition in the development of the key concepts used relating to community control. Community control grew from the international human rights movements of the late 1960s, with these values and aspirations embraced by Indigenous leaders and communities and key health professionals attempting to create more appropriate health services for Aboriginal people. The current 129 ACCHS (NACCHO, 2008) throughout Australia reflect the successes of this movement. In parallel, successive governments developed policy that resulted in a shift from self-determination and community control to self-management or administrative rationalism and in the past decade, mutual obligation and back to protectionism. The burden of disease and health inequalities has increased despite these community control and government policy initiatives (Condon, *et al.*, 2004a and Zhao, *et al.*, 2004).

There is also an argument (Kunitz and Brady, 1995) that community control no longer holds currency, because no Aboriginal community will achieve a “pure or ideological” form of control, as resources will always be funded from external sources with “strings attached”; there will always be conditions on funds to achieve agreed outcomes. Partnership Agreements, alliances and collaboration between Indigenous communities and governments or stakeholders based on “power-sharing” also undermine the concept and ideology of community control.

To assist the establishment of the community control sector, there is a need for an agreed set of definitions of what comprises a community, community control and how community participation can be conceptualised. A number of authors (Bossert and Beauvais, 2002, Shannon *et al.*, 2003, and Kamrul Islam *et al.*, 2006) support this requirement for definitional and conceptual development of community control. Shannon *et al.*, (2003, p11) recommended the analysis, development of definitions and models of community control. Kamrul Islam *et al.*, (2006) recommended the facilitation of developmental or enabling frameworks that support communities to work towards community control based on geographic location, population size, makeup and capacity with the development of tools to assist identify the key contextual elements for individual communities – urban/remote, demographics, and burden of disease, along with a measurement of social capital inclusive of community participation and trust. Bossert and Beauvais (2002, pp 26-27) recommended the development of scopes and degrees of autonomy with the appropriate level of de-concentration, devolution, delegation and privatisation for each community. These authors (*ibid*) also proposed a decision-making or delegations framework that delineates the community’s role in the health service operations including the level of governance and accountability for service planning; delivery, and/or support functions; and health service evaluation, including efficiency and financial soundness, equity, quality and the performance measurement of outcomes.

Capacity for engagement and participation

I identified from the literature that the capacity for engagement and participation is the most difficult part of PHC to put in to effect. The community control sector has a history of failures or limited success, where engagement and participation is not only difficult to achieve, but also to sustain. The focus of much work in this sector has centred on the structures and mechanisms to achieve control. Until recently, there has been little discussion about the meaning of developing capacity and the skill base necessary to facilitate community control. Similarly, there is work to be undertaken for both governments and the community control sector to define and develop the

mutual core capabilities and competencies for community control, participation and collaboration.

Inherent in these arguments are the tensions and conflict, if not incongruence that will always exist between governments and the community control sector. The tension exists due to two frames of reference argued Scrimgeour (1997): that of the western, rational administration and Indigenous culture; a target and performance orientation and the journey towards empowerment or self-determination; self management and empowerment; self-determination yet dependent on external funders and service providers; and collaboration and/or partnerships and “community control”. Acknowledging this community control aspiration of many Indigenous groups and organisations, Shannon *et al.*, (2003, p 18) argued for a broader continuum of engagement with a range of stakeholders; including governments, education and research institutions, non-government organisations, and advocacy alliances.

Boothroyd (1986, p19) highlighted this argument of *choice* of engagement, participation or contribution, when identifying types of Indigenous planning according to a beneficiary participation model. Boothroyd (*ibid*) identified a range of behaviours that are the result of *how* community activities are planned, decided or implemented. *Table 2: Alternative Forms of Native Community Planning*, illustrated the four behaviours as: ritualistic, placatory, autocratic and/or developmental. These behaviours may be present singularly or occur concurrently. The motivation or choice of individuals to engage or disengage, contribute to or withdraw from decision making was examined, particularly when the, “...*internal social structures of some so-called ‘communities’ are better characterised by political divisiveness and factionalism*” (Moran 2004, p 340).

Table 3: Alternative Forms of Native Community Planning (Boothroyd, 1986, p19).

	Planning is Directional to decisions/action of band	Planning is Peripheral to decisions/action of band
Planning is Participatory	Developmental Planning	Placatory/Wish-list Planning
Planning is Centralised in some body	Autocratic Planning	Ritualistic Planning

My appraisal and analysis of this literature has highlighted the diverse and conflicting nature of community control and the impact of participation. The arguments followed that, until the issues of leadership and involvement of the community are addressed, dysfunctional forms of participation and decision making processes will dominate and further diminish and undermine the desire for community control and self-determination.

Risk Management

I identified three key issues relating to risk through the examination of the literature. The key risk for future work is the impact that any project or intervention may have on Indigenous people, including the research results presented in this thesis (refer Chapter Five). Hyatt (1997, p 228) and Popay (2006) explored the nature and impact of government policy and the frequent use of external consultants for urban renewal and community development projects. After projects were

completed, communities were frequently further disadvantaged due to lack of consultation, incomplete change management and the associated emotional and physical exhaustion. Popay (*ibid*) described this as a breach of the psychological contract between governments and communities. This breach has a long-term and negative impact on communities as people can be already harmed through generations of inappropriate approaches to engagement and “integration”. Hyatt (1997, p 228) came to the same conclusions as Popay and argued that this breach and the resultant shame, fatigue and illness, caused greater personal and community breakdown and dysfunction, with greater conflict in self-management policies, such as, “... *you’ll be self-determining, self-managed or else*”.

The second critical risk not managed adequately through the development and implementation of the THB was that of the community’s expectations. The Commonwealth and Territory Health Ministers of the day, acclaimed the Tiwi CCT as a great success, and the work of the THB was applauded locally and nationally. It could be argued that the promoting of the successes and achievements, without a realist assessment of the risks, particularly the weaknesses and threats to the THB and the Tiwi people, resulted in raised and unrealistic expectations even though the risks had been clearly illuminated in the CCT evaluations (Beilby and Pekarsky, 2002). In an attempt to quickly achieve credibility with the Tiwi people, the DoHA and the NT DHCS glossed over these identified key risks.

Thirdly, during the transition to the THB, from late 1999 and early 2000, there was no identified risk management plan that analysed the health Board’s strengths, weaknesses, opportunities or threats. The Board moved quickly into undertaking “full” control for the governance, management, service provision and advocacy for the health of the Tiwi people. A new commercial venture commenced within two years of the Board being established. New health programs and capital works planned and commenced, with a rapidly expanding budget. The evaluation of the CCT (Robinson, *et al.*, 2001) saw the two governments withdraw their support and impose a governance and accountability attitude, characterised by the “purchaser/funder/provider” split, (Hughes, 2003) that exemplified the economic rationalist approach and legacy to health care management from the late 1980s in the UK, NZ and Australia. This “purchaser/funder/provider” approach encouraged greater accountability to the purchaser and funder of services, but not to the individuals or communities who were the recipients of services. This approach and culture epitomised the cavalier attitude, “... *all care, and no responsibility*”.

My appraisal of the literature identified that governments wanted to demonstrate the success of Aboriginal community control, but did not know what a successful health Board looked like and how to measure and demonstrate health outcomes in this context.

Problem Representation: Who has the Problem?

The literature review also assisted to identify that the problem of community control was viewed solely as a Tiwi problem, and not one jointly shared by Governments. A key issue then for this research is, reframing the question and asking, “... *who has the problem?*” Viewing the problem from a diversity of vantage points ensures that alternative perspectives are made with differing solutions and options identified. Kelly and Sewell, (1991, p115) offered an alternative solution for organisations and communities when suggesting:

“... wisdom in retreat, in rest, renewal, preparation, review and consolidation. The movement backwards can ready people and increase their energy for the next movement forward, and this does not always have to entail losing ground forever.”

The authors (*ibid*, 1991) also suggested alternative approaches and ways of “working with”

organisations and communities. Instead of “doing everything”, there are choices for which parts of the health service work could be undertaken and how they are to be facilitated. The “community of intention” (*ibid*, p 99), identified the options of work and for capacity building for community controlled organisations:

- community service: the work for or on behalf of others (*ibid*, p 83), resulting from existing community demand, with the exchange of skills, knowledge and products;
- community action: campaigning or advocacy – the relaying of implicit messages from the wider social movement and long-term struggle, usually involving human rights and land rights, (*ibid*, p 86);
- community work: brokering (*ibid*, p 90) endeavouring to permanently provide access for the most disadvantaged people to the social systems that have been set up to serve them;
- community development: the restructuring of services through change management, where problems resulting from the inadequacies of social systems (*ibid*, pp 93 - 94) have been identified; and
- community of intention: the work of ensuring continuity and sustainability (*ibid*, p 99).

Grim (2003, pp 242-243), the Assistant Surgeon General and Director of the Indian Health Service (IHS), identified the 1976 *Indian Self-Determination and Education Assistance Act* (PL 93-638) as the key mechanism that allowed Indian tribes to contract with the IHS for services otherwise undertaken by the federal government. In 1994, this Law was further amended (*ibid*, 2003) to allow communities to assume operational and administrative control over IHS programs with the federal funds transferred to the communities, to administer these programs. As a consequence, stated Grim (*ibid*, 2003):

Almost all of the 562 federally recognized tribes currently provide some level of health services to their members; approximately 52% percent of the IHS federal budget is transferred directly to tribes and to urban Indian health programs for this purpose.

Grim (*ibid*, 2003) argued that the model developed by the IHS with the participation of Indian people in decisions affecting their health produced further significant health improvements, including: Indian life expectancy had increased by 7.1 years since 1973 (although it remains 6 years below that of the general US population); and while significant disparities still existed, the rates of death attributable to pregnancy and childbirth, tuberculosis, gastrointestinal disease, infancy, accidents, pneumonia, influenza, homicide, alcoholism, and suicide had declined. Grim (2006) spoke of the range of options that the IHS in America and Alaska offered Indigenous communities: the choice to “pick and choose” programs or services for implementation or participation with, that are most meaningful and achievable for the community, based on community capacity.

Cornell (2008), Co-Director of the Harvard Project on American Indian Economic Development supported Grim (2003) claiming that two key factors had been particularly important in achieving increased equality in health and economic outcomes for American Indians and Alaska Natives:

- the change in government policy towards Indigenous populations based on self-determination, coupled with a change in the role that government played in Indigenous

communities, including the delegation of accountability; and

- a set of actions and investments – not so much of money but of time, energy and ideas – by Indigenous communities themselves.

A new challenge presented in the literature and questioning “whose problem?” is the study of Indigenous health in northern Australia: “Bureaucrats and Bleeding Hearts” (Lea, 2008). Lea (2008) established the “dissonance” or conflict (*ibid*, p 9) within the providers in Indigenous health in northern Australia: *the bureaucrats* – their generally entangled, circular, self-perpetuating inertia (*ibid*, p xvi) and; *the bleeding hearts* – the health professionals who [anguishing and rescuing], become institutionally ordinary when they consider themselves to be doing such unorthodox and radical things as travelling to isolated communities, and dealing with dramatic issues of ill health and poor living conditions (*ibid*, p xvii). The poor health data and status of Indigenous people in the NT over four decades (Condon, *et al.*, 2004a and Zhao, *et al.*, 2004) continues to highlight the impact of these inappropriate approaches to Indigenous health and the creation of dependents and victims of Indigenous people despite: elevated and increased levels of chronic disease; increased reporting of chronic disease, but still associated with under reporting; and increased service demand, yet associated with continuing under resourcing to meet this demand.

Lea (2008, p 229) proposed an integrated and systemic approach to addressing the health inequalities in the NT and to overcome the entrenched beliefs and behaviours of government administrators and service providers. Working across the sectors in collaboration with Indigenous people, Lea (*ibid*, pp 228 – 229) proposed the following strategies, many of the outcomes from the Fifth Annual Chronic Disease Network Workshop, in Darwin in May 2001:

- control at an individual, community or organisational level;
- an approach to practice with people, through prevention across the life span;
- advocacy built into programs and action;
- capable people, through building strong community teams;
- securing and managing funding; and
- having in place the appropriate systems to support the health teams and “interventions”.

Indigenous Health: A Contemporary Public Health Matter

The health status of Indigenous people in Australia is expressed in the significantly shorter average life expectancy, higher rates of mortality and morbidity, higher rates of burden of disease and increased risk factors (National Health and Medical Research Council [NHMRC] 2003a; Condon *et al.*, 2004a; Condon *et al.*, 2004b; Zhao *et al.*, 2004; Li and Guthridge 2006; Thomas *et al.*, 2006). The poorer health status of Indigenous people is also a direct consequence of the social, economic and environmental inequalities experienced by ATSI people. Over the past 20 years, the Indigenous and non-Indigenous health status has experienced significant gains, but the gap has widened between the two across a range of disease indicators (Thomas *et al.*, 2006, p147), specifically ischaemic heart disease, diabetes mellitus and renal failure.

Over the past four decades, the NT Aboriginal population has experienced mortality reductions for infants and young children, maternal and perinatal conditions, communicable diseases and injury; however, mortality from non-communicable diseases now comprises more than 70% of NT Aboriginal deaths. There has been no reduction in non-communicable disease mortality over recent decades and the incidence and burden of chronic diseases such as diabetes, cardiovascular and kidney disease have been rapidly rising in the Aboriginal population (Zhao *et al.*, 2004, p450).

The current health status of the Indigenous population in the NT is a major concern locally, nationally and internationally. Condon *et al.*, (2004a, p448) state that whilst there has been a decline in Aboriginal mortality over the past four decades in the NT in all age groups:

“... the widening of the relative [mortality] gap mirrors that seen for many disadvantaged populations across the world in recent decades”.

Of significant interest therefore, are the key issues related to this widening gap in the relative mortality and morbidity rates, aetiology and determinants of health for chronic diseases in the NT Aboriginal population despite over 40 years of Commonwealth accountability.

Australian Government Intervention: A Unique Research Context

This research is being undertaken within a unique and rapidly changing context, currently dominated by the changing political landscape with new legislation and policies being developed and implemented. These changes are providing major challenges to the concept of community control and Indigenous governance, and in particular of ACCHS. The research was also undertaken over the forty-year anniversary of the 1967 Referendum (27 May) that enabled Indigenous people to be included in the Australian census and gave the federal government the power to make laws in relation to Indigenous people. There have been many Commonwealth and NTG laws introduced by successive governments that impact directly today on the status and welfare of Indigenous people in Australia and specifically the NT. Appendix B identifies the legislation that has impacted on ATSI peoples including:

- human rights, racial discrimination and equal opportunity;
- family law and the interests of Indigenous children;
- Indigenous governance and self-determination, land rights and native title; and
- heritage and cultural protection.

A number of these laws recognised the rights of Indigenous people and the Australian Government's obligations under the United Nations, International Convention on the Elimination of All Forms of Racial Discrimination. Many of these laws have also been amended and/or repealed by successive Commonwealth governments.

In August 2006, the NTG created a Board of Inquiry to investigate and report on allegations of sexual abuse of Aboriginal children as a response to the Alice Springs crown prosecutor, Nanette Rogers report in May 2006 (Australian Broadcasting Corporation, 2006) that highlighted the deficiencies in the NT criminal justice system and its lack of capacity to deal with victims of violence, rape and abuse. The Board of Inquiry was established to find better ways to protect Aboriginal children from sexual abuse. The Inquiry gathered and reviewed a

vast amount of information that resulted in 97 recommendations. On the 15 June 2007, *The Little Children are Sacred Report* (Wild and Anderson, 2007) was handed to the NT Chief Minister. Underlying the Inquiry's findings was the common view that sexual abuse of Aboriginal children occurs largely because of the breakdown of Aboriginal culture and society. Important points made by the Inquiry included:

- child sexual abuse is serious, widespread and often unreported;
- most Aboriginal people are willing and committed to solving problems and helping their children and are also eager to better educate themselves;
- Aboriginal people are not the only victims and not the only perpetrators of sexual abuse;
- much of the violence and sexual abuse occurring in Territory communities is a reflection of past, current and continuing social problems which have developed over many decades;
- the combined effects of poor health, alcohol and drug abuse, unemployment, gambling, pornography, poor education and housing, and a general loss of identity and control have contributed to violence and to sexual abuse in many forms;
- existing government programs to help Aboriginal people break the cycle of poverty and violence need to work better. There is inadequate coordination and communication between government Departments and agencies, and this is causing a breakdown in services and poor crisis intervention. Improvements in health and social services are desperately needed; and
- programs need to have enough funds and resources and be a long-term commitment.

The AGI into Indigenous communities in the NT was announced on the 21 June 2007 as a result of the *"Little Children are Sacred"* Report (Wild and Anderson, 2007). The then Prime Minister, John Howard, and Minister for Families, Community Services and Indigenous Affairs, Mal Brough, announced "national" emergency measures to protect Aboriginal children in the NT from abuse and give them a better, safer future. The Australian Government announced immediate, broad ranging measures to protect children, stabilise communities, normalise services and infrastructure and provide longer term support to build better communities (FaCSIA, 2007).

The Minister for FaCSIA outlined the emergency measures to protect children and provide immediate mitigation and stabilising impacts in communities. The measures included:

- introducing widespread alcohol restrictions on NT Aboriginal land;
- introducing welfare reforms to stem the flow of cash going toward substance abuse and to ensure funds meant to be for children's welfare are used for that purpose;
- enforcing school attendance by linking income support and family assistance payments to school attendance for all people living on Aboriginal land and providing meals for children at school at parents' cost;
- introducing compulsory health checks for all Aboriginal children to identify and treat

health problems and any effects of abuse;

- acquiring townships prescribed by the Australian Government through five year leases including payment of just terms compensation;
- increasing policing levels in prescribed communities, including requesting secondments from other jurisdictions to supplement NT resources, funded by the Australian Government;
- requiring intensified on ground clean up and repair of communities to make them safer and healthier by marshalling local workforces through work-for-the-dole;
- improving housing and reforming community living arrangements in prescribed communities including the introduction of market based rents and normal tenancy arrangements;
- banning the possession of X-rated pornography and introducing audits of all publicly funded computers to identify illegal material;
- scrapping the permit system for common areas, road corridors and airstrips for prescribed communities on Aboriginal land; and
- improving governance by appointing managers of all government business in prescribed communities.

A taskforce of eminent Australians, including child protection experts, logistics and other specialists oversaw this NT emergency response. Magistrate Sue Gordon, chair of the National Indigenous Council and author of the *Gordon Report into Aboriginal Child Abuse in Western Australia*, (Gordon *et al.*, 2002) took a leadership role on the Taskforce.

The Northern Territory National Emergency Response Act 2007 (Cwth) was passed by the Commonwealth Government, on the 17 August 2007 after a public hearing on the 10th of August and after 27 hours of debate with an extended sitting of the Senate. This legislation was based predominantly on the work of Helen Hughes in her book titled *"Lands of Shame"*, (Hughes, 2007). The emergency measures are outlined in Chapter 15, *Way Ahead for the 'Homelands'*, where the policy reforms are documented (*ibid*, pp184 – 188).

A critical argument that has emerged as a result of the AGI is the conflict between a self-determination approach and [any] external interventions, for the "good" of the people (Martin, 2007), and what is defensible and not. Martin (*ibid*) explored this conflict when comparing the political responses to the *Little Children are Sacred Report* (Wild and Anderson, 2007) the NTER. The dichotomies argued by Martin (2007) are referred to in *Table 3: Problem Identification, Two Positions – "the left and the right"*, where Indigenous health and welfare problems exists due to structural disadvantage, "the left" or as a consequence of long-term policy and political failure, "the right".

"The left" position highlights the nature of Indigenous culture based on traditional law and communal existence, and where successive governments have failed to redress colonisation and value the contribution of ATSI people to the broader Australian society. This failure of governments to address the history of dispossession has resulted in structural disadvantage,

characterised by collective trauma, alienation and poverty (Martin, 2007). “The left” solutions to this structural disadvantage include both symbolic reconciliation, “saying sorry” and structural change based on supporting and investing in Indigenous sector, to “close the gap” between Indigenous and non-Indigenous people.

Table 4: Problem Identification, Two Positions – “the left and the right” (Martin, 2007)

Assumptions about causes	
Structural disadvantage (the left)	Policy/political failure (the right)
<ul style="list-style-type: none"> ▪ Aborigines communitarian, worthy 	<ul style="list-style-type: none"> ▪ Aborigines morally, socially “backward”
<ul style="list-style-type: none"> ▪ History of racism, dispossession 	<ul style="list-style-type: none"> ▪ Government elites create “cultural ghettos”
<ul style="list-style-type: none"> ▪ Past government underinvestment in services, infrastructure 	<ul style="list-style-type: none"> ▪ Isolation from general society, productive labour and market forces
<ul style="list-style-type: none"> ▪ Past failures to respect, recognise culture and rights 	<ul style="list-style-type: none"> ▪ Failed collectivism
Outcomes: collective trauma, alienation and poverty	Outcomes: “welfare passivity”, collapse of norms
Assumptions about remedies	
Addressing disadvantage (the left)	Addressing past failure (the right)
<ul style="list-style-type: none"> ▪ Saying “sorry” 	<ul style="list-style-type: none"> ▪ “practical reconciliation”
<ul style="list-style-type: none"> ▪ Indigenous-specific beneficial legislation 	<ul style="list-style-type: none"> ▪ Wariness of or hostility to special measures
<ul style="list-style-type: none"> ▪ Government funding for services, infrastructure within remote areas 	<ul style="list-style-type: none"> ▪ Increased reliance on market mechanisms, moving off welfare, mobility
<ul style="list-style-type: none"> ▪ Support for the “Indigenous sector” 	<ul style="list-style-type: none"> ▪ “mainstreaming” service delivery
<ul style="list-style-type: none"> ▪ public support for “culture”, diversity 	<ul style="list-style-type: none"> ▪ “culture” private choice, not to be public funded
<ul style="list-style-type: none"> ▪ support for “community development” 	<ul style="list-style-type: none"> ▪ “carrot and stick”, individual responsibility

“The right” position argues policy and political failure over the past four decades by successive Commonwealth governments, by allowing ATSI people to function as separate from mainstream Australians. This policy failure is reinforced through the concept of “passive welfare”, where ATSI people have relied on government handouts, rather than creating a sustainable existence for themselves. The solutions to this policy failure, “the right” argue is based on practical reconciliation, and the inclusion of ATSI people in mainstream policy and Australian life, with culture and responsibility an individual, not collective matter.

The current Labor Commonwealth Minister for Indigenous Affairs, Jenny Macklin has committed to the continuation of the AGI in the NT to enable an evaluation and identify

what's working and what changes are required. Whilst the AGI continues, the more politically contentious interventions such as the removal of the Community Development Employment Projects (CDEP) and the Permit System are being phased out or abandoned.

The Australian Government, on the 21 June 2008, released the report *Northern Territory Emergency Response: One Year On* (Commonwealth of Australia, 2008a). The Report documented the main emergency response measures (*ibid*, p 5) including: increased coordination and logistics to engage with communities and provide basic services; additional law and order resources and implementation of bans on alcohol and pornography; additional resources to support families, with the building of "safe houses" and provision of more child-protection workers; welfare reform and employment including income management and changes to the CDEP; improved child and family health, predominantly through the implementation of health checks and follow-up treatment for children (AGI, Phase 2, initiated in February 2008); enhanced education with strategies to improve the attendance of children going and staying at school; and housing and land reform with the implementation of basic environmental health strategies to repair existing homes and clean up communities, and the alternative management of public housing.

The Commonwealth Government also established the NTER Review Board, whose role was to establish and conduct an independent and transparent review. Public submissions were called for in advertisements appearing in the national media (The Weekend Australian, 12 and 13 July 2008). The AGI highlighted the deficit in Government policy, planning and resourcing in Indigenous health and welfare over decades.

'Noble Savage' or 'Wounded Warrior'?

The recent debate of self-determination and empowerment has been influenced by the diverse choices for Indigenous people, especially around wishing to live on outstations or traditional "homelands". The homelands "movement" as it has been described, enabled Indigenous people to live on their traditional lands, in ways that met their needs for culture and self-reliance in small communities, similar to traditional families, or tribes. This has encouraged commentators to pass judgement on the homelands movement describing the return of the, "... noble savage, who ... existed in peaceful harmony with nature" (Rowland, 2004).

The homelands movement was described by the HRSCAA (Commonwealth of Australia, 1987), as a reaction to a number of changes occurring in Indigenous policy; assimilation to self-determination and land rights in the early 1970s (*ibid*, p16). The driving motivation for these policies was a strong desire for Aboriginal people to return to traditional lands so as to meet their obligations to the land, their past, present and future traditional owners, to undertake ceremony and maintain culture – hunting, fishing and gathering, protecting sacred sites:

... the movement has also been a reaction to the stresses of living in settlements, reserves and missions and the practice of bringing diverse groups of Aboriginals together to live in these artificial communities. There was widespread dissatisfaction with the institutionalised nature of settlements and missions and a recognition that they had enormous social problems. They characteristically contained many people living as 'guests' on land which traditionally did not belong to them, alongside traditional owners. For Aboriginal people the perceptions of these communities were as 'no good', 'too much trouble', 'people fightin', 'too much worry', 'sad place', and 'too

much sickness there'. By contrast, outstation life offered a return to a 'healthy social and physical environment, away from the tensions and trouble associated with large communities and mixed groups (Commonwealth of Australia, HRSCAA, 1987, p14).

Rowland (2004) argued that this concept of 'noble savage' has permeated the writings in anthropology, cultural studies, philosophy, political science, literary and art criticism, and in the popular media over many years. Rowland (*ibid*, 2004) argued that when Indigenous peoples are stereotyped as 'noble savages', they are once again frozen in the past and therefore can have little to contribute to human history. Rowland (*ibid*, 2004) maintained that there is a continuing need to search for a view that focuses on a much more positive engagement with Indigenous peoples, than just on ecological and environmental issues.

Trudgen (2000) provided a detailed analysis of the dysfunction in *Yolngu* communities that included drug dependency, community violence and murder, self harm and suicide, and child neglect and sexual abuse. Trudgen (*ibid*, pp 12 - 38), documented the dispossession of country and culture of the *Yolngu* people through a history of pastoral wars, loss of international trade and with the introduction of missionaries throughout East Arnhem Land. The impact of this "cultural imperialism" combined with a destructive intercultural environment, has created what Trudgen (2000, pp 165 – 175) referred to as, "learned hopelessness", due to the: diminished authority of traditional leaders; confusion about how the western economy works; insecurity about land tenure; non-recognition of ancient law that once brought peace and prosperity; loss of roles and mastery; and creation of dependency – through welfare, alcohol and drugs. Trudgen (*ibid*, pp 60 – 65) highlighted the impact of "... *naming, blaming, and lecturing,*" on *Yolngu* people, citing that this behaviour actually makes things worse and sets up projects and programs to fail. Another factor described by Trudgen (*ibid*, pp 186 – 197) is what he calls the "multigenerational legacy of trauma", as a consequence of long-term victimisation, stress and trauma. This phenomenon, as described by Trudgen, is as though the whole community is affected by the "post-traumatic stress disorder".

Trudgen (*ibid*, p 251) though, has an intense belief in the *Yolngu* people's potential and ability to survive, and that they can become, *djambatj mala*, "... great warriors, once more". Great warriors, once more can only be achieved through (*ibid*, pp 225 – 226) motivating and equipping the people to take control of their own lives and their contemporary living environment. Trudgen recommends: taking the people's language seriously; the training of dominant culture personnel; approaching education and training in different ways; replacing existing programs with ones that truly empower the people; and dealing with some basic legal issues, security of tenure and recognising the people's traditional law.

Trudgen is not without his critics (Mowbray and Senior, 2006, pp 216-229). Trudgen's work was viewed as a study that strayed into neo-conservative populism, which emphasised loss of control and learned helplessness, together with negative and destructive behaviours, where "... *warriors lie down and die*", without recourse despite ongoing evidence of a resilient culture, adapting to changing internal and external influences, and with local and national leadership. Mowbray and Senior (*ibid*, 2006) argued that Trudgen's reliance on simplistic solutions for these complex and intractable problems aimed at the individual, rather than at a community level only reinforced both a neo-liberal and neo-colonial approach that pervaded his descriptions and analysis.

Trudgen's analysis of the cultural and health issues faced by the *Yolngu* raised the dilemma

between the concepts of “freedom of choice” or self-determination and understanding, knowing or self awareness of, “... what’s best for you”. Unfortunately, this dilemma is played out in many arenas characterised by the statement where some individuals or total communities are “*betrayed to slow destruction by the spirit of improvement*”, what Watson (2004) declared as, “*simultaneously ... manifest[ing] specific authoritarian liberal practices of unfreedom*”.

These conflicting and inconsistent theories of structural disadvantage and policy and political failure, self-determination and neo-colonialism, “noble savage” and “wounded warrior”, mark the spaces where general and particular discourses overlap and clash. Kowal and Paradies (2005) argued that practitioners who seek to escape neo-colonialism must inhabit only the discursive space of public health congruent with self-determination, leaving them in a bind common to many postcolonial situations. Practitioners must relieve the ill-health of Indigenous people without acting upon them; change them without declaring that change is required (*ibid*, 2005).

Summary and Conclusion

This review of the literature has reinforced the lack of agreed definitions and clarity around the concepts and models of community control, what comprises a “community”, and what is meant by community participation. After 40 years of policy development and change, there is still significant confusion in a number of operating assumptions within the community controlled sector. Governments have made significant policy decisions without clarity around the specific terms and concepts. This, it could be argued has added to the poor health status of Indigenous people. There is also evidence from the literature of government’s incapacity to work with Indigenous communities, again over many years, to develop and implement governance and accountability frameworks whilst managing the risk to Indigenous communities. The final key issue identified from my literature review was: whose problem? Frequently the assumption is that: “... *it’s all their’ problem*”; “... *they’re’ accountable and responsible*”; “... *they need to build capacity*”; and “... *they need to change*”. Whose problem, indeed!

The analysis of the dynamic and at times, contradictory research context and discourse has highlighted, the long-term and continuing deficits in Indigenous health status. This context has also reinforced the stereotyping and diminishing of Indigenous culture through the implementation, amendment or the re-introduction of legislation and policies based on assimilation and the mainstreaming of services. The research context has highlighted the Australian government’s struggle to meaningfully engage with ATSI people and address the enormous gap in education, health and welfare between Indigenous and non-Indigenous Australians. This Chapter has affirmed that Government legislation and policy impacts directly on the concept of self-determination and empowerment for all Indigenous people and on the notion of community control itself.

Chapter Three: Research Methods

“Learning as we go – living knowledge”

(Department of Health and Community Services, 2005 pp 41-42)

Introduction

The important first steps in researching with Indigenous people was the project initiation process and the need to engage with the Tiwi people, explore what was important for them and what they wanted from the research. Significant attention has been given over the past decade to the development of a number of key approaches to researching with Indigenous people and communities. These developments undertaken in collaboration with Indigenous scholars were to ensure that the research methodology aligned with the values and ethics of undertaking research projects with Indigenous people and communities. The project initiation and the facilitation of a Research Agreement with the THAC are examined.

This chapter also describes the research methodology and approach to undertaking research with Indigenous people with key activities identified and explored. The research aim and objectives of the facilitation of a community controlled health services for the Tiwi people, using collaborative action research are described with the research methodology and activities outlined, including a description of the data collection and analysis and the proposed research outcomes.

The introduction of an anthropological examination of the motives of the THAC, blended with an organisational analysis approach in response to the changing Tiwi context and demands of the Australian Government Intervention into the NT are also described and justified. The research limitations are also examined.

Researching with Indigenous People

Researching with Indigenous peoples is linked to the exploration of their lived realities and their traditional and lay knowledge. The analysis of research and its relationship to Indigenous inquiry is emphasised in the seminal work undertaken by Smith (1999, pp 30 - 31) *Decolonising Methodologies: Research and Indigenous Peoples*. Smith (*ibid*, 1999) argued that the long and extensive “traditions” in western research are driven by a set of values and assumptions that are in opposition with the realities and lay knowledge of Indigenous communities. Western research values, stated Smith (*ibid*, 1999) presumed that Indigenous history and context are contained within this dominant knowledge system.

Smith (*ibid*) did not seek concessions for Indigenous research methods, but an acknowledgement that it comes from a different, less rational and systematised approach that is open to the “lived” realities of Indigenous people and one that incorporates tradition and lay knowledge. Smith (*ibid*) was also seeking a greater understanding and awareness of an adaptive research approach, one that reflected; changing contexts and demands; the need to respond to changing demands and obligations, environment and culture; and the different timeframes, faced by Indigenous people. Within this adaptive research context,

integrity of the research process and rigour is maintained through detailed data collection and analysis of emerging themes, using appropriate cultural and relevant research methods.

Also challenging the traditions of the western scientific approaches, Brown *et al.*, (2001, p 7) identified the development of research partnerships or agreed “rules” of engagement as critical to researching with Indigenous people. Fundamental to undertaking research with these groups is the ability to believe in each other’s truth, to listen and reciprocate. Brown *et al.*, (*ibid* pp 11-12, 21) emphasised the process of engagement as “two way” reflecting the two cultures and working in “equal” partnerships to avoid misunderstandings and mistrust.

Over the past six years, the National Health and Medical Research Council (2003a, 2003b, 2003c and 2005) and research centres (Henry, *et al.*, 2002; Street, 2004; Cooperative Research Centre for Aboriginal Health, 2006) have developed guidelines and frameworks for ethical ATSI research. The National Health and Medical Research Council (2003a, 2003b) released an agreed *Strategic Framework for ATSI Health Research Development* after a significant number of consultations on its development. The combined, identified core principles for Indigenous research from these sources include:

1. ethical and practical research, with a focus on achieving benefits to the community with improved health outcomes;
2. a comprehensive and holistic definition and approach to health;
3. the development of community priorities with community involvement throughout;
4. the adoption of research approaches ‘respectful’ of Indigenous peoples and their cultures;
5. the communication of research plans and results;
6. the employment and training of Indigenous researchers;
7. the involvement of and collaboration with research institutions, between health practitioners and researchers and across disciplines; and
8. the process of research is as important as the outcome.

The contribution of Public Health Anthropology (Singer and Baer, 2007 p 33) to research with Indigenous people is also significant where the aim is to achieve a greater understanding of the community’s health concepts and needs and how these arose. Castro and Singer (2004, p xiv) described a key aim of medical anthropology as understanding the health concepts of patients and populations, but within a political and cultural context related to the colonisation of traditional and disadvantaged groups, and with emancipation associated to a commitment for change. The impact of change or the intervention within this emancipatory approach is also important to the research outcomes. It is from these coeval contexts that my research approach and methods were developed with the THAC.

Partnerships between Indigenous communities, policy makers and researchers were also identified as key mechanisms to improve health outcomes; with a direct connection made between the research, results, policy development, and the implementation of the results into

practice, relevant to the community's situation. The values and ethics in ATSI health research (NHMRC, 2003c and 2005) included: reciprocity, respect, equality, responsibility, survival and protection and spirit and integrity. Each element provides the basis on which researchers may collaborate and undertake research with Indigenous people. In developing my approach to researching with the Tiwi people I developed a Personal Statement of Research Values (refer to Appendix C) to underpin the project based on the NHMRC guidelines (2005, pp 8 – 14).

Research Initiation

My engagement with the Tiwi people was an essential process to commence the research. The Human Ethics Research Committee sought confirmation of an appropriate engagement process along with the development of a Research Agreement (refer Appendix D). The Research Agreement was developed with the THS and documented my values and steps (NHMRC, 2005) required for commencing the research. The Research Agreement also included my core value statements that underpinned the research (refer Appendix C). To undertake the research with the Tiwi people, I incorporated the following steps (NHMRC, 2005, pp 15 - 30) into my approach:

1. relationship building with members of the THAC;
2. conceptualisation and thinking about what it is that the THAC wants to achieve and how;
3. development of the “research” questions and approval by the THAC;
4. data collection and management of the information;
5. data analysis and looking for meaning;
6. developing the data into information and providing reports for the THAC;
7. dissemination and sharing the results with the THAC and THS; and
8. learning from our shared experience.

The THAC met monthly as part of the THS management committee, with advisory committee members representing each of the three Tiwi major communities. I attended as an invitee of the THAC, with the specific aim of assisting the transition of the THAC to the future THB.

The THS had also developed a mission statement in 2007 that reflected the integration of health and well-being as part of the Tiwi culture and provided clues as to how this could be achieved.

Tiwi Health Mission, 2007

Our life is precious, our dreaming and culture important, our country beautiful. The workers of Tiwi Health strive to provide a high standard of care by using a culturally appropriate and holistic approach to community well-being.

To make this happen we all need to “Yoyi” (dance) to the same goals.

Aim and Objectives

Research Aim

The aim of the research was to work with and learn from the Tiwi people, of what is meant by community control or self-governance and how community control can be developed by the THAC. This aim arose from the early discussions with both the THAC and the Remote Health management. As previously described, the intent was always for the THAC to return to community control (the what) by the end of 2007.

Research Objectives

The initial two meetings with the THAC, and then with the DHCS Remote Health management and the Chair of the Tiwi Land Council, from July to September 2006 (refer Table 6) explored what the THAC wished to achieve in relation to community control. Five research objectives were identified as a result of these meetings:

1. What is community control for the THAC?
2. How is community control to be implemented by the THAC?
3. What is the pathway, the key building blocks for community control?
4. What are the key implementation issues and risks for the Tiwi people? and
5. Is there a common framework for community control?

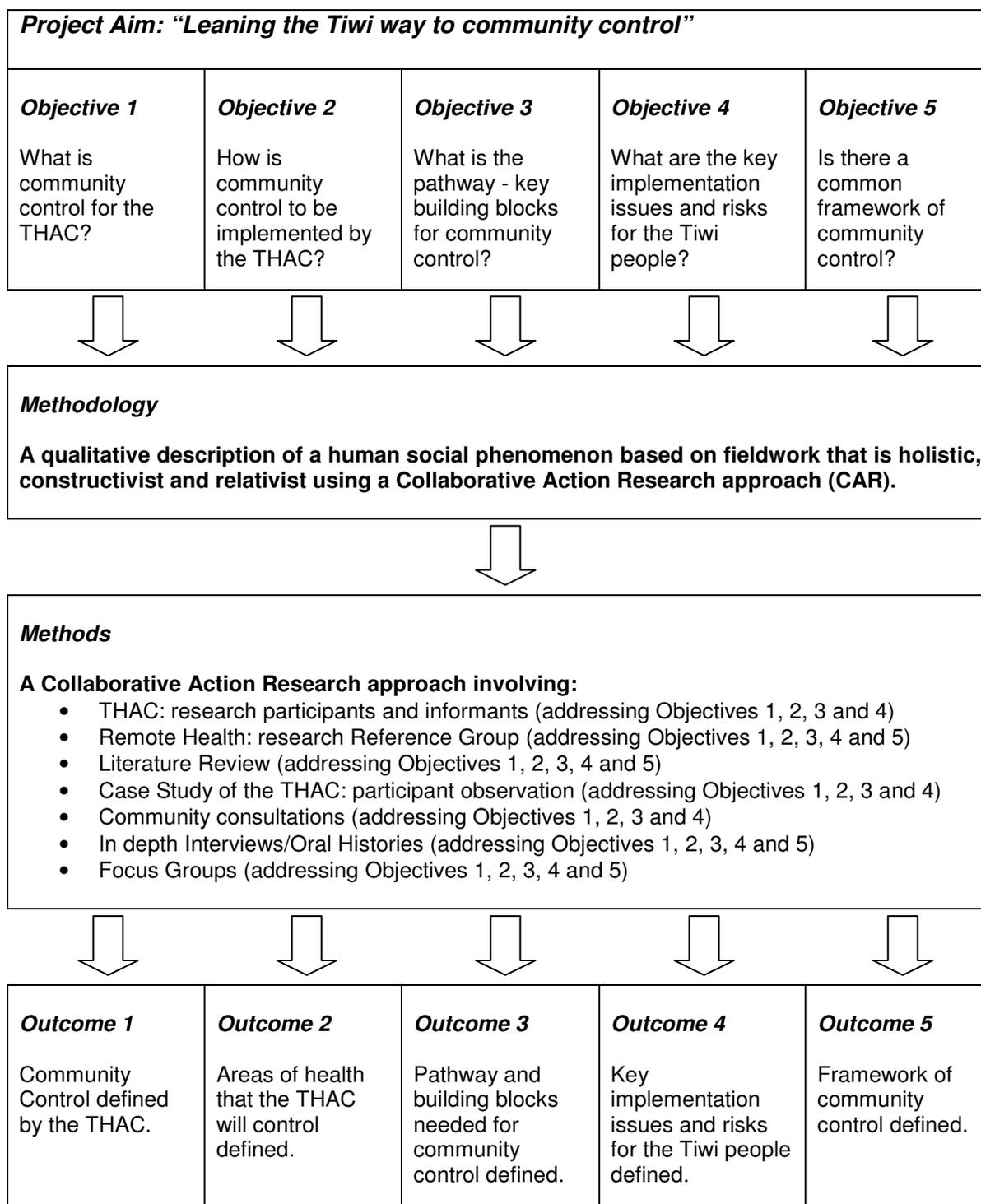
Through the identification and implementation of the key community control processes, issues and risks, it was anticipated that this would also assist in improving the health outcomes for the Tiwi people. This research also planned to identify a framework for community control and the key capacity issues that may then be applied to other ACCHS to assist with long-term sustainable implementation and risk management. Figure 1, the Project Design was developed after the initial three meetings to integrate the various stages and components of the research: the aim; objectives; methodology and methods; and outcomes; to assist the THAC understand what was being asked of them in the various stages of the research. I developed a detailed Project Plan and Timeframe (refer Appendix E) to guide the project through the various research phases and activities and these were used for the Research Proposal and ethics approval processes.

Methodology

Collaborative Action Research (Checkland, 1999, p 146, Baskerville, 1999, Kayrooz and Trevitt, 2005, p301) was the research methodology, an approach that was both summative, identified the THAC's understanding, issues and problems related to community control; and formative, established processes to improve the effectiveness of community control while still under

development.

Figure 1: Project Design



The Collaborative Action Research (CAR) methodology was supported by the NHMRC (2003a, p 21, 2005), Winter and Munn-Giddings (2001) and Labonte *et al.*, (2005) as being

appropriate to undertake research with Indigenous people. A qualitative methodology underpins CAR, due to the causal and holistic relationships that influence how an organisation or community operates (Kayrooz and Trevitt, 2005, p 342) or actually exists; “systems reality” as termed by Pawson (2006). I viewed the CAR approach as providing the THAC with ownership of the research with clearly described steps for them to achieving community control. Also identified with the THAC were the capacity building required and risks to be managed so to avoid, “... *being set up to fail, again*”. The CAR processes were also compatible with the core anthropological approaches of identifying and understanding key issues and concerns (summative) of the THAC and the development and implementation of interventions to improve the health outcomes (formative) within this emancipatory framework (Castro and Singer, 2004), including organisational structures and processes relevant and cogent with the local Tiwi people and culture.

Kayrooz and Trevitt (2005, p 296) identified the iterative nature of CAR where data is collected, analysed and integrated through each step of the research cycle:

- Step 1: plan, develop an appropriate approach or solution to the agreed problem;
- Step 2: act, implement planned and agreed solutions;
- Step 3: observe, identify what worked and what didn't;
- Step 4: reflect, immersed in the context; and
- Step 1: plan, back to beginning phase.

Collaborative Action Research is by its very nature, dynamic and requires a flexible approach. My role was to facilitate the CAR steps whilst clarifying the research aim, objectives and research questions with the THAC and the Reference Group members. It was proposed that the CAR cycle would be used for each key research objective or question with the development of a living, “work-in-progress”. This “living knowledge” that emerged throughout the research steps would have meaning and relevance for the Tiwi people as their problems, actions, beliefs and responses to the community control or self-determination outcomes were documented and implemented.

I used participant observation and group discussion as the dominant forms of data collection. I undertook extensive and detailed notes of my time spent in the THAC meetings and other community meetings that I was invited to; listening to the stories of their daily lives and priorities, their culture related to their health outcomes and recording their responses to the THAC agenda items, the issues raised and the decision making processes. I also made notes of their stories and responses in their own words, as far as possible. I had to ask for translation into English when conversations were held in Tiwi. I also tried to seek an understanding of the THAC member's motivations and actions and how these impacted directly and indirectly on their lives and their health.

The THAC notes were analysed after each meeting. The data analysis involved the development of a “... *sense of argument*”, (Holliday, 2007, p 90) including (refer Appendix H: Data Collection Template and Example):

- examining and reflecting on the observations, interactions and “voices” and identifying what was important or significant for the THAC members;

- progressive coding and cross referencing of the observations and responses;
- the creation of a number of key themes from the observations and responses; and
- themes confirmed with the THAC members and cross referenced with interviews, and new literature and reference material.

It was also proposed that the research findings would be disseminated concurrently as documented in the Research Agreement, throughout the CAR process and integrated into the THAC ways of working and future plans for community control. Capacity building through skill transfer to members of the THAC was to be encouraged both formally and informally over the time of the research. Intellectual Property rights and the ownership of specific research products were discussed and developed with the THAC. Three types of knowledge for ownership and dissemination were developed throughout the research: solely by the Tiwi people; jointly by the Tiwi people and the researcher; and solely by the researcher.

The process of analysing the meeting notes over the two years of the data collection, reflecting on the THAC action or lack of action between meetings, the coding and cross referencing of the longitudinal observations and responses, became the major form of data analysis. This two year timeframe enabled the key themes to emerge and be examined, allowed the key issues and themes to be revisited and the accessing of new literature and reference material as they were published. Interviews were held with members of the Reference Group, individually or as a group to explore and clarify emerging issues and themes. The planned community consultations and focus groups did not eventuate due to the changing approach described following (Revised Research Approach and Methods).

My contribution to this research is based on over three decades as a nurse and health administrator, with the past five years at director level within the Northern Territory (NT) Department of Health and Families (DHF). My awareness of the significant health and social welfare issues confronting Indigenous people came from working initially with a large urban population in Blacktown and Mount Druitt, western Sydney in the early 1990s, where I was confronted with the realities of working with Aboriginal people to improve their outcomes and address their social determinants of health. I was also employed from the late 1990s for five years by an international consulting agency that undertook projects for Commonwealth, State and Territory Governments that included health policy evaluations in rural and remote Australia. These experiences and current employment have provided me with a privileged entry to working with the members of the THAC, staff of Tiwi Health and colleagues in the Remote Health Branch of the DHF. In this research, my role included that of participant-observer, role model, mentor, educator and facilitator; by no means an “innocent bystander”. There was also the potential for significant conflict between my research and employment role and one that I needed to be careful in maintaining separate. The analysis of findings and development of conclusions were based on “objective” criteria drawn from the literature and the specific methodologies incorporated into the research.

Revised Research Approach and Methods

The research commenced with the assumption that the CAR approach and the linked iterative phases within the CAR cycle of; plan, act, observe and reflection would best suit researching with the THAC. Engaging with the THAC to understand and develop strategies that would improve the health of their people was fundamental to the community control

rhetoric and the values espoused in researching with Indigenous people (National Health and Medical Research Council, 2005 pp 8 - 14). I also used the concept of "*collaboration*" in relation to the action research methodology, to reflect the values of community control and community engagement of equal contribution, rather than participation. The level of engagement achieved through participation, from passive through to active, has been questioned and debated not only in the research literature but also by Indigenous people themselves. After the initial months of engagement with the THAC to assist the move toward community control as described in the Findings, the research data identified the lack of engagement by the THAC on a number of levels, as well as the lack of action taken by the THAC as part of the CAR cycle. The THAC were actively involved in the planning, observing and reflecting phases of the CAR cycle but lacked the motivation and/or capacity to undertake and participate in the action phase.

Through my own observations and data collection, the analysis of the themes, reflections and debriefing with the staff of the THS and Remote Health, the research moved to gaining a greater understanding of why collaboration was so difficult for the THAC and why achieving the agreed actions from the THAC was so illusive. The shift to an anthropological and organisational analysis approach evolved and occurred seamlessly as I observed, listened and documented the meetings of the THAC; agenda items, who attended meetings and reasons for non-attendance, who was involved in the discussions and decision making, the actions emerging from the meetings, and the activity or lack of action outside the meetings. Understanding what "lay beneath", overtook the CAR approach and became the dominant research method.

A blended anthropological and organisational analysis approach thus became the foundation of the research method; one that combined the detailed understanding of the key motivations of the THAC members with the opportunity for self-determination (emancipation). This methodology is not incompatible with CAR. Anthropology and organisational analysis also provided a means for understanding the structure, patterns and processes of the THAC meetings and gaining a greater understanding and sensitivity to relationships and behaviours of the THAC members. Understanding the internal issues of culture, leadership, initiation, mentoring, capacity building, alliance building and dispute resolution, along with organisation and systems functionality, sustainability and resilience, all became dominant themes for the research in the context of Indigenous community control and self-determination. The structure and patterns of the internal and external relationships also became important and core themes for the research: understanding the issues of engagement and collaboration; support and capacity building; partnerships and governmentality; sustainability; and systems functionality.

Anthropology (Rosman and Rubel, 2004, pp 14 - 25) offered a great understanding of the culture of people: their behaviours, beliefs and ideas; how families, groups and organisations are structured and how they are linked to the community functions of politics, economics, art, ceremony and other activities; the meanings and patterns of their social relationships with the Traditional Owners and Elders and the relationships with women and youth. Additionally anthropology assisted with the appreciation and observance of cultural norms, laws and rules and the changes that are constantly occurring within the culture; as well as the contradictions that emerged due to this change and the integration or lack thereof due to this lasting artefact.

This research emphasised the cultural and social anthropological aspects, the motivation and

behaviours of the THAC members over time and place (Silverman, 1992). The research approach emerged into an understanding of the unique motivations and behaviours of the THAC that are the essence of postmodernism anthropology: research that avoids the traditional positivism approach and the offering of generalisations (*ibid*, pp 21- 23). Cultural and social anthropology exists within a post-modern epistemology to seek an understanding of the power relations or inequalities that exist within groups or processes that coexist contemporaneously (coeval), and that are inherited from colonised or subjugated relationships (Meyers, 2005).

A crucial ingredient of this craft [cultural anthropology] is the ability of grasping a coeval experience with others, (Meyers, 2005).

Understanding this “coeval” experience (understanding and ways of improving outcomes through emancipatory action) of the groups in the research method and the inherent values, are core to this approach. Again, the power differentials between the THAC and governments and the internal and external stakeholders became a dominant theme in the research.

Grace and Chenhall (2006, p 390) support this anthropological approach when researching with remote Aboriginal communities and advise using interviews and groups discussions with the major/dominant community groups, such as the THAC. These groups, state Grace and Chenhall (*ibid*); “... are elected to represent and act in the interests of the local community and therefore knowledgeable about the “community’s” problems and likely to have good ideas about how to address them”. Interviewing established and representative groups, who can also identify others to assist with the research provides the method for, “... rapid, exploratory studies”, (Grace and Chenhall, *ibid*) essential when given limited time and dealing with the sensitivities required when entering remote Aboriginal communities. The major limitation of this type of research method, argue Grace and Chenhall (*ibid*) is lack of representativeness.

Organisational analysis was used to complement this anthropological approach, as the THAC has been established within a western administrative paradigm. Steyaert and Bouwen (cited in Cassell and Symon, 2004, p 141) developed a research methodology that analyses groups in their “natural” context; such as work groups, teams, committees or communities. Using this natural work setting, the authors proposed an exploration of the group through group observation and response to a specific set of questions: in this context the THAC, and what is community control and how do they wish to implement community control?

Organisational analysis is presented as a social constructionist approach (*ibid*, p 143), one that facilitates both data generation and data-processing. The interviews and group discussions, resulting from the THAC meetings provided the opportunity to hear different accounts or voices at the “same” time on the “same” phenomenon or problem. The THAC were asked to tell their stories concerning the problems concerning community control. Each story was aligned to or expanded the story of another THAC member, or contrasted with a previous story. The aim of this organisational analysis, Steyaert and Bouwen argue (*ibid*, p 141), “... is to catch in a condensed way the range of different voices”. There are also organisational standards and processes associated with western administrative systems. These were examined in relations to agenda setting, committee function and action and committee outcomes.

The data collection template (Appendix H) identifies the difference stories that emerged from

the THAC meetings over the 24 months of the research, capturing the range of voices and motivations for the THAC members. Some stories related specifically to the THAC and meeting agenda, other stories related to Tiwi culture, Tiwi health needs and issues and, others the impact of the Australian Government Intervention in the NT. The analysis of the stories identified a core set of themes that emerged consistently over the months of the THAC exploration and observation. The core themes were compared and contrasted with those that resulted from the anthropological analysis. “... *the natural mix of differences ... [is] 'caught' with the evolution of ... different voices as they develop and emerge in a living social context, expressing the construction and deconstruction of shared meaning (ibid, p 141).*”

The key research informants remained the members of the THAC; that included nine males of whom, seven were senior community representatives and four traditional owners, and four women, two of which included staff from the Tiwi Health Service (Table 5). The THAC meetings were the major source of data with 14 meetings/field trips occurring over a two year period (Table 6). THAC meetings usually lasted from two to three hours and were held in each of the three major Tiwi communities; Nguiu, Milikapiti and Pirlangimpi. Members of the Tiwi Land Council were frequently invited to the THAC to provide relevant history, viewpoints and data for the research. Meetings were also at times held in Darwin to meet with the DHF, Remote Health management staff.

Table 5: Key Research Informants

Key Informant	Gender	Age and Comments
No. 1	Female	40, senior woman from Milikapiti
No. 2	Male	50+, senior man and traditional owner from Pirlangimpi
No. 3	Male	50+, senior man from Nguiu
No. 4	Male	30+, senior man from Nguiu
No. 5	Male	50+, senior man and traditional owner from an outstation
No. 6	Male	50+, senior man from Nguiu
No. 7	Male	60+, senior man and traditional owner from Nguiu,
No. 8	Male	50+, senior man and traditional owner from Nguiu
No. 9	Male	30+, male from Nguiu
No. 10	Male	30+, male from Nguiu
No. 11	Female	40+, female from Nguiu
No. 12	Female	50+, Manager, Tiwi Health Service
No. 13	Female	50+, Administrative Officer, Tiwi Health Service, resident of Nguiu

The research shifted from the proposed action research to a rapid anthropological and organisational analysis of the motivations of the THAC and Tiwi peoples move towards self-determination and community control, due to the changing and dynamic context in which the research was being undertaken and the subsequent impact on the members of the THAC (as described in Chapter 1: The Australian Government Intervention: A Unique Research Context). The requirement to change the research approach and methods reflected the need to be consistently aware of the impact of the research on the THAC members and the need for a flexible research design and plan. I was confident that the analysis of the motivations of the THAC would still assist with the move towards community control of their health service.

Table 6: THAC Meetings

Meeting dates	Location and Comments
17 July 2006	Nguiu, initial meeting and presentation of the research concept
22 August 2006	Nguiu, discussion of the research questions
15 September 2006	Darwin, meeting with 2 members of the THAC, Chair of the Tiwi Land Council, Director of Remote Health and Manager of Tiwi Health Service
	Time taken from the initial submitting research ethics approval, to the granting of the ethics approval (seven months).
23 April 2007	Milikapiti, first meeting after ethics approval granted
4 June 2007	Nguiu, discussion of what a new health board would look like
5 July 2007	Nguiu, community meeting with discussions about the Australian Government Intervention (AGI)
13 August 2007	Milikapiti, discussions of the impact of the AGI
25 October 2007	Milikapiti, discussions included members of the Tiwi Land Council and the re-establishment of the THB
2 November 2007	Darwin, meeting with 2 members of the THAC, Director of Remote Health and Manager of Tiwi Health Service
15 November 2007	Darwin, meeting with Director of Remote Health and Top End Manager, Remote Health
11 December 2007	Nguiu, meeting of THAC with Director, Menzies School of Health Research
15 February 2008	Nguiu, presentation and discussion of the key themes and findings, and where the traditional owners approved use of the "Kurlama" for presentation of the conceptual framework
9 April 2008	Darwin, meeting of the Chair of the THAC, Director of Remote Health and Manager of Tiwi Health Service, to develop political support
12 June 2008	Nguiu, meeting about making the future THB work

Response to the Research Initiation

The initial findings and response to the research initiation (Chapter 5) identified a number of major areas of concerns and potential risks for the research, with a number of areas coming

into conflict with the principles and values espoused by the National Health and Medical Research Council (2005). The risks and challenges that emerged and resulted from researching with the THAC were evident from the initiation of the project and included:

- Participation: the THAC comprised up to 15 members, representing each community and some outstations, gender and Tiwi youth, but rarely did more than five or six members regularly attend. The most frequent attendees were the Traditional Owners or Elders, three who were THS employees at times over the project. If meetings were held in Nguiu, attendance was higher; if held at Pirlangimpi or Milikapiti members had to be flown in to attend. The dates and times of THAC meetings frequently conflicted with other meetings: for example TLC, with members having concurrent representation on all the committees. Illness and ceremony also prevented regular attendance. The level of participation and reasons were explored and analysed more fully in the Findings.
- Oral tradition: whilst aware of the dominance of oral traditions in communication in Indigenous communities and organisations, I was not aware of the impact that this would have on the research. I produced for the THAC as part of the project's ethics application a Research Agreement (Appendix D), Information Sheet (Appendix F), and Consent Form (Appendix G); and for later project stages; standard letter to politicians and government agencies (Appendix I); project officer Job Description (Appendix J) and project officer Expression of Interest (Appendix K). These I presented at the THAC meetings, but rarely were they read or feedback offered or referred to at later times by THAC members. Frequently prepared papers or documents were left on the meeting room table at the end of meetings. Minutes of meeting were recorded by a staff member from the THS. These were circulated at the meeting as most THAC members do not have access to email. Most communication between THAC members occurred using discussion and debate with little reference to documents or papers produced specifically for the THAC.
- Timeframes: the timeframes for meetings and actions to address the THAC concerns remained totally in the THAC member's hands. Both the THS manager and I were aware that community control relied on the THAC making decisions and having the time to address their issues; including full and considered community consultations. For the most part, the THAC meetings were postponed or delayed, or started late due to relying on the timeframes of the Tiwi people. This became a major risk for the THS and the research and influenced the need to change the research methodology.
- Oligarchy: the leadership and decision making relied solely on the Traditional Owners and community elders who dominated the membership of the THAC. The THAC members represented and advocated for their own communities or outstations and frequently submerged themselves in the day-to-day needs of their family or community's health needs rather than strategically considering the health needs of the Tiwi population as a whole. This leadership style highlighted the dominance of meetings and community action by a few senior men, the conflicting agendas and the ambiguity around what the THAC wanted to achieve.

As a consequence of the initial meetings and engagement with the THAC, I commenced a journal to document my insights, feelings and concerns and to try to understand the motivations and behaviours of the members of the THAC. As previously stated, even the monthly meetings were difficult to plan and coordinate and at times postponed with many of the THAC members not attending.

Allowing the research process to “unfold” under the influence and pace of the THAC and respecting the philosophy of self-determination, highlighted for me, not only their areas of concern related to health policy and service delivery, but also the issues of community representation and participation. As a consequence I shifted the focus from the CAR to an anthropological and organisational analysis approach that to some extent changed the nature of the research questions. I identified a number of key issues as part of this shift in approach and to guide the refinement of the research questions. I found that the key issues could be grouped into two major areas for my consideration and analysis: the social and political context, in which the research was being undertaken, and the meaning of and future directions for community control for the THAC.

Social and political context for the Tiwi people

I quickly became aware of a strong Tiwi culture combined with traditional knowledge (ceremony and initiation, dispute resolution, and debt and obligation) but with a preparedness to be flexible and adapt their culture and behaviours to address the many present-day issues that arose. The complexity, burden and extent of the local health and welfare issues faced by the Tiwi people as well as the members of the THAC impacted on attendance and participation in meetings.

The conflicting political agendas between community control, self-determination and self-management verses assimilation, mainstreaming and mutual obligation were also frequently raised by the THAC members. This conflict was highlighted at meetings that discussed the future of the Tiwi Land Council with the introduction of shires throughout the NT, changes to the land ownership, and the proposed removal of land permits and CDEP. I also found it extremely challenging, the expectation that Tiwi people could contribute to the community control of their health services and participate in meetings and community consultations despite lack of basic resources: the lack of access to public or private transport between the Tiwi communities; and the lack of remuneration for participating in key decision making committees, resources that I took for granted.

Meaning and the future directions for community control

The funding agreements with the Commonwealth and the NT government conditional on the achievement of prescribed outcomes became ongoing issue, and again made me question; “... *what does this say about community control?*” and why the lack of trust with key stakeholders external to Tiwi, specifically the DHCS and AMSANT. I became aware of the significant ambivalence that existed within the members of the THAC around wanting to move towards community control of their health services and not wanting to be, “... *set up to fail*”. The issue of shame remained a dominant issue and motivator for the THAC over the period of the research. I also found ambiguity around the extent of the proposed, “accountability and ownership” for the health and welfare of the Tiwi people under community control, and the degree of governance, service provision and/or support and administrative functions. I would find myself frequently asking, “... *would a non-Indigenous population/community be expected to take full accountability and ownership for the health of their own community, to the extent expected of Indigenous communities?*” I also found that the THAC members had the awareness and capacity to move towards community control, mixed with great variation in the level of commitment and participation by members of the THAC. I would often ask myself, “... *what’s stopping them?*”

As the researcher, I also had to start with myself and understand the nature of my connection with the THAC: a white middle-aged male and health bureaucrat, working with a group of

Tiwi people. Initially I was cautious not to “... *make a wrong move*”, not to embarrass myself or create a hostile response, be “politically incorrect”, though these did come. I also had to reflect on the appropriateness of the research: the project plan and timeframe, the research approach and methods, even though these had been outlined the Research Agreement. Whilst I did not ignore the Research Agreement, I had to put it aside.

I was readily welcomed to undertake the project, as this met the THAC aspirations and aim to regain community control of their health service, since the demise of the THB in September 2003. In the initial meetings, whilst listening and providing support, I waited to allow their motivation to emerge and desire to build. Many of these early meetings were purely observational and I documented many instances of traditional knowledge and stories: the importance of culture (dancing and painting and impact on health, and of sorry business), the impact of alcohol on the health of the community and the level of community dysfunction. Many issues were raised that impacted on their daily lives and these took precedence over the research project and questions. In these early stages, I discussed mainly the underpinning assumptions for community control and sought a response to, “... *what is community control for the Tiwi people and how do they want to implement community control?*” I was asked to attend the Tiwi Land Council meeting that included over 50 Tiwi people, by the THAC Chairperson to present the project and what was required of the Tiwi people. The THAC Chairperson publicly supported the project but openly challenged the commitment by the DHCS and my proposed timetable for moving towards community control.

I took the notes of meetings related to the project and documented the outcomes. These I distributed to the Director of Remote Health, the THS staff and the THAC. It was not until six months into the project that I raised with the THAC the concept of the community control “*enabling framework*” that had been developed and advanced by the NTAHF. Thus, the CAR process was modified to accommodate the THAC issues, whilst developing levels of awareness of what community control required and the involvement of the THAC members. I had to wait for the “right time” for the THAC to want to commence the community consultations and in-depth questions. I also questioned who is best to undertake these processes?

A number of limitations are identified as part of the research methodology and project initiation. As previously described, the THAC were the major informants and thus provided limited representation of the Tiwi people and community. Most members of the THAC were elders and dominant males in the community, with little representation from youth, women and people from outstations or homelands. The research, due to limitations on time (monthly visits over 24 months) and the inherent sensitivities of researching with Indigenous people relied on a rapid assessment methodology working with a small, but influential and accessible pool of Tiwi people to provide data and information. The data was rich and plentiful and came from many sources; observations, interviews, group discussions, community visits, meetings with senior health bureaucrats and information sourced from newspapers, reports, local projects and initiatives but specific to the Tiwi communities and time in which the data was collected. The members of the THAC were aware of my role as a senior health professional in the Department of Health and Families. This could have been a limitation that prevented the THAC members from disclosing issues and sensitive information. I did not find this to be the case, as concerns and issues were readily discussed. I was aware for the potential for either under disclosure or for me to be used for political purposes in my role in the Department of Health and Families.

Summary and Conclusion

Establishing the original project plan required that I address a predetermined sequence of research processes: the project initiation; determining mutually agreed aims and objectives linked to the research methods and activities; developing the project plan; undertaking and refining the literature review; undertaking the data collection and analysis; identifying key themes and concepts; and finally documenting findings and conclusion. The project plan also identified a number of potential risks that could impact on the research being undertaken and completed successfully. As a first step to undertaking this project, I explored fully the issues and processes of researching with Indigenous people, in an effort to engage effectively with the Tiwi people and avoid the traps, frequently described with working with people from a different culture. What could not be foreseen were the demands that already existed on members of the THAC, nor the confusion nor burden that resulted from the NTER.

Unable to commence the CAR as planned, I shifted the methodology to a rapid anthropological and organisational analysis approach. This involved me going back to the data source, the members of the THAC, observing, listening and finding alternative sources to collaborate my findings. The research process unfolded as I continued to attend the THAC meetings and explore the meaning of community control and how they wished to implement community control. I also attend a number of community meetings where the interventions from the NTER were discussed and debated.

On reflection, the dominant issue from the early phases of the research, was that the project is the, *“Tiwi’s journey, not mine”!* Whilst, willing to be an active traveller, I had to be willing to subjugate my aim and objectives to those of the Tiwi people, if my research was to be not only ethical, but also honest. The major themes from observing and listening to the members of the THAC, and those that emerged from the data analysis assisted with this understanding. As a participant observer, I became aware of the underpinning themes for the THAC related to community control, the impact and contribution of:

- Tiwi traditional and contemporary culture;
- Tiwi and Indigenous governance;
- Tiwi leadership;
- community capacity building and mentoring;
- governments and external stakeholders; and
- the “enabling framework” or pathway to community control.

These emergent themes are explored fully in Chapter Four: Research Findings.

Chapter Four: Research Findings

"Kurlama" (also spelt kulama) or yam ceremony is a traditional ceremony that is performed at the end of the wet season when a certain kind of yam is harvested, cooked in a specially made earth oven, indicated by sticks placed around it and eaten by the men. Particular songs, accompanied by tapping sticks are sung by both men and women at this ceremony. At each interval there is wailing as people think about the past and relatives who have passed away.

(Tiwi Traditional knowledge, ww.ozoutback.com.au/ accessed 23 February 2008)

"Kurlama is everything ... coming together ... the land, people and animals"

(Personal Communication, Tiwi Health Advisory Committee, member 15 February 2008)

Introduction

Kurlama is a central belief system used throughout Tiwi culture and is incorporated into daily life, ceremony, dance and painting. Large concentric circles appear as the main element in contemporary paintings, representing the *Kurlama* circle or ceremonial dancing ground. The *Kurlama* is depicted in many forms throughout the Tiwi culture and even adapted into western religion. Paintings of the *Kurlama* are found throughout the Tiwi communities, in outdoor public spaces and buildings and in the Catholic Church in Nguiu, as part of the altar, sanctuary and font. Local artists also print the *Kurlama* onto fabric for clothing and bags. As part of the Tiwi belief system, when a gold ring forms around the moon during the final stages of the wet season (March to April), the Moon-man (*Tapara*) performs *Kurlama*, the annual yam ceremony. *Kurlama* is the annual celebration of life where the Tiwi people reflect and contemplate on their achievements and difficulties, their relationships in families and communities, as well as those who have, "... *past on*" or died over the previous 12 months. The ceremony is a time for the resolution of conflict and worry, a time for making a declaration and commitment to identifying ways to improve their relationships, to make better the outcomes for their people and to a better life, over the next year. The song and dance performances express the wishes and desires of the participants for a healthy and prosperous future. *Kurlama* represents abundance and it is the time when Tiwi names are given to babies.

The "*Kurlama*" has been used with the permission of the Tiwi traditional owners to represent the research findings and provide the conceptual framework that integrates what community control means for the THAC (Figure 2). The *Kurlama* or conceptual framework integrates the key research themes associated with the "centrality" of community control or self-determination for the THAC members, the inner concentric circle. Surrounding this inner circle are the key themes or elements of: culture and governance; Indigenous or Tiwi governance; leadership and capacity building. In the outer concentric circle are the surrounding community control themes associated with the development of stakeholder partnerships, in particular with governments and their processes in achieving community control and finally, the underpinning mechanism, the "enabling framework". Though

identified as separate entities, the key themes or underlying elements of community control are not discrete but interconnected each impacting on the other and together presented as an “integrated oneness”. Each key theme and associated findings will be explored individually using this conceptual framework, the *Kurlama*.

Figure 2: THAC Community Control Conceptual Framework and Key Themes



Reflection as a cultural expression has a deep psychological impact on the Tiwi people. Members of the THAC indicated that many forms of cultural expression, including some aspects of the *Kurlama* ceremony have disappeared or diminished with the introduction of alcohol and drugs, where today few ceremonies are enacted and maintained. This chapter documents the research findings resulting from the data collection and analysis and emergence of the six major themes. Specific research findings are documented within boxed sections with source, explanation and relevance provided.

Tiwi Culture and Governance

... people belong to the land, not the land to its people ...

(Ngarinyin Response to the Wik Decision, by The Kamali Council and its Chair, Paddy Neowarra, 1997, Indigenous Law Bulletin, <http://www.austlii.edu.au/au/journals/ILB/1997/33.html>, accessed 17 July 2008)

Mick's (Dow Dow) use of the English legal terms in trying to explain things to her was an interesting way of translating Arrernte concepts into the English words he thought would be more meaning for Olive Pink. In today's more bureaucratic world it is perhaps appropriate that the words most commonly used among English-speakers to describe the Arrernte responsibilities to maintaining the places of the sacred landscape have changed to "owner" and "manager". Mick's own words in 1934 directly equated Arrernte Law to European law and its processes. In doing so, he kept intact the Aboriginal notion that the performance of ceremony is the real "work" of daily life, the work through which the eternal "Law" of the gods fashions the Law of the land in the world of the present. "Owner" and "manager", on the other hand, use the language of commerce rather than law and in doing so, they cover the real significance of the Arrernte Law.

(The Indomitable Olive Pink, Marcus, 2001, p113)

Introduction

The THAC spoke frequently of *Kurlama* and ceremony and the role that culture plays in their daily lives. Whether waiting for meetings to begin, or in meetings whilst describing an incident, or during breaks, the role of culture was described and used to explain their health concerns and how the Tiwi people addressed these issues. This was the "*real work*" (Marcus, *ibid*) of the members of the THAC in keeping their culture alive, many who are Tiwi Traditional Owners and Elders.

This section will present the findings of how contemporary Tiwi culture continues to influence the THAC and assists them to understand and make decisions related to community control and their governance systems.

The potential of non-Indigenous people to "*cover the real significance*", (Marcus, *ibid*) to conceal or ignore the real meaning of Indigenous "work" cannot be underestimated and lies at the heart of what is meant by Culture and Tiwi Governance. The arguments of hegemony and the colonisation of Indigenous belief systems by a dominant culture cannot be ignored and must be acknowledged when considering Tiwi governance.

Contemporary Tiwi Culture

I found that Tiwi culture as described by Hart *et al.*, (1988) can still be seen readily in the daily lives of the people of the Bathurst and Melville Islands and is actively reported by the members of the THAC. The influence of *Kurlama* as an integrating force that moderates the spiritual, physical, emotional and social lives of the Tiwi people and that dominates their

world has been referred in the Introduction of this chapter and is used as the conceptual framework for presenting the research findings. As previously described by Goodale (ibid, pp 143 - 144), continuity and change were the two leading features of contemporary Tiwi culture; many expressions of traditional culture remain but within the context of change and the impact of western culture and structures.

During my time spent with the THAC, I found that “*Pukimani*” is a term now mostly solely used to indicate a funeral with the associated *Pukimani* (funeral) poles. Visiting the Tiwi art centres today, you can see *Pukimani* poles being carved and decorated for the local tourist trade and for art galleries and museums throughout the world, besides being erected around the graves of the deceased. But today, funerals dominate the lives of the Tiwi people due to the high rates of disease. Obligations to family and bands still dictate attendance at funerals that results in the closure of all community organisations on the days of the funeral. People travel to the major Tiwi communities using what ever means of transport is available, even planes are chartered to enable people to attend to, “... *sorry business*” or funerals.

I also found that key to understanding the impact of culture was in the translation of the word “*Tiwi*” that means, “... *we*” or “... *us*”. The Chair of the THAC explained the meaning of *Tiwi*, as “... *we, the only people*”, and that in the world of the Tiwi there were no others, only “... *us*”.

Impact of Tiwi Culture on Governance

The impact of Tiwi culture, ceremonies and rituals cannot be underestimated even in 2009. I have provided in the introduction to this section examples of how both *Kurlama* and *Pukimani* continued to impact on how the Tiwi people viewed their community, organisational structures and processes and how these continued to act as a force for reflection, change and the continuance of obligation to family and clan in relation to ceremony. I found that whilst not “dictating” the lives of the Tiwi people, as traditional culture and taboos had in the past, cultural artefacts remained an important touchstone for elders to base alliances and for decision making. The members of the THAC also reinforced that their culture was not static and was ever changing reflecting the impact of western culture and especially that of the western health and medical culture.

Cyril, Matthew and Marius (traditional owners) commenced a discussion whilst waiting for other members of the THAC to arrive.

Traditional owners in bands, skin groups or clans hunted and lived together. In the past, ceremonies were many more, sacred and sincere. When someone passed away (for example) in 1972 we would mourn for six months. We'd mourn in traditional clothing (as evidenced in a photograph in the health centre meeting room where the THAC was being held). We'd sing and dance each morning. We'd stay at home and feed those that are mourning. Then there'd be a final ceremony. Before the grog came. There are hardly any [ceremonies] today. We don't practise the culture. Today, the processes of mourning aren't there. As soon as we bury, that's it. The day after ... just finished. Alcohol has broken it [ceremony] down.

Many influences [on our culture] lots of things, culture not so strong, western culture – not good or bad, things move on, we adjust, we understand. Language has changed.

THAC, 23 April 2007

This passage reflected the deep appreciation, knowledge and understanding of their culture and the role that ceremony played in sustaining the Tiwi people, by members of the THAC. The example cited of a traditional Tiwi funeral going on for up to six months, the mourning and daily singing and dancing, the obligation to the mourners, and the final ceremony highlighted the role that culture played in the lives of the Tiwi people.

This passage also reflected a grieving for the past and the impact of western culture and alcohol and drugs on the continuance of ceremony. There was ambivalence in the statement: traditional culture mixed with the changes of new culture – *not good or bad, things moving on, we adjust, we understand.*

The THAC members argued that they had a considered and broad Tiwi, “world-view”; that they had a strong and flexible Tiwi culture, one that contained the answers and some of the resources necessary to address any issue that arose. Using these sentiments as the starting point, I found that the THAC could identify their aspirations and move forward to achieve their potential.

The group spoke of their desire to identify young Tiwi people to be their future leaders and so to mentor into key governance roles.

A “core” group [of elders or traditional owners] who are experienced and who can guide the younger people. To draw in, to sit with the older men, encourage more. There is a place for ceremony – younger men, feel out of place, but at ceremony, a young man can be recognised as an elder, we sing them, but mainly who the father is, if father elder, expectation to be leader.

We need incentives, to help the young people, to think more about being part of the Advisory Committee, contributing to the whole community, involved in programs.

THAC, 23 April 2007

This statement of culture and governance reflected the process of initiation of the young men, guiding them through the stages, imparting knowledge, developing alliances and strengthening the community. I found that the THAC still wanted to engage with the younger men and women, and support their transition (mentoring, “... *singing them*”) into senior roles, as had occurred in the years of traditional initiation, over some ten to 12 years. It was also evident that the THAC women members also wanted to identify young females to mentor into senior health leadership roles. Through these discussions, I established that incentives could be used to entice and retain youth in mentoring roles, but needed further investigation.

The THAC gave examples of Tiwi people “painting up” to keep sickness away.

Ochre is applied to the body, if the person is feeling unwell. They then rest. The next day they are okay and well.

THAC, 25 October 2007

I found that the concept of PHC was still compatible with the Tiwi contemporary understanding of health and wellbeing. Illness prevention was part of the Tiwi vision and meaning of health; "... *Our life is precious, our dreaming and culture important, our country beautiful*" (Tiwi Health Service, 2007). I found that this broader understanding of health included all aspects of life and was inclusive of dreaming, culture and country. The members of the THAC cited body painting, dancing and smoking ceremonies as actions used to prevent and ward off illness and diseases. Health promoting activities, including the "Tiwi for Life" program based on Tiwi culture and understanding has been used to develop health promotion and illness prevention capacity. Tiwi culture impacted on how the THAC viewed health and the avoidance of disease.

The THAC group response to the *Northern Territory, National Emergency Response Act 2007*, included discussion of the protection of sacred sites with the continuing access of Tiwi people to these public areas, the foreshore and sports areas for ceremony. The removal of Aboriginal Land Permits concerned the members, as this allowed free access of non-Tiwi people to Aboriginal land, "... *many unknown visitors on our land*".

THAC, 13 August 2007

I found that the proposed removal of the permit system created significant concern for the Tiwi people as it had the potential to reduce or remove any obligation or responsibility that Tiwi people might have to visitors (non-Indigenous people) in their communities. This interplay of culture, debt and obligation (*Pukimani*) within the Tiwi community, along with the changes imposed on the Tiwi people through Commonwealth legislation, was exceedingly challenging for the THAC members, as the forced legislation was viewed as "undermining" traditional knowledge, law and beliefs.

At the April 2008 THAC meeting, the members proposed a new name for the Tiwi Future Health Board, based on culturally appropriate title.

"Ngininawula" means "our", whereas Tiwi means "us", when culturally Tiwi was all they knew and understood. The name change is symbolic and represents moving into "our" health board, based on Aboriginal Community Control.

In the future, we'll be known as the Ngininawula Health Board.

THAC, 9 April 2008

"Ngininawula" is a declaration of community control, meaning "... our" health service. I found that achieving community control, again from aspiration to reality was being enacted. A dominant cultural theme, expressed throughout many THAC meetings, was waiting for the "right time, the right season", for change. The Tiwi world-view was that the culture provided the structure, adaptation and timeframes, just as the Tiwi people adjusted to the seasons.

I confirmed that the impact of culture on decision making was intertwined into the roles of the elders, men and women, family and community alliances and networks, debt and obligation and the mentoring of the young men and women into leadership roles. These aspects of Tiwi Governance will be explored and discussed in the following findings sections Leadership and Mentoring and Capacity Building.

Summary and Conclusion

Under the impact of hegemony and colonisation by western religious, political, governance and social systems the traditional Tiwi culture has undergone significant change and diminution over the past 100 years. Unfortunately, this diminution has not been replaced with culturally appropriate and sustainable Tiwi governance symbols, structures and processes. The damage and dysfunction resulting from introduced western culture, such as alcohol and drugs, gambling and associated violence were compounded with the move away from the “real” Indigenous “work”. Western culture and reduced traditional beliefs continue to impact negatively as evidenced in the poor social determinants of Tiwi people: poor education and health outcomes, poverty, unemployment, substandard and inadequate housing.

The impact of favour, debt and reciprocal obligation was also evident in the lives of Indigenous people, as described by Noel Pearson and when explaining the legacy of “demand sharing”:

I have come more and more to the view that discrete indigenous communities, whether they be on community held Aboriginal lands, on the fringes of country towns or in urban centres are by their very nature – thick with kinship and embedded relationships, obligations and traditions - ...” (Pearson, 2007)

Yet, I found that the THAC did not “uphold or to go back” to traditional ways, but rather argued for legitimacy of what has meaning for them. To progress this shift into the 21st century and achieve a future community controlled health Board while securing a future for Tiwi people, the THAC saw that there was a need for a blend of traditional and western culture. This included an acknowledgement of what the Tiwi people feel are important along with evidence-based western practice that provides for and improves the health and wellbeing of Indigenous people, in a sustainable and long-term way.

“Both ways” has been previously cited and is currently used by the Batchelor Institute of Indigenous Tertiary Education (2006) to develop a curriculum that contributes to appropriate concept of Indigenous knowledge and learning. “Two roads” has been described by the KWHB (2003, p 68), as symbolising the parallel journeys of Indigenous people, western organisations and the intersections between. “Both ways” and “Two roads” acknowledges the differences, but also how the two cultural systems can work together to produce innovative adaptation and solutions to the health inequalities between Indigenous and non-Indigenous Australians.

Tiwi Governance

Indigenous cultures are diverse, and Indigenous ways of meeting governance challenges may be equally diverse. This is not a problem. It's a solution.

Stephen Cornell, Co-Director, Harvard Project on American Indian Economic Development, (Reconciliation Australia, 2007a, p 41)

Introduction

The use of the term “Tiwi Governance” by the THAC members was an authoritative and unambiguous statement about what the Tiwi people wanted for the management of their health services: health services planned, designed, managed and provided by and for Tiwi people. This statement reinforced one that most non-Indigenous Australians take for granted: an individual’s right and responsibility for one’s health and wellbeing and also for one’s family and community through self-determination.

As with the previous finding, governance for the THAC is embedded within their culture and the way that the Tiwi people interact with their community and environment. The larger Tiwi communities are linked with outstations and there is also the interlay between the elders, families and clans, skin groups, gender and with the Tiwi youth. The key steps to achieving a Tiwi community control currently exist, but risks remain.

This research theme and finding examined what the members of the THAC mean by Tiwi governance, what the THAC required for their health services, how they saw their health services governed and finally the risks associated with achieving community control.

Defining Tiwi Governance

I found that the THAC members were not familiar with and did not use the term “community control” as a concept for their health service. The THAC spoke of leading and managing their own health services and having the knowledge and skills in particular, “... *to understand when the funds were inadequate or when as a group they were being misdirected*”. They spoke of their aspirations and goals to again have their own health Board and Tiwi governance, where they had once failed. The THAC members spoke of their shame to their people and also to the external stakeholders, as a consequence of the failure of the THB in 2003, but also their strong desire to change and adapt to the new circumstances and environment, and to achieve once again, their own health board, “... *on our terms*”. The members of the THAC stated that they did not see any benefit from blaming anyone for the failure of the THB.

In the context of my findings “Tiwi Governance” and community control are synonymous. The focus of community control within the ACCHS was predominantly on achieving self-determination and self-management outcomes, whereas the focus of the THAC was on addressing the huge gap between the aspiration and the reality, and the small steps necessary, to secure the future for their health services, they believe were needed. The THAC viewed Tiwi Governance as a continuous journey. They were aware of the steps

needed to achieve this small but significant goal, but also the risks.

I found that the THAC were aware of the steps needed to create the future health board, that included the development of organisational strategy and structures with the employment of a project officer to assist coordinate the development processes. Processes that were also identified included governance training (training that many members of the THAC have already achieved, but will require upgrading), and the community consultations needed to identify health needs and health plans. The THAC also wanted to ensure that the future health Board, "... runs well ...", that they had the business rules in place to support their board and staff, so as to avoid criticism, such as poor financial management and favouritism to particular individuals or families.

Governance is described by Reconciliation Australia (2007a) as assisting Aboriginal Community Controlled organisations to develop their health strategies and plans, business rules, training and capacity, team work, community involvement and participation and the ability to engage with external partners. Using the Reconciliation Australia's (2007) framework, I established that the governance of the THS required capacities in three major areas:

- Board leadership; through the development of leadership capacities in strategy, governance and management, and developing the health service vision, mission and strategic plans, business rules, powers, roles and responsibilities, and the monitoring and evaluation of performance;
- Service management; coordination of the agreed range of health and welfare services identified by the Tiwi people; and
- Organisational support; through the range of resource and administrative functions, human, technical, natural, infrastructure, capital and logistical.

The THAC members were explicit in that they required Tiwi people trained and prepared for all roles in the THS, acknowledging that this may take several years; for example, the need for Tiwi doctors and nurses to be prepared and employed. Discussions with the THAC included the possibility of Batchelor Institute of Indigenous Tertiary Education facilitating a Bachelor of Nursing program at Nguiu in coming years once the new secondary school at Pickertaramoor has Year 12 graduates, similar to that implemented at Tennant Creek, using a community development approach.

The concept of health for Tiwi people, already established by the THS in 2007, encompassed a holistic and integrated belief; "...*Our life is precious, our dreaming and culture important, our country beautiful*", (Tiwi Health Service, 2007). The concept of health as described by the THS reflected a respect for life that embraced the physical being but also the Indigene dreaming, culture and country. The current THS Mission statement (*ibid*, 2007) also described the approach to the provision of health services by health leaders, managers, administrative and support staff, Aboriginal Health Workers, doctors, and nurses and midwives; health services that are high quality and culturally appropriate, that are integrated and comprehensive and lead to community well-being. The THS Mission Statement (*ibid*, 2007) was also an acknowledgement of the WHO Declaration of Alma Alta (WHO, 1978) statement on PHC and the underpinning key principles that include: the access to equitable, appropriate and affordable health services based on community participation.

The THS Mission Statement was also about how services were governed and the relationship that the Tiwi people wished to develop with governments and key stakeholders in the Aboriginal Community Controlled Health sector. Tiwi Governance is about planning for health services, engaging with all Tiwi people, and using community's resources and ideas, to strengthen today's people and communities; ... *"To make this happen we all need to "Yoyi" (dance) to the same goals"*, (Tiwi Health Service, 2007). This process of engagement ("Yoyi") is a fundamental expression to the implementation of Tiwi governance.

"Tiwi For Life": an example of community control

The "Tiwi for Life" (TFL) program was a highly successful strategy initiated during the Tiwi CCT from 1996 up until 2003 when the program ceased. The TFL program was originally funded by the THB with its focus being, the implementation of illness prevention and health promotion strategy and activities developed and facilitated by, and in, the community.

The program implemented a range of comprehensive and selective PHC activities, such as sports days and tobacco prevention week. The TFL program staff were members of the THS, but did not get involved in the day-to-day running of the health service.

The TFL program also developed networking capacity with other organisations; for example, Health Week was facilitated in partnership with DHCS, Diabetes Australia, and Council for Aboriginal Alcohol Program Services. The DHCS Sexual Health program was also part of the TFL team.

Other, non-clinical community based activities included environmental health audits of the community and houses, and the establishment of cleaning teams to improve the housing conditions, removal of rubbish and burnt out, or broken down vehicles and the culling of "wild" dogs and pigs cohabiting people's housing.

"Tiwi for Life" programs were activities initiated and facilitated by people in their own communities: in schools, women's centres, arts centres and social clubs.

Discussions of how governance may be approached, involved the development of the health Board leadership and the implementation of health services. I found that the THAC members drew on the experience of the previous successful comprehensive PHC program, TFL. Using TFL as an example, the key service delivery attributes were identified and included: the engagement with the communities; development of comprehensive and selective health teams; development of team roles and responsibilities; the need for training and skills development; compliance with rules to achieve the goals and objectives; leadership through the team coordinators; and program evaluation. The TFL program could be used in the future as a "local" example and cultural representation for how Tiwi governance can impact positively on a community initiated and managed health service.

I also determined that the TFL example could be used to explain the dynamic and changing nature of the governance "playing field" and how the "interplay" between the team members and the strategy is very important. The THAC wanted to re-establish this key community health development and illness prevention program as part of the implementation of the future board.

How Tiwi governance is enacted will rely heavily on the interplay between the board strategies, the interaction between individuals, families and clans, skin groupings, gender, and the geographic location of groups, including the outstations and communities, throughout the Tiwi Islands. The concept of a “hub and spoke” (Figure 3) model that integrates and allows for connecting across Tiwi groups is currently being discussed in Remote Health management and will need to be actively pursued with the development of the future Board. The promotion of the hub and spoke governance models recognises the dynamic nature of the Tiwi communities and their interactions, including the transient nature of the population during the dry and wet seasons. During the dry (April to November) there is a lot of hunting and fishing with people living in outstations or camping, resulting in a marked decline in core community numbers. During the wet season, when roads are impassable, the people shift into the major centres from the outstations, to gain greater access to food and services.

Figure 3: “Hub and Spoke” Governance option based on geographical locations

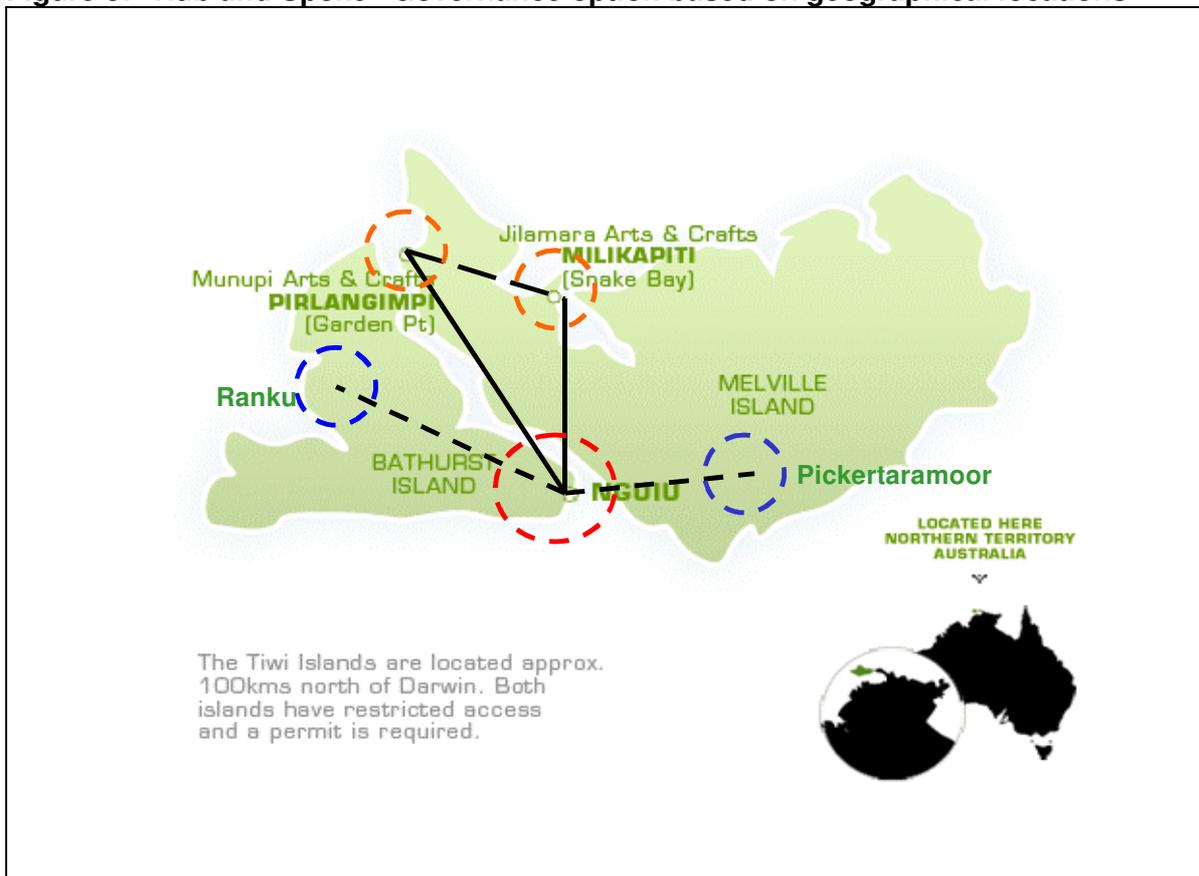


Figure 3, identifies one example of Tiwi governance based on the hub and spoke option connecting people based on communities, or geographic locations. Similar governance options could be developed for skin groups or families, service delivery and future enterprises as each emerge and are established. Primary, secondary or tertiary hub options can be defined based on agreed criteria, and identifies which centres are accessed by whom and where resources are allocated based on health need. Figure 3, also highlights the major communities of Nguiu, Pirlangimpi and Milikapiti, and the outstations of Ranku and Pickertaramoor. The latter is the location of the new Tiwi secondary school that opened in February 2008. Engagement between and amongst these communities and outstations will be needed to sustain Tiwi governance. Basic issues such as the lack of public transport and

communication between these communities remain major barriers to community engagement and participation.

A key to progressing Tiwi health governance will be the continuous review and updating of the associated structures and processes based on timely evaluations of outcomes. These reviews will provide the THB with their “*governance story*”, based on their aspirations, values and mission. This “*governance story*” will provide a rich history and context to the future development of their health systems, services and people.

The “How” of Tiwi Governance

The research project was about working with the THAC to re-establish an Aboriginal community controlled health service. The health service will need to involve many members of the Tiwi community in the roles necessary to achieve community control. Tiwi people will also be involved in governing the health service as nominated and/or elected members of the board or employees of the health service fulfilling roles of health worker, management or administrative support staff. Attracting and developing the capacities in Tiwi people will be a necessary first step.

It is anticipated that Tiwi people will be involved in many PHC or community development programs to promote health and wellbeing, or in illness prevention programs. It is planned that in collaboration with research units, such as the Menzies School of Health Research (MSHR) that these programs will be evaluated and improved upon, using the local Tiwi knowledge and skills with a proposal currently before the THAC. It is also hoped that the proposed collaboration with MSHR will result in skill transfer to assist the Tiwi community develop the expertise, knowledge and capabilities to govern, manage and evaluate the health service in a sustainable matter.

Determining future health need

A key role and competency of the future health board will be to determine the health needs of the Tiwi people and community. This will be achieved through an analysis of the population health data combined with community consultations. Determining health need will require a strategic approach and move beyond the “wish list” approach by members of the THAC that currently exist and as previously described. The THAC identified the current health needs as the:

- provision of a range of comprehensive and selective PHC programs, including but not limited to chronic disease prevention (especially renal and diabetes), mental health (suicide prevention), sexual health and safe behaviour education and the redevelopment and implementation of the TFL program;
- access to a range of health professionals, in particular both generalist and specialist medical staff;
- access to health workers and nurses “after hours”, when the health centre is closed in the evenings and weekends; and
- access to health professionals in the smaller isolated “outstations”, where residents do not have transport to travel into the three major centres of Nguuu, Pirlangimpi or Milikapiti.

The issue of suicide prevention became a major issue in the middle of 2006, with the unauthorised publication and identification by a United Kingdom newspaper of a large number of Tiwi people who had died through suicide (Scott-Clark and Levy, 2006). One THAC member argued:

“... this suicide business, we know them better than anyone else, ... we can look after them, ... we need to break the cycle.”

(Personal communication, Tiwi Health Advisory Committee member, 4 June 2007)

This breach of Tiwi culture by the United Kingdom newspaper, exposed internationally the community dysfunction with the naming of deceased people galvanised the THAC into action. The Tiwi people have as a result developed a “rapid response team” to intervene when people exhibit unsafe behaviours, especially if they had been using alcohol and other drugs. We discussed the issue of suicide, the successes of the response team and the decline of suicide at the THAC in December 2007. The THS Manager stated that there had been only one suicide on the Tiwi Islands in the preceding 12 months, July 2006 to June 2007, a middle aged white male.

A constant request by Tiwi people was for the use of health vehicles that are used daily for transporting patients or clients to and from the health centres. The health vehicles were to be used for attending meetings or ceremony, especially “sorry business” or funerals, or to go hunting and fishing. There was great reluctance by the health staff to allow health vehicles to be used for these identified purposes, as the health vehicles are essential for emergency medical or trauma retrievals and transporting patients to the airfields for flights to Darwin. Again, I found the conflicting priorities between Tiwi people and health staff were major concerns for on-going management, and one not readily resolved when access to public transport was so limited.

I also identified that a highly sensitive issue for the Tiwi people was the repatriation of deceased people who had been transported to Darwin acutely ill and subsequently died, or whose bodies had been flown to Darwin for autopsy. The THAC talked about establishing a funeral fund, using royalties for coffins and flights, so that funerals “on country” could be organised. I question whether non-Indigenous Australians would tolerate this situation.

The THAC members were observed to be currently involved in a range of activities that identified and addressed the health and welfare needs of their community. These were mainly reactive and in response to emergencies. A number of the PHC activities had ceased due to conflicting agendas and lack of resources. The objectives of the THAC defining community control and identifying how the health service is to be implemented was a first step towards achieving self-determination.

Implementing Tiwi Governance

This research formally commenced in April 2007, and involved discussions with the THAC at their regular monthly meetings. The focus of each meeting was the progression towards the re-establishment of the health board and what initial steps were necessary. The first meetings were about establishing relationships and trust between the THAC and myself, but these were soon overtaken by the NTER into the remote NT communities, commencing July 2007. Meetings turned to the impact on the Tiwi people of the proposed 99 year leases in Nguiu, the funding of additional housing, the protection of sacred sites with the removal of

the permit system, the removal of the CDEP payments to Tiwi people and the introduction of financial quarantining and management of welfare payments.

I presented and discussed the “enabling framework” for the development of an ACCHS (2006) at the October 2007 THAC meeting as identified through the literature review (Chapter 2). An agreement was reached to re-establish the health board based on Tiwi principles with agreed decision making processes. The THAC considered the status of the current committee, but acknowledged that it had been limited to the sharing of information, and little more. The next stage of development towards “community control”, Stage 2: Committee Formation, as defined by the “enabling framework” involved the THAC in:

- committee development, though unincorporated at this stage;
- engaging with service providers and community members in developing and delivering health and community services;
- access to funding to provide for meeting costs and governance training; and
- the employment of a facilitator to project manage future work.

Additional meetings were held with the Director of Remote Health, DHCS to outline the proposed action and move towards the establishment of the proposed health Board structures and processes. A major priority for the Advisory Committee was the establishment of a single contact point for all external agencies, including the Commonwealth and Territory Governments and AMSANT. The single point of contact was to demonstrate real ownership by the Tiwi people and the focal point for anyone wishing to discuss Tiwi health issues, whether the NTER, community consultations, and the training of Board members and staff.

Subsequent action resulted in the development of the Project Officer job description and the Expression of Interest to attract a suitable candidate for the facilitation of the future Board. Once the Project Officer was appointed by the THAC, planned for November 2008, further work required would include:

- development of a Project Plan for a return to Community Control;
- funds sourced to support the return to community control;
- funds for additional housing in Nguui;
- funds to be identified for service provision based on population and demographics; and
- community consultations to underpin the return to community control as well as the identification of health need and the development of Tiwi-wide and local health plans.

Full details of the “enabling framework” will be described and discussed later in this Chapter.

Achieving Community Control

The “enabling framework” for the development of an ACCHS established by the NT

Aboriginal Health Forum (Department of Health and Community Services, 2006) members was characterised by flexibility in developmental stages and timelines. The framework, as described following, encouraged the building of local culture, structures and processes. The enabling framework has seven developmental phases with the THAC, currently positioned between stages 2 and 3 as described:

1. No engagement – where there is little information sharing, service provision uncoordinated and where service duplication and gaps exist;

2. Information sharing – little more than information sharing and being asked to advise on specific programs that affect the community;

3. Committee Formation – where funding is provided for meeting costs, governance training and the employment of a facilitator;

4. Developmental – where the committee is part of the NTAHF, health plans are in development with IMC and investment of new funds under an Auspicing agreement identified;

5. Partial Community Control – where the IMC are being achieved, specific programs are being implemented as part of a specific program contract, using pooled Commonwealth and Territory funds for PHC services;

6. Full community control – where the health service committee manages all PHC services and becomes an ACCHS (legal entity); and

7. Regional Community Control – where services developed further to cover regional areas and a number of communities.

The challenge for the THAC was to commit to this developmental pathway and to emerge from each stage with a sustainable and resilient health board, one that also reflected the development of self-determination in the broader Tiwi community.

Tiwi Ways to Achieving Community Control

In June 2008, I undertook an analysis of the data in relation to the Tiwi Governance theme and identified six emerging “concepts” that I then presented and discussed with THAC members. The six concepts were used as anchor points for the THAC members as they progressed with the tentative and exploratory steps towards community control.

- Governance as a “benchmark” tool: Governance can be used as a tool that can assist the Tiwi people move from a position of great hope and aspiration to a position of “reality”, where achievements are made in self-determination and control, without losing the “hope” and whilst managing their expectations. The benchmark analogy can act as a Tiwi picture or story of the journey towards self-determination using steps that can be measured against specific goals, assessment of what has been achieved, identify what next steps are needed, and the key points that the THAC and the future health board need to reflect on.
- Leadership: The role of the THAC and the future health board will be to provide the community leadership for self-determination by modelling and encouraging “proactive” behaviours and achieving outcomes as agreed. The outcomes to be achieved will include Tiwi Governance business rules and decisions making process

that are adaptable to the changing context and circumstances.

- Engagement with the community: The members of the THAC and of the future health Board will need to engage with the communities in meaningful and productive ways. These “ways” are embedded in the Tiwi culture – alliance building, dispute resolution, initiation and mentoring, and the need to re-emerge through the previously described “Leadership”. Full and meaningful community participation and representation needs to be fully explored by the future health board and the project officer.
- Addressing conflicting agendas and priorities: The conflicting principles and values, agendas and priorities, will emerge as in any group or community. The Tiwi people are not immune to conflict within and between communities and outstations. The Tiwi people have a tradition in dispute resolution and the innate ability and culture to “talk through the issues” and come to a consensus. This is where the Traditional Owners and Elders play a most significant role.
- Health programs embedded in the TFL program: The redevelopment of community based comprehensive PHC including health promotion and illness prevention, are priorities for the Tiwi people, not only to demonstrate leadership and capability, but also to demonstrate self-determination. These programs include the successful TFL and suicide prevention programs, as previously described.
- External support and advocacy for the THAC or future health Board: A major issue for the THAC is the role of external agencies and their potential to advocate or hinder Tiwi health services. The potential for conflict between the THAC and external agency “demands” where frequently raised. Tiwi leaders have a tradition in alliance building to secure a future for their families and communities and these traditions could be implemented in a Tiwi way that provides support and influence.

Resulting from these six Tiwi Governance principles, some important questions remain:

- What health services are to be provided by the future Health Board? This question will be addressed more fully in the section on Tiwi Leadership, in this Chapter.
- What is community control and Tiwi Governance when conditions are dictated by external agencies: governments (funders) or AMSANT? What do these mean for community control and self-determination? What “business rules” and processes need to be put in place to address these inherent conflicts between the THAC and the external entities? Do these relationships and processes only reinforce the lack of Tiwi power and authority? These questions will be addressed more fully in the section Governmentality, in this Chapter.
- What management indicators and reports are to be developed: for whom and for what purpose, the future health Board or for external agencies? This question will be addressed more fully in the section on Governmentality, in this Chapter.

***“Yoyi”*: Dancing to the Same Goals**

Throughout the period of my research with the THAC and the broader Tiwi community the concept of “Yoyi”, “... *dancing to the same goals*...”, was never far from the surface and helped to establish new partnerships, test early relationships and do the work with Tiwi people to build the new vision of Tiwi Governance. Through the THAC meetings and the process of data collection, trust and compassion became the two dominant emotions that I experienced. These were expressed in several ways. Often I was asked to remain with the THAC members to discuss issues of Tiwi self-determination and concern when staff of the THS were asked to leave. On several occasions I was given immediate permission to involve myself in the THAC affairs as part of this research; hand shaking became hugs; jokes were shared and at times I was the “butt” of the joke; but also, I was openly challenged and/or defended in meetings. Compassion grew from the sharing of stories of Tiwi people “... *passed on*” due to disease or violence and a shared expression that this should not be happening and must be righted.

I found that the development of relationships built on trust and compassion were based in valuing each other so that partnerships and collaboration emerged and grew. This particular vision of, “... *“Yoyi”*, “... *dancing to the same goals* ...” is reflected in the approach to “both ways” education and learning by the BIITE. “Both ways” is the exchange of ideas and processes, where both people and parties contribute to, and from which new knowledge is gained with neither losing nor compromising.

Risks to Achieving Tiwi Governance

A major risk to achieving sustained governance, as demonstrated by the THAC was of the conflicting agendas and motivations in and between the members. The THAC members expressed the need for urgent and immediate action to establish the Health Board, so as to address the vital health and welfare needs of the Tiwi people that included suicide prevention, reducing alcohol and drug use, tackling community violence and addressing chronic diseases, especially renal disease and diabetes. This approach was at times subject to the immediate wants of some members representing and advocating for their community; for example, “demanding”: access to medical staff, access to the clinic staff after hours, health staff to visit the isolated outstations, access to and use of clinic vehicles for community “business”.

The review of the literature (Chapter 2 and Table 3) highlighted the diverse and conflicting nature of community control and the impact of participation. This disparity between the “urgency” for action, and “apathy” was argued by Boothroyd (1986) when highlighting the types of community planning where the key drivers or motivations were described as a mixture of ritualistic attendance, “... *going through the motions*”, or placatory and appeasing behaviours, the “... *wish list not linked to action*”. I would argue that the THAC members, many who are also community elders and traditional owners were “going through the motions” and withdrew or provided resistance as a result of lack of power to affect the wants or needs of their communities. I found the impact of “going through the motions” was debilitating for the THAC members, in both the short and long term as reflected in their variable attendance (withdrawal) and lack of action (resistance) between meetings.

THAC members were also expected to advocate for their communities. I found that the community expectation that these elders will “... *look after all their communities health needs*”, was a significant cultural artefact. This advocacy role frequently became the “wish list” that reflected the pressure from the community on the THAC members, and again, the

lack of power of the “advisory” committee members to make decisions and allocate resources. I felt at times this mixed and conflicting motivation (advocacy verses passivity, not linked to outcomes) undermined the whole research project.

I was presented with many arguments as to why actions did not or could not occur outside the THAC; a reliance on too few elders within the community, with a small number of THAC members being on many of the key Tiwi councils or committees (too many hats, worn by too few elders). I found that these individuals quickly became overextended and exhausted. Another key contention was the lack of transport, public and private and basic communication (telephones and computers) between the communities. The THS would regularly organise charter flights from Darwin to the three major communities to bring THAC members into meetings. Unless transport was provided members frequently could not attend the monthly advisory committee.

A number of the THAC meetings were limited to the few “usual” and regular attendees. A small number of the THAC members were also employees of the THS and had as part of their employment access to transport, computers and telephones. Non-employees had limited resources to attend meetings. When “sitting fees” were ceased, the response was immediate and antagonistic:

“... no money, not interested, we’ll leave it to the white people!”

(Personal communication, Tiwi Health Advisory Committee member, 13 August 2007)

I found that especially over the latter months of 2007, a mixture of exhaustion and resignation surfaced in the THAC members. Two community leaders explained the feelings of the THAC related to the teams of people coming through the Tiwi Islands as a result of the AGI:

“... people not worried because so many people coming through”,

“... life goes on, ... what can we do?”

(Personal communication, Tiwi Health Advisory Committee member, 13 August 2007)

This mixture of exhaustion and apathy was a major area of risk for the continuing development of the health board. It cannot be ignored that many members of the THAC are themselves elderly people, aged in Indigenous terms and are experiencing the diseases and living conditions of most Indigenous people living in remote settings. The ability for sustained employment, attendance at meetings and achieving actions between meetings has to be balanced with understanding the conditions in which many of the community leaders live and work.

My observations of and participation in the THAC meetings, identified both “autocratic” and “ritualistic” leadership and decision making (Boothroyd, 1986, pp 13 - 42) where only a small section of the community (an oligarchy) participated in the meeting and, where no formal consultations by the THAC members with the Tiwi people were undertaken or evident. Members talked at length through issues that created community concern. These were repetitious and were not addressed between the monthly THAC meetings. Frequently they would seek permission and break into speaking Tiwi, in order to fully inform each other and

debate the issues. Breaks in the meeting frequently occurred to allow for individual differences to be aired and addressed. Non-verbal communication and body language was a constant feature of all meetings, and could not be analysed by the non-Indigenous staff or myself.

Only once did I experience an incident where one member became autocratic and argumentative. The argument related to the lack of access to health services in an outstation, after the health clinic had been vandalised by local people and made unserviceable. The members of the THAC addressed this behaviour by allowing the member to “vent”, after which further discussion occurred amongst the advisory committee. I found whilst not ignoring this autocratic behaviour, senior leaders re-engaged the discussion around the issue, highlighting their well developed mediation and alliance building skills. The outcome was to approach the TLC for funds to repair the health clinic.

Although the Tiwi people appeared to be very experienced in community work and understanding how initiatives or projects are achieved, or alternatively become failures, I found that this current level of “advisory” committee approach and structure continued to marginalise most of the THAC members and encouraged this ritualistic and placatory behaviour. The fundamental issue for the THAC was the lack of power and the inability to make decisions and allocate resources. This has resulted in only a token consultation by the THS, one that I’m sure most THAC members were aware. To encourage critical thinking within a strategic long-term approach, a “developmental” process is needed to support the involvement of the whole Tiwi people, and this has to be linked to community actions and decisions.

Tiwi Governance confronted

As the TLC meeting broke for lunch, approximately 15 women from the Tiwi “Strong Women’s” group arrived and demanded to have a meeting with the TLC president. They objected loudly that they had not been invited to the TLC meeting and that their views were not being asked. They insisted a meeting be organised for them, now or in the near future, for them to contribute to the discussions. The women’s raised voices resulted in chaos, so I left for the Health Centre and returned at 3pm for the flight back to Darwin with the TLC staff. On returning to the meeting, a much more “friendly” environment was found. The Tiwi “Strong Women’s” group members were in a line receiving cheques for their attendance (sitting fees) at the quickly organised meeting.

TLC meeting, Nguuu 5 July 2007

This TLC meeting in July 2007, just after the commencement of the NTER consisted of over 50 Traditional Owners and Elders, all men. For two to three hours, discussions related to the NTRE and the leasing of land in Nguuu for private housing, the protection of sacred sites and the cessation of the permit system and CDEP. The meeting took place without involvement of the senior women’s group of Nguuu.

Was the absence of an invitation to the women to the meeting an oversight by the TLC president? Was the confrontation “manufactured” by the Tiwi Strong Women’s group as a means of accessing “sitting fees”?

I was confronted by this display of “self-determination”. Self-determination I discovered may result in unintended consequences and at times perverse outcomes.

Summary and Conclusion

Tiwi governance or community control was embedded in the four key expressions of traditional Tiwi culture: in ceremony, alliance building, dispute resolution, and mentoring. I found that currently, the THAC is focussed on their cultural processes leaving particular governance and management outcomes neglected or not addressed. This focus on processes reinforced the gap between rhetoric and aspirations and the “reality” of achieving community control and self-determination.

The research also uncovered a number of barriers to the THAC achieving community control: apathy and exhaustion resulting from the lack of human and physical resources to actively engage and take on a sustainable leadership role; the lack of transport and communication logistics with the inability to plan effectively and consult widely and involve communities; conflicting agendas and priorities between THAC members and community members; lack of effective partnerships with internal and external stakeholders; and advocacy and leadership not translating into outcomes.

Tiwi governance, I found was typified by a continual and dynamic interplay between aspirations and the capacity of the THAC to achieve community control. The journey for the Tiwi people will require additional human and financial resources, the development of governance skills, expertise and knowledge, and the establishment of effective alliances, to enable the health Board to operate effectively.

Leadership

If father elder, son expected to be leader.

(Personal Communication, THAC Member, 13 August 2007)

“... paint(ing) a picture about the old way, talk(ing) about how the old way of health and health services were delivered, and ... the new way, and how things would happen”.

(Katherine West Health Board, 2003, p 50)

Introduction

My findings described and analysed in *Tiwi Culture and Governance* at the commencement of this Chapter, identified that prestige and influence were the traditional domain of the “big man” of the household that represented the Tiwi, “... *primitive paternal oligarchy*” (Hart *et al.*, 1988, p 82). The number of wives a “big man” had, increased his time available for building status and power through visiting other members of the band or bands outside the immediately family, developing and holding ceremony, alliance building through dispute settlements and daughter bestowal, with the accumulation of debt or obligation. Culture has provided the Tiwi people with a complex web or interconnection within and between bands that maintained law, authority and control.

Culture also provided the Tiwi people status through public roles at ceremony and dispute settlement with the development of mutual trust between members. Thus, the “big man” (or “big men”) provided the leadership and continuity for the Tiwi people. Much has changed since the original observations by Hart *et al.*, (1988), but the dominance and authority of the Traditional Owners and Elders can still be seen in the THAC and how community needs are identified and decisions made.

The meetings and discussions with the THAC highlighted the role that leadership plays within the Tiwi community and how their aspirations for Tiwi governance involved both active participation and succession planning to meet the current and future health and wellbeing needs of their people. This key theme of the findings will define what leadership means for the THAC, what contemporary leadership may look like, how the transition to this new leadership may happen and how leadership can impact on the future governance roles and the lives of the Tiwi people.

Defining Tiwi Leadership

I found that the role played by the Traditional Owners and Elders is still a dominant feature of authority and control within the Tiwi community and organisations, such as the TLC, the Tiwi Island Training and Education Board (TITEB) and the THAC. Traditional Owners and Elders currently provide the leadership for the THAC that now includes a small group of women. It is same few elders (oligarchy) who represent the community in most formal committees: the TLC, THAC, and TITEB. As leadership is embedded within the Tiwi culture there is also a

sense of “ritual” or going through the motions (Boothroyd 1986, 19 and Moran, 2004), the expected roles played out by the Traditional Owners or Elders.

The stated aspiration of the THAC was for the “active participation” of the Board members in the governance of the organisation. Active participation was about purposeful contribution to the meetings, resulting from consultation with community members, preparation for the meetings and with advocacy for the community’s health needs. I identified limited evidence of active participation, but a mixture of autocratic and ritualistic leadership that supported the types of Indigenous planning as outlined by Boothroyd (1986, p19) and Moran (2004, p 340).

The reasons for this limited active participation by members of the THAC has been explored in Tiwi Governance, earlier in this chapter when I identified a number of structural barriers to effective committee involvement and community representation: the reliance on too few elders; many over extended with different responsibilities; taking on of many and at times conflicting leadership roles simultaneously within the community; and the lack of access to resources, transport and basic communication technology to undertake these allocated responsibilities. I have also argued that these autocratic and ritualistic leadership and decision making behaviours are cultural artefacts or conventions, and that the members of the THAC are essentially conforming to the community’s expectations of these Traditional Owners and Elders, and the roles they played in traditional society. The reality is that leadership within the THAC is invested in this elder group who do represent the oligarchy and the accepted, “rule by a few” by the Tiwi community as a whole.

I have also related leadership, within the Tiwi context specifically to the traditional roles that the elders played in the community (refer to Tiwi culture and governance earlier in this chapter). Such traditional leadership behaviours are incompatible with contemporary thoughts on Indigenous leadership, as defined by Reconciliation Australia (2007a, p 52): working to motivate people to achieve outcomes; accountability for authority and duties as leaders; building consensus through strong and trusting relationships; exhibiting ethical and honest behaviour; and encouraging leadership and team building throughout the organisation and the community.

The Reconciliation Australia (*ibid*) workshop outcomes highlighted that Indigenous leadership is very complex and involves more than understanding kinship, bands and families and traditional culture and laws. Leadership involves addressing the frequently re-occurring conflicting agendas with and between family and community members. The leadership required by the future KWHB members (Katherine West Health Board, 2003, p 114) involved challenging cultural traditions and the building of capacity especially in the areas of financial management; for example, the development of the “money story”, and conflicts of interest especially around nepotism and cultural mediation. The development of these “Indigenous leadership” behaviours and capabilities have the potential to significantly shift or eliminate inappropriate leadership behaviours embedded in traditional Tiwi culture, ritual and convention.

Boothroyd (1986, p19) defined Indigenous planning (or leadership) as being non-manipulative participatory and developmental, and involving the whole community; councils, elders, women, and youth linked to community action and decisions. These developmental processes would assist in shifting the Tiwi and THAC traditional leadership to a more contemporary model, involving a more diverse and broad representation, along with the capacity to address conflicting community agendas and values.

Contemporary Tiwi Leadership

Inherent in the implementation of community control is the development of leadership potential and capacity for members of the future health board. The qualities necessary for leading the future health board will need to be identified and built on with the introduction of the new board's structures and processes.

A key component of achieving community control and embedding contemporary Tiwi leadership identified by the NTAHF (Department of Health and Community Services, 2006) was the employment of a project officer. The THAC discussed at length the role of the project officer and the development of the project plan to assist in the transition to community control. The specific roles identified for the project officer involving leadership development were to:

- establish the plan and timetable for a return to community control;
- work with the THAC to establish the future health board;
- assist establish the rules for future health board membership: election, nomination or combination of each with consideration for the continuity from the existing committee to the new health Board;
- assist in the coordination of governance training and the mentoring of new and young members to the future health Board;
- facilitate in depth community consultations about the return to community control and the roles and responsibilities of the community;
- assist establish new funding arrangements with governments; and
- develop the key strategic relationships with community control stakeholders, for example AMSANT.

The involvement of the THAC in the recruitment and selection process for the project officer will be essential to facilitate the development of leadership and of trust between the THAC and the project officer. The project officer will also need to have credibility to work with the THAC, the Tiwi Traditional Owners and Elders and to undertake the identified activities. Currently (November 2008) an "Expression of Interest" (Appendix K) for the project officer position is due to be advertised.

Once the decision was made for the establishment of the future health board, the THAC members turned their thoughts to whom should comprise the membership of this board and how this membership could be achieved. The initial discussion involved a model of elected representatives, but soon moved to a mixture of elected and appointed membership ensuring a mix of representatives from all communities, bands and gender, youth as well as elders. Disrupted or lack of continuity from the current leadership group to the new board was viewed as a major risk.

During the discussion, I felt that there was a real reluctance for the elders to relinquish their traditional leadership roles or powerbase in the community. Is this reluctance to "let go" of the leadership role, again due to ritualised behaviours that represent a barrier to achieving a meaningful and purposeful participation and involvement by members of the community and

hence dilute the impact of the oligarchy? In contrast to this maintaining of conventional leadership norms was the expressed desire by the THAC for, “... *encouragement of and incentives for new and young members*”, to join the future health Board. The members of the THAC also expressed the desire to, “...*develop new leaders through succession planning*”. Only time will tell if this was rhetoric; to appease the health bureaucrats present and myself, or a real aspiration?

A key role of the project officer will be to facilitate a review of the existing THAC structures and processes to promote contemporary leadership behaviours whilst reducing organisational isolation, duplication and the spreading of limited resources, especially people, too thinly. There are many opportunities for conflict to develop between the project officer and the THAC involving this change management. The THAC will also need to participate in the development of new board structures and processes that will underpin the establishment of a new legal entity. A number of the THAC members have already completed Certificates in Business Governance through TITEB, though this training was completed over three years ago and will require some updating.

The community consultations will also provide the opportunity for members of the new health board to demonstrate leadership through advocacy and collaboration whereby community participation is linked to community action and decision making. The community consultations should result in the development of strong and trusting relationships between the future Board members and the community, where the leaders can exhibit ethical and honest behaviours and become role models for the Tiwi community.

The establishment of a pooled funding agreement between the future health board and the Commonwealth and Territory governments is a complex and fraught process. The THAC identified achieving agreement on the funding model and quantum as a major source of conflict and distrust between the parties (THAC meeting, 5 July 2007). Roles, financial delegations and accountabilities of the new board and governments will be required. Leadership from the THAC will be essential, with support provided by the project officer and Remote Health management. Unless the new board members provide contemporary leadership, the risk of failure could be high.

The last key function of the project officer would be to develop and engage support from the many stakeholders across the various education, health and community sectors, including but not limited to the Commonwealth Government and the Office of Aboriginal and Torres Strait Islander Health (OATSIH), NTG, DHF, AMSANT, Charles Darwin University and the MSHR, the new Tiwi Shire Council, the TLC and the TITEB. Stakeholder partnerships and the associated alliances can provide the future health board with significant encouragement and advocacy, and potential additional financial and in-kind support. The MSHR has a proposal for greater collaboration with the development of a research hub, currently being considered by the THAC. These alliances will be essential for the sustainability of the new health board, a vital factor absent from the functions of the THB from 2000 to 2003. Whilst developing a new and autonomous legal entity to guide and manage the health services to be provided for the Tiwi people, the need for collaboration and partnering cannot be underestimated. The development of leadership capacity that allows for this level of complex partnering will need to be considered.

The development of contemporary Tiwi leadership to achieve community control along with the implementation of the new health board will provide the current THAC membership with significant new challenges. Moving from the traditional leadership built on cultural convention will require the development of both individual and community capacity with a

shift to a leadership that no longer relies on an oligarchy, but on active community participation and leadership that questions cultural norms and conflicting agendas, a leadership that can navigate and mediate the differences in knowledge between the two cultures.

Transition to New Leadership

Linked to “Tiwi Governance” is what the Tiwi people want for the management of their health services; health services planned, designed, managed and provided by and for Tiwi people. The THAC members identified a number of leadership prerequisites for the new health Board and the transition to the new organisation. The previous Board’s administrative centre had been located on the mainland in Darwin over 80 kilometres away. Darwin is 45 minutes by plane and over two hours by boat from the Tiwi Islands. The THB employed mainly non-Tiwi people including the Chief Executive Officer. The THAC were adamant that the new Board’s administrative centre would be located at Nguiu and employ local Tiwi people in leadership positions, service provision (Aboriginal Health Workers, medical officers and nurses), and administrative and support roles. The THAC members were aware that this would require immediate and long-term education and capacity building for local Tiwi people.

Another key role of the new leadership identified by the THAC was to ascertain through an ongoing process of community consultation, not only the health needs and concerns for the Tiwi people, but also what is good for the community’s health and wellbeing as a whole. This leadership role of identifying the health need will be supported through the new health board’s role in securing the funds from governments to achieve the range of health and community services, needed to achieve improved health gain and outcomes.

Once the new health board is established, leadership will be enabled and supported through the development of the Tiwi Health Plans. As previously stated the THAC already has an understanding of the value of comprehensive PHC services that address the social determinants of health, including the TFL approach that they wish to see reviewed and reintroduced across the communities. Access to appropriate health services remains a key concern for the THAC and where leadership can play a significant role. To support this comprehensive approach, the THAC also viewed as important the maintenance of specific PHC programs including mental health (suicide prevention), alcohol and other drugs, sexual health, chronic disease management – diabetes, renal program and the emergency and trauma services.

Through initiating, reviewing and maintaining new and existing services, the new health Board can impact directly on the community’s and external stakeholder’s opinion of their leadership capacity. The contemporary leadership provided, especially through the future stages will also develop a sense of credibility and sustainability with communities and stakeholders.

Summary and Conclusion

The transition stage to the new health Board will provide the THAC members numerous opportunities to develop and demonstrate a new approach based on contemporary leadership values. The THAC members are currently struggling with the shift needed from the traditional leadership styles to the new ways of guiding and supporting their people to improved health outcomes.

Tiwi Traditional Owners and Elders have developed and use a range of complex leadership qualities that still impact today: whether it is the development of ceremony and *Pukimani*, dispute resolution, initiation, debt and obligation and alliance building. I have found that whilst there are many challenges, the THAC will need to develop their own capacity whilst relying and trusting on the relationships that are essential with their own communities and external stakeholders. There is the potential for ceremony to be used to highlight or accentuate a particular leadership issue or strategy, or dispute resolution used to negotiate new pathways to achieving agreed health outcomes and debt and obligation re-defined and used to develop and define roles and accountabilities between and among communities, community members and external stakeholders. Alliance building was also traditionally used for the benefit of the “big man” and his family. Leadership through, alliance building that embraces existing and new stakeholders has the ability to be used to forge key relationships that will impact on the success of a future health Board.

Contemporary Indigenous leadership is about developing “new ways”, whilst acknowledging traditional culture and the legitimate meanings that these can contribute.

Capacity Building

It is impossible to set communities on the path to recovery from the sexual abuse of children without dealing with the basic services and social ills.

(Wild and Anderson (2007). Ampe Akelyernemare Meke Mekarle "The Little Children are Sacred": Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse. Darwin, Northern Territory Government.)

Introduction

In traditional Tiwi culture, the elders mentored the young men through the successive stages of initiation, from the age of 14 (*Marukumarni*) with young men forcibly removed from their families until around 24-26 years of age (*Mikingula*) (Hart *et al.*, 1988, pp 102 - 103). It is through this period, that the young men learnt the Tiwi ways until full initiation.

The Traditional Owners and Elders used mentoring as the real "work" of daily life, the work through which the traditional laws and the continuity from one generation to the next were maintained. Though this traditional form of initiation is no longer formally practised, capacity building and mentoring remain as core components of Tiwi culture and much of what happens today is reliant on these elements.

This research theme will define what is meant by building capacity and social capital within the Tiwi context, examine examples of capacity building provided by the THAC that represented current social capital development that involved individuals, groups, organisations and communities and provide evidence of a "lost opportunity" where engagement with Aboriginal communities in the NT was compromised.

Defining Capacity Building and Social Capital

Capacity building is used extensively in many organisations as a means to improving the knowledge, skills, teamwork and understanding of the work environment of employees or members, to improve overall organisational performance. Capacity building can occur at several levels: at individual, family and group, or organisation and community levels, (Cooperative Centre for Capacity Building, 2004). A major legacy of capacity building is system or organisation sustainability where strategies are interwoven and embedded into the organisation's or community's social fabric (Ricks, *et al.*, 1999). Capacity building is what is required and argued for when the THAC discuss improving the health outcomes of their people and communities.

Ricks, *et al.*, (1999) used social capital to describe the mosaic or interweaving and strengthening of strategies where one or more activities or processes collectively underpin and support another, and where the skills and knowledge acquired by individuals and groups result in sustainable and resilient systems and processes. The field of social capital encompasses several other forms of resources or assets that collectively may include: human, environmental, physical, political, economic, spiritual or cultural (*ibid*, p 42). The authors also highlighted the processes for building social capital: being in trusting

relationships; identifying with community; experiencing the reciprocal bonds of caring; engaging in mutual learning; having a community-based governance model and system; and enhancing or creating different capitals, resources or assets (*ibid*, p 43).

Sustainability is about long-term survivability of behaviours, processes or systems and resilience is about the ability of the individual, organisation or community to adapt and respond to changing and challenging circumstances. I would assert that when the THB was established in 2000 and up until its demise in September 2003, it was neither sustainable nor resilient as it lacked the key elements of both community-based governance and trusting relationships with the key funding bodies.

Capacity building and mentoring are enabling processes that have as outcomes, self-determination, self management and community control. Capacity building and mentoring requires active participation and commitment by individuals and communities, and as described by a member of the THAC, “... *leading to learning*”. I found that, “... leading to learning” and the passing on of knowledge were key roles of the THAC and the future health board. These building processes were embedded in traditional Tiwi culture, where the Board or its members lead individuals and communities in learning, by example and through mentoring.

A “core” group (of elders) who are experienced and who can guide the younger people. To draw in, to sit with the older men, encourage more.

THAC, 23 April 2007.

Leadership and mentoring are needed – between elder and young Tiwi. There is a, ... place for ceremony – younger man, feels out of place, but at ceremony, a young man can be recognised as an elder, we sing them [ceremony], ...

THAC, 13 August 2007.

I found that the above examples of Tiwi capacity building or mentoring identified two key cultural elements; the guiding or encouragement of young Tiwi men and the need for an appropriate place, “...*to sit with older men*”, a space where the youth are safe and feel connected, not “... *out of place*”, where ceremony can occur between the elder and the young Tiwi. The most important function of capacity building and mentoring is their relationship to sustainability and systems resilience, and for the THAC to establish the critical links between learning and improved health outcomes. Unless mentoring occurs and continues, the long-term goals of the capacity building will be undermined, whereby individuals or the THAC are set up to fail.

Members of the THAC reported:

... problems with non-Indigenous people; the need to check government funds; assessing whether funds are adequate to run the THS ...,

THAC, 5 July 2007

The THAC members expressed a number of principles, “... *not for negotiation*”, when

considering the appointment of the future health board members and the recruitment to management and administrative positions. For example, the THAC goal was for the health Board and Chief Executive Officer (CEO) to be Tiwi and for the future Board to identify Tiwi people to be trained into, "... *real jobs*", such as accountants and administrative staff. I found that the THAC wanted Tiwi people to be educated and trained in budgeting and accounting so that funding streams, recurrent budgets and grants for health plans and programs would be adequate and these staff could provide the "checks and balances" to the Commonwealth and Territory Governments.

The THAC also identified roles for Tiwi people in service provision such as; medical practitioners, nurses and midwives, allied health staff including pharmacists and nutritionists, Aboriginal Health Workers, mental health workers and alcohol and other drug workers. Support roles for Tiwi people in assisting to operate the health service also included information technology, community educators and "outreach" staff to homelands. The THAC argued against the employment of non-Indigenous people into key roles when local Tiwi people with education and support could do the job. The THAC were aware of the long lead time to achieving some of these capacity building outcomes, but argued that the education and training of the Tiwi people must start now.

Many researchers, across the political spectrum (Carson, *et al.*, 2007, Hughes 2007, Pearson 2008, and Smith 2007) cited the employment of Indigenous people into "real" jobs, as fundamental to developing individual and community capacity, building social capital and resources that are sustainable and resilient. I found that the THAC argued that Government polices at all levels are needed to support the aim of Indigenous employment.

Building Capacity and Social Capital to Improve Health Outcomes

The THAC provided many local examples of how Tiwi people and their communities build capacity and social capital to address their health issues and concerns. The following examples provide a range of strategies currently being examined or undertaken as part of daily Tiwi life. Of concern to both the THAC and the researcher was the ability for these programs to be sustained in the long-term as a number have not survived.

Learning is About Community Control

This example highlighted the building of capacity and social capital using traditional Tiwi community consultative processes.

The Tiwi Island Training and Employment Board (TITEB) had previously provided a Certificate IV in Governance Training to members of the THB.

We need extensive consultations. That is part of the process!

THAC, 23 April 2007

This example voiced by a member of the THAC, provided an understanding of the critical role that, "... *consultations*" play in the development of community capacity and control. The nature of the consultations, "*extensive*", was viewed as part of the process towards self-determination, and one that encouraged community participation and engagement. The use of consultations as "... *leading to learning*," again reinforced the Tiwi culture of mentoring and the importance of engaging with community members as occurs with dispute resolution.

Building Capacity and Social Capital

The following three examples provided current evidence of on-going mentoring and building of capacity and social assets within the Tiwi community.

Tiwi Youth Forum

Tiwi Youth Forum was facilitated during the month long school holidays, in July 2007. The aim of the Forum was for Tiwi elders to meet with local youth and start identifying the health concerns and issues for this group. A two day session was held, after which most of the youth went bush or fishing. After this initial attempt, future youth forums are planned for 2008.

THAC, July 2007

Tiwi for Life

A THAC member raised the “Tiwi for Life” program that had provided an integrated and holistic approach to PHC, health promotion and illness prevention for the local communities. The “Tiwi for Life” program included cleaning the community and personal development with broad community participation and representation.

The community needs to be involved in the “deal”.

THAC, 23 April 2007.

Suicide Prevention

Youth suicide emerged as a major health crisis from the late 1990s on the Tiwi Islands (Hanssen and Falk, 2005). The authors *ibid* (2005) reported that cluster suicides in the NT, including the Tiwi Islands were related to a number of variables, the most important being: inadequate education, unemployment, poverty and poor health status. As a result of “cluster” suicides related to the use of alcohol and drugs, involving youth from 10 – 24 years of age, the Nguiu community developed a Youth Diversion and Development Group (Tiwi Times, 26 January 2006).

One member of the THAC spoke of the need of services for; *“suicide business”* (suicide prevention), so that the Tiwi people can, *“... look after own, ... we know them better than anyone else. We need to break the cycle”*.

THAC, 4 June 2007.

Tiwi Secondary Education

The following example of capacity building is of the development of the senior college for Tiwi youth with senior community input to the school council, youth council and school curriculum.

Senior community members saw only one solution: to build their own school.

Obtaining funding was a difficult and at times highly political battle, but the dream many Tiwi islanders have held for decades was realised this year when the \$16 million Tiwi College finally opened its doors.

Forty-eight children have just completed their first term at the college, where students fly in to Pickertaramoor, nestled in a patch of tropical forest, on Mondays, and fly home to their communities at Melville and Bathurst Islands on Fridays.

During the week, they live in residences called family group homes, alongside staff who have been specifically hired by the Tiwi Education Board to carry out a parental role during the school week. "This secondary school will certainly give my people the opportunity to equal other people in this country," says Cyril Kalippa, a respected Tiwi Islands traditional owner.

Traditional owners at the Tiwi Islands said they believed it was important that their children were educated in a boarding-school type arrangement that was free from the social dysfunction of Tiwi Islands communities.

Tiwi College principal Peter McNamara says the fact it's an independent school means that Tiwi islanders have been able to institute their clear ideas of how they want their school to run.

"I personally think one of the problems has been that we have not set the bar high enough for indigenous kids," he says. "At this school, we want our kids to be able to access anything that is available to anyone else."

The Australian, 5 April 2008

This example provides a clear example of Tiwi people building capacity, social capital and community control. The Tiwi Secondary College was established in early 2008 to meet the local Indigenous education needs and implement ways of ensuring school attendance and the provision of a focussed learning environment for study amongst Tiwi youth. Tiwi capacity building is also about ensuring access to education that most non-Indigenous people take for granted.

Understanding the Value of Traditional Foods

Little is known about the nutritional value of traditional foods on the Tiwi Islands, with this example providing evidence of the desire to better understand the use of food.

Again, whilst waiting for the THAC to commence discussion led to the nutritional value of mangrove worms that are used to supplement the diet of many Tiwi people.

Mangrove worms, they taste like oysters – salty, milky, cheese. How to eat them – fresh, boil and have like a soup.

Mangrove worms were described as, "... like our medicine". We need research to understand the nutrition value of mangrove worms and do they assist with a healthy diet.

THAC, 11 December 2007

This small scenario highlighted the THAC desire to gain more understanding, contribution and benefits of the traditional diet using western research methods. Culturally, the mangrove worm is, "... like our medicine". Several "social capital" outcomes could be achieved through participation in this research including identifying the nutritional benefits of local food

including the mangrove worm, developing research capacity within the Tiwi people and the possibility of commercial enterprises based on the production and sale of traditional foods and medicines.

Collaboration in Capacity Building

The Tiwi population has a long history of being the “subjects” of research. The THAC received numerous applications from researchers and research teams to undertake investigations into the causes of ill health and disease, evaluations of health improvement interventions and the resulting outcomes on the health and welfare of the Tiwi people. This “collaborative” effort has raised many issues for the THAC, as evidenced in a meeting between the THAC and the Director of the Charles Darwin University (CDU), Menzies School of Health Research (Menzies) in December 2007. The Director, Professor Jonathan Carapetis presented to the THAC a proposal for a long-term relationship with the THAC based on the development of a research hub. The following describes the approach and benefits to the Tiwi people, a proposal that is still being considered by the THAC.

Research hubs in collaboration with Menzies

The proposal presented by Professor Jonathan Carapetis involved the establishment of research hubs facilitated by Menzies, based on the Tiwi Islands. The establishment of the research hubs would result in building stronger research partnerships with the Tiwi people, where the future health Board and communities would be involved in:

- ▶ having a permanent dialogue (trusting relationships) with Menzies;
- ▶ setting the research questions, to improve local education and health (identifying with the community);
- ▶ designing the research interventions;
- ▶ changing local policy and practice in response to the research;
- ▶ building local capacity for research (engaging in mutual learning); and
- ▶ leading to the employment of local people to undertake and assist with the research (enhancing or creating different capitals).

The THAC asked many questions of and expressed concerns to Jonathan:

- ▶ where does the research go and who benefits?
- ▶ what causes health problems?
- ▶ what has been the benefit of the 20 years of working with the Tiwi people already?
- ▶ are we having and receiving proper treatment?
- ▶ is the research helping us?
- ▶ new medicines are not effective!
- ▶ need for research on prevention of illness and individual treatment;
- ▶ not enough information on the causes of diseases!
- ▶ white people have introduced many changes that have resulted in diseases, such as alcohol and “fast food”; and
- ▶ we need to fully understand the information and statistics.

THAC, 11 December 2007

This example highlighted the suspicion of the Tiwi people to years of being research subjects, “... *being experimented on*”, with health and health outcomes not improving, even getting worse. These statements are extremely important as evidence of capacity building and social capital, by questioning the, “*so called experts or authority figures*”, and not accepting as fate the rationale for, approaches to and outcomes of research. I found that this

example highlighted the THAC aspirations to not only improve the health and welfare outcomes for their communities, but also leading and contributing to research and using research as a vehicle for the future employment of Tiwi people.

Tiwi Football

The successes of the local football teams and achievements of Tiwi footballers in the national league occupied much of the discussion at many of the THAC meetings. This edited article from the Sydney Morning Herald (2006) highlighted the role that football plays in developing Tiwi capacity and social capital whilst addressing social dysfunction.

A team in big league kick-starts hope on troubled Tiwi islands

TEENAGERS are no longer talking about killing themselves on the Tiwi islands, which have the nation's highest suicide rate.

"The change has been amazing. Virtually overnight, the kids are walking tall and proud with smiles on their faces," says Brian Clancy, who has been associated with the islands for 20 years.

At 2.30pm tomorrow Tiwi's Australian rules football team - the Tiwi Bombers - will run on to an oval in Darwin for their first match in the Northern Territory Football League. The match is believed to be the first by an all-Aboriginal side in a major competition.

"The boys are ready to make history. They have been training virtually non-stop for four months," said the coach, Greg Orsto.

About 900 of the 2600 people who live on the islands play football, which is said to be the country's highest participation rate.

Long, who won the Norm Smith medal and played in two AFL premierships, said football was not just a sport on the islands, but the "key ingredient of living in the communities". "Kids pick up a footy as soon as they can walk and never really put it down. It helps keep them focused away from the social problems. That's why having a Tiwi side in the NTFL is so important."

The manager of the Tiwi Islands league, Bill Toy, said some teenagers had given up smoking Cannabis because they wanted to play for the Tiwi Bombers.

Officials of the NTFL-AFL, which administers football in northern Australia, said promoting the game on the islands gave teenagers a chance of overcoming social problems such as drug and alcohol abuse.

Tiwi islanders have an average life expectancy of only 48 years. They also have the country's highest rate of kidney disease. "The kids have new hope," Toy said.

Sydney Morning Herald, 13 October 2006

The role of football on the Tiwi Islands cannot be underestimated as a capacity building and social capital strategy. Successful football players can act as role models and mentors for the young players. In his book "Holding Men: Kanyirninpa and the health of Aboriginal men", McCoy (2008, p 145) reflected on the positive contribution of football with an Indigenous man;

“Like joining in together now. Back then they had corroborees”.

With the achievements of the football league for men, the development of a women’s league is now being considered.

“Capacity Building” Tainted?

The Board of Inquiry into child sexual abuse within Aboriginal communities in the Northern Territory (2007) and the consequent AGI has impacted significantly on all Indigenous communities throughout the NT, including the Tiwi Islands. I attended several THAC meetings in the latter part of 2007, where the AGI was discussed and a diverse range of opinions expressed. I viewed the Board of Inquiry as a positive step towards addressing the crisis within the Indigenous communities and providing the mechanism and strategies to tackle these issues. I viewed the Board of Inquiry and its recommendations as part of an “enabling process”, to engage with communities, and one that offered many opportunities for Indigenous people including the Tiwi people. The following is an account of my personal response and reflections on the Board of Inquiry and its subsequent use within the context of this research and the concerns expressed by the THAC.

“The Little Children are Sacred”

The Inquiry and subsequent report, “the Little Children are Sacred” (Wild and Anderson, 2007), examined the problem of sexual abuse within Aboriginal communities in the NT and possible solutions. Rex Wild QC and Pat Anderson co-chaired the Inquiry. Rex Wild was a former NT Director of Public Prosecutions and senior lawyer and Pat Anderson is an Alyawarr woman who is well known as a strong supporter of disadvantaged people and has many years experience working with Aboriginal people, especially in Indigenous health.

Purpose of the Board of Inquiry

The Board of Inquiry was created by the NTG in August 2006 to research and report on allegations of sexual abuse of Aboriginal children. The Chief Minister asked the Inquiry to investigate concerns about serious child sexual abuse in Aboriginal communities. The Inquiry was established to find better ways to protect Aboriginal children from sexual abuse.

What the Inquiry learned

The Inquiry gathered and reviewed a vast amount of information that was shaped into 97 recommendations for the Chief Minister. Underlying the Inquiry’s findings was the common view that sexual abuse of Aboriginal children is happening largely because of the breakdown of Aboriginal culture and society.

Important points made by the Inquiry:

- ▶ Child sexual abuse is serious, widespread and often unreported.
- ▶ Most Aboriginal people are willing and committed to solving problems and helping their children. They are also eager to better educate themselves.
- ▶ Aboriginal people are not the only victims and not the only perpetrators of sexual abuse.
- ▶ Much of the violence and sexual abuse occurring in Territory communities is a reflection of past, current and continuing social problems that have developed over

many decades.

- ▶ The combined effects of poor health, alcohol and drug abuse, unemployment, gambling, pornography, poor education and housing, and a general loss of identity and control have contributed to violence and to sexual abuse in many forms.
- ▶ Existing government programs to help Aboriginal people break the cycle of poverty and violence need to work better. There is not enough coordination and communication between government departments and agencies, and this is causing a breakdown in services and poor crisis intervention. Improvements in health and social services are desperately needed.
- ▶ Programs need to have enough funds and resources and be a long-term commitment.

It could be argued that the Inquiry was a prime example of an “enabling” process, taken over and used for political purposes, and used to promote and re-establish protectionism of Indigenous people (*“protect the children”*) and the further assimilation of Indigenous people, with the mainstreaming of Indigenous health issues. A key purpose of the Inquiry, argued by Wild and Anderson was to make visible to ATSI people and the Australian population as a whole, the need for change at a community level, supported through education. The Inquiry was also a significant attempt to engage with ASTI people about the critical issues impacting on children that required their ownership. I now argue that the use of NTER legislation (Commonwealth of Australia, 2007) only further alienated a significant proportion of both the ATSI and non-Indigenous community. This breach of trust and of the inherent psychological contract (Popay, 2006) with Indigenous people and the resultant damage done to this “enabling process”, will take many more years to address. This aspect of the research finding addressing Government’s accountability in partnerships will be explored in this Chapter.

Summary and Conclusion

I found that the cultural construct of capacity building and mentoring is embedded within the daily lives of the Tiwi people. I also found that the THAC used capacity building as a key strategy and resource to support health promotion and illness prevention activities. Examples of current successful capacity building included: the THS suicide prevention team; the establishment of the Tiwi Secondary College at Pickertaramoor outstation and the celebrated achievements of the Tiwi football league. Each in their own way has contributed to the building of the social capital of the Tiwi people and also addressed a number of the social determinants of Indigenous health. Each has within its core elements, leadership, mentoring and learning.

Examples have also been described where capacity building and enabling processes have been used for the benefit or advantage of others, and not necessarily for the benefit of the Tiwi people. Strategies that are not based on the short and long-term requirements of the Tiwi people need to be questioned and revised. A number of opportunities for capacity building and mentoring were also provided; research activities that use a “bottom up” approach and are supported by key alliances, and employ and use local people to benefit greatly the building of Tiwi capacity and social capital. Unfortunately, I found that many of these strategies have not been adequately resourced and sustained in the long-term; the Tiwi for Life program has been the most significant failure.

The definition of health and how improved health outcomes may be “enabled” are based on two core Tiwi values: PHC where learning is achieved through doing and sharing; and the local term, “... *Yoyi* ...”; dancing to the same goals. Much can be achieved by supporting to these Tiwi values.

Governmentality

We're about working with governments, ... not for governments.

(THAC member, 15 February 2008)

"Unless people engage with Indigenous people and make sure there is a real partnership, and not a dictatorial approach, we are not going to see any sustainable gains, ... It has got to go beyond the term of any one government and this is why the bipartisan approach is so important, ... It's that community development, community empowerment and community engagement type of model that we are engaging,"

(Tom Calma, The Aboriginal and Torres Strait Islander Social Justice Commissioner, at the Annual General Meeting of Australians for Native Title and Reconciliation, 22 February 2008).

*Primum non (or nil) nocere is a Latin phrase that means, "... **above all else, do no harm.**" It is one of the principal precepts all students are taught in medical school. It reminds a physician that they must consider the possible harm that any intervention might do. It is most often mentioned when debating use of an intervention with an obvious chance of harm but a less certain chance of benefit.*

(Yeager, 2002, p 496)

Introduction

I have used the concept and theme of "governmentality", to accentuate the relationship between the THAC and governments: both Commonwealth and NT, and their political processes and bureaucratic structures. "Governmentality", also highlights the potential for conflict between governments and Indigenous communities with the government's use of democratic or mandated powers: in the setting of policy and the providing of resources and funding within the Indigenous community control context. This use of power within a western context and culture is frequently at odds with what Indigenous people want and need, and one that may result in more harm than good. "Governmentality" also refers to the inherent characteristics of governments and in particular of accountability: accountability for the partnership entity, but also the people, communities and organisations that comprise the partnership.

The modern human rights movement of the 1960s saw the initiation and adoption of a number of United Nation covenants and conventions (the International Covenant on Civil and Political Rights [ICCPR], the International Covenant on Economic, Social and Cultural Rights [ICESCR] and the Convention of the Elimination of All Forms of Racial Discrimination [CERD], 1966) based on (Part 1, Article 1) the right of all peoples to self-determination, including the right to freely determine their political status, pursue their economic, social and cultural goals, and manage and dispose of their own resources.

This Section of the Findings will define “governmentality and the predicament of governments, provide evidence of how the THAC is weary and disenchanted with these relationships with governments, and will identify what Tiwi people and the future Health Board need to progress community control and to avoid a repeat of the THB (2000-2003).

Defining Governmentality and the Predicament of Governments

The study of government was enhanced by Foucault (1991), who in the second half of the 20th century created the term and concept of “governmentality”. The analysis of “governmentality” created a new understanding of power in society, where Foucault encouraged a broader view that included social control; a proposition that went far beyond the traditional and formal hierarchical, “top-down” power of the state. Foucault identified three core characteristics within an individual’s or community’s environment that impacted on the rights of the individual or community: freedom of choice, assuming there is a range to choose from; enterprise, the ability to gain (personally or economically) from the venture or activity; and finally, the autonomy of decision making that can empower, or conversely disempower.

Power can manifest itself positively by producing knowledge and certain discourses that get internalised by individuals and guides the behaviour of populations. This leads to more efficient forms of social control, as knowledge enables individuals to govern themselves. (Rose, 1996:155)

The key dilemma for governments (Edquist, 2007) is to identify and use the best mechanism for achieving its objectives and mandated policies (and we must not forget also, about getting re-elected). Two propositions are argued by Edquist (*ibid*): firstly, through its formal agencies and instrumentalities, the individual, family or community are the “subjects” of government, and consequently subject to the whims of governments and their agencies. Secondly and conversely, people can be viewed as “citizens”, subjects in their own right, with associated personal rights and obligations and with power over their own destiny and fate.

The formal use of power or governance is characterised (Reconciliation Australia, 2007b, p 12) by the full assignment and exercise of power and authority, the determination of group membership and entity, the ability to make important decisions and to enforce them, to carry out its rules and responsibilities, resolve conflict and negotiate with others and plan future strategies. Accountability lies and remains with those who are invested with formal governance.

Governments, argued Foucault (1991) also have at “their disposal”, the ability for “power sharing” as an option, where the individual or community may assume control to achieve self-determination through empowerment. As individuals and communities embrace these self-governing capabilities, a shift results in accountability from the government to the individual or group (by becoming citizens) creating an alternative form of social control. This use of social control is espoused by the concept of “neo-liberalism”.

Neo-liberalism has emerged due to a number of political and environmental factors, the dynamics involved are described as follows:

- the delegation of power from governments, using policies of deregulation, increased (consumer) choice, increased levels of education, and free trade agreements within a

global economy;

- community control, self-determination, and self management – a mixture of human rights and neo-liberalism;
- identification and introduction of an agreed set of behaviours that are, *“the right thing to do”* – for example “healthism¹” (Skrabaneck, 1994) where governments want individuals and communities to be healthy and health promoting, to undertake and comply with healthy behaviours (non-smoking, taking exercise, eating healthy diets, etc);
- “normalisation” – governments create incentives, (positive and negative, carrots and sticks) so there is compliance around the agreed set of “right” behaviours. It is argued that this is only another form of social control and regulation; and
- “self esteem” – linked to what is “the right thing to do” and good, again the use of social control and reinforcing compliance.

In this research, the notion of governmentality refers to individuals or communities, where power and decision making is de-centralised and its members play an active role in their own self-government. Control is thus regulated from “inside” the individual or community and thus they have the potential to become auto-regulating and auto-correcting. If the individual or community succeeds in becoming “auto-regulating and auto-correcting”, this creates further demands on “government normalisation”, to further increase the government’s control (sometimes viewed as covert and subversive), with further incentives and compliance. If unsuccessful, and individuals or communities fail, the government may argue that the accountability and ownership of the outcome (positive/negative) resides at a local level, *“... it’s your fault ...”*; the individual’s, family’s, community’s, but certainly not the government’s.

“Power sharing” and increased decentralisation and delegation of government’s power as a means to support self-determination (Bossert and Beauvais 2002), can be used in ways that can displace or disconnect accountability from government and elected bodies to individuals or communities. This displaced accountability, often viewed as, “... all care, no responsibility” can establish further, a culture of blame and victimisation where unsuccessful attempts by individual, families or communities result in the, “... set up to fail” syndrome. The impact of failure and associated victimisation, by governments or dominant cultures on Indigenous people and communities can establish a climate of apathy that further reinforces the cycles of oppression and dysfunction, as claimed by Watermeyer (2006, p 269), when discussing disability and social change in South Africa; *“... once oppression has been internalised, little force is needed to keep us submissive”*, or Trudgen (2000) when discussing dependency and hopelessness in the Yolngu people of East Arnhem.

A key question therefore remains; what are the responsibilities of governments when implementing community control in Indigenous communities?

¹ “Healthism” begins when governments (Skrabaneck, 1994) ... use propaganda and coercion to establish norms of health and ... to attempt to impose norms of a “healthy lifestyle.” All human activities are weighed in the balance of their real or imagined effects on health: all human activities are divided into “healthy” and “unhealthy”, prescribed and proscribed, approved and disapproved, responsible and irresponsible, based on this measure.

A “History” with Governments

I found that the establishment of the THB and its subsequent failure in 2003 resulted in the distrust of governments by the members of the THAC. The lack of trust was stated at many of the THAC meetings I attended, and one that could be readily understood when claimed by the Tiwi people.

In July 2007, with the implementation of the AGI, the TLC facilitated extensive discussions with over 50 community men involving the Commonwealth agreement that allowed for a 99 year subleasing (selling, transferring or mortgaging) of Nguiu land for residents to own their own homes or businesses or to make available for community organisations and government agencies. Changes to the permit system were also discussed with the Federal Government’s commitment to fund an additional 25 houses preconditioned on the removal of the permit system. Concerns were also expressed that the Tiwi people needed to be ready to take on the increased governance accountabilities.

Discussion, including the TLC involved:

Problems with non-Indigenous people, ... Tiwi people feeling the need to “check up” on funds and accounts, ... funds not being adequate to support population (population data manipulated by governments), ... NT government not fully committed to the THB and raising expectations and frustrations, and ... the length of time for the transition back to the THB.

Examples were given of the “Commonwealth” being more forthcoming with assistance and support and that processes with the Commonwealth were more transparent.

TLC meeting at Nguiu, 5 July 2007

This example demonstrated the Tiwi people’s need for transparency of decision making and the allocation of funds with their involvement in government processes, their ownership of the outcomes and continued disillusionment with governments, especially the NT.

In February 2008, a further meeting was held between members of the THAC, the TLC and management staff of the THS. Again, discussion focussed on the AGI developments, the consultation and coordination processes. The core issue was again agreement of Traditional Owners to the 99 year lease for private housing in Nguiu, the “Better Housing: Better Health” initiative, and strategies to reduce overcrowding and improve living conditions and cleanliness in Tiwi housing. Discussion went to the proposal for private housing at Pirlangimpi and Milikapiti, conditional on a 60 year lease.

A response to this proposal for private housing at Pirlangimpi and Milikapiti, from a member of the THAC was that this was, “... *black mail*”, (or should I term this, “... *white mail*”).

The loud retort was, “... *but that’s what they did here (at Nguiu)*”.

THAC Meeting 15 February 2008, at Nguiu

The commentary disclosed the perceived double standards being applied to people of the Tiwi Islands, and between those living in Nguiu and those living at Pirlangimpi and Milikapiti.

The THAC members could see that preconditions were being applied to the Tiwi people, to control and enforce certain behaviours, with “compliance to the 99 or 60 year leases”.

Gruen and Yee (2005, pp 538-540) in their article titled: *Dreamtime and awakenings: facing realities of remote area Aboriginal health*, described the impact of decades of policy and political failure associated with Indigenous structural disadvantage. For Gruen and Yee (*ibid*) the realities faced by Indigenous people were summed up in three words: “hardship”, “sufferance” and “invisibility” with the following examples provided:

- *Hardship* referred to the struggle of daily living; the overcrowding (usually more than a dozen people in a three bedroom house), cracked concrete floors, window screens broken, the plumbing occasionally blocked and the house covered with graffiti. The supply of fresh fruit and vegetables was limited, and what is available was very expensive. Most available “take-away” food was greasy and fried. Alcohol was also identified as part of the hardship, the associated violence, noise and disruption to daily living and sleeping at night time. Poor literacy, the authors stated, was one of the biggest barriers to local Aboriginal people assuming real responsibility in imposed systems that are complex and unfamiliar.
- *Sufferance* described the resignation to diseases where families tolerated sickness, and over the decades they had developed no improved expectations of the “health system” and its ability to respond to their needs.
- *Invisibility* alluded to the level of undiagnosed and untreated illness in the community with many chronic diseases not apparent until acute complications present, such as rheumatic heart disease. The associated perception that rheumatic fever has been eradicated from Australia only reinforced this concept of invisibility. The issues of lack of, or the inability to, access appropriate health services are not well understood by most health professionals living in Australia’s major cities.

Gruen and Yee’s (*ibid*) descriptions reinforce the outcomes of decades of neglect, policy failure and structural disadvantage, with the ensuing “breach of the psychological contract” between governments and Indigenous people. The lack of attention to these issues has set up Indigenous communities to fail and the potential for them to continue to fail exists until appropriate programs and adequate resources are provided to address the realities of remote Aboriginal health.

The Prime Minister, Kevin Rudd’s apology to Indigenous Australians on the 13 February 2008, evoked a range of responses when the THAC meet two days later. Responses included:

“ ... when he spoke, he impacted ... ”;

“ ... I was shaken up ... ”;

“ ... about moving on, not blame ... ”;

THAC Meeting 15 February 2008, at Nguiu

The future for Indigenous Australians and closing the gap in health inequalities is hopefully related to regaining trust, reducing their psychological pain and dysfunction, so that Aboriginal people can again control their lives and destinies. As I finalise this thesis, there has been the release by the Commonwealth Government of the, “Northern Territory Emergency Response: Report of the NTER Review Board” (Commonwealth of Australia, 2008b). As reported by Paul Toohey (The Australian, October 17, 2008) a member of the expert panel, *“has broken ranks to slam the report, saying it was overly emotive and recommended perpetuating “a slow form of genocide”.* Sue Gordon, the Aboriginal magistrate who presided over the NTER, prior to the Report’s release was reported (Pearson, The Weekend Australian, October 4 –5 2008) as “urging caution”:

... My concern is just for the people in the 73 communities and town camps, nobody else, and the women and children. There’s still people who aren’t putting those Aboriginal people first. The snipping that goes on, it doesn’t seem to be for the benefit of the people in the communities but, rather, other people who have another agenda.

The Report, though contentious should provide the opportunity for a full debate on the intervention’s successes and failures.

Rules of Engagement with External Agencies

“Governmentality” also refers to the managing of relationships between the THAC and with external stakeholders. The THAC members were eager to establish a set of “business rules” for external agencies to engage with the THS and communities. I found that the re-establishment of the future health Board was an attempt to achieve “real ownership”; an entity and a level of authority that will create a focus for “anyone” wanting to discuss issues with the future health Board. Issues such as: the impact of the AGI; the 5 year action plan; the 99 year lease of land in Ngiuu; pooled funding; and the preconditions associated with the funding. This “focus” has the potential to create a central entry point for external stakeholders and a means by which the THAC members are able to coordinate consultations and responses.

The role of the future health Board is also to develop their business rules and to guide Board members in their response to governments and other external agencies. The business rules will assist with formal engagement and coordination of responses when discussing future health plans, implementation stages, resources and funding. A criticism of government agencies, by the THAC was their multiple and frequently overlapping strategies that lead to confusion and increased frustration. I found that the THAC argued about the government’s lack of capacity and their inability to work successfully with Indigenous people.

Key external stakeholders identified by the THAC were Commonwealth and NT politicians and especially government departments including the Commonwealth Department of Families, Community Services and Indigenous Affairs (FaCSIA), DoHA, DHF and AMSANT. Key relationships are required to be developed with all stakeholders.

The provocative newspaper article, *“Great Aboriginal con”*, (Aird, 2008, The Australian, Monday 28 April) in response to the Labour Governments, Australia 2020 Summit (19 and 20 April 2008), argued the need for strong and sustainable relationships and shared competencies between Indigenous people and governments:

The con is when Aboriginality is exploited for personal or organisational benefit and it is permitted by either weak, ineffective bureaucracy or an uncritical mainstream Australia. The con operates on a national scale and there are perpetrators and victims on both sides of the cultural divide.

Sadly, there is an industry built around indigenous affairs and many of the stakeholders will fight tooth and nail to keep the status quo.

The exploitation of the Indigenous agenda by non-Indigenous people has a long history, and one that assists to reinforce the disparate power relationships between the dominant culture - governments, organisations, structures, processes, professions and researchers with Indigenous people. Aird (*ibid*) argues that this exploitation serves the non-Indigenous population by maintaining the status quo and that “real” change is not in the interest of these dominant groups. Governments, and it could be argued, organisations such as Aboriginal Medical Services, are interested more in their own survival than that of Indigenous people. Again, it is about the inherent power relationships and how power is used by the dominant group to achieve “its” outcomes. Aird also included Indigenous people in this argument. Could it be that the “*primitive paternal oligarchy*” within Indigenous culture, as described by Hart *et al.*, (1988) is being maintained by the Tiwi Traditional Owners and Elders to serve the needs of this dominant group within their own people, groups and communities? I find this a difficult question to contemplate, but one to be asked all the same.

Besides formal meetings between the THAC and governments (DoHA and DHF) to develop the future and funding arrangements, meetings are also needed with AMSANT to discuss how they can support and advocate for the future health Board and assist with the funding negotiations. Aboriginal Medical Services Alliance Northern Territory has an established and long-term capacity within the Indigenous health sector to negotiate on behalf of emerging community control services and is illustrated by the following examples: history of working with the non-government sector – Central Australia Aboriginal Congress in Alice Springs, Danila Dilda in Darwin and the KWHB; Aboriginal leadership, with the development of a strong remote and urban focus; advocacy and brokerage on behalf of organisation with lesser capacity and political know-how; providing access to training and support and the sharing of systems and knowledge - governance, management and audit.

A meeting was held with government staff to discuss the funding options with FaCSIA. Families, Community Services and Indigenous Affairs saw the need for community consultations to agree on strategic and priority need. Discussions involved a number of contentious areas, for example:

- ▶ *The role of AMSANT – the THB (2000-2003) had not engaged effectively with AMSANT for a number of reasons, particularly gender issues for the Tiwi Traditional Owners and Elders. There is now a need for the THAC to engage with AMSANT for support, sharing of ideas and tools and for their advocacy role when dealing with governments.*
- ▶ *The role of the TLC – the role of the Council in the previous Board was not viewed as helpful with individuals impeding Tiwi people progress towards community control.*
- ▶ *Relationships with government’s will also need to be managed, with bureaucrats not wishing to offend Aboriginal people and thus being unhelpful – “never say, No”, and being*

polite;

► *When the THB was located in Darwin, from 2000-2003, this led to dislocation, dysfunction and distress.*

Meeting with government staff, 15 November 2007

These four examples of Tiwi people working with governments and across sectors highlighted the complexity and demands placed on the THAC members when trying to progress community control. The relationships with alliance organisations and “natural” supporters raised issues of power and control, capacity and resulting benefit. This meeting reinforced the cultural perception of the Tiwi people: “... *us! everyone else are others*”, including mainland Aboriginal and non-Indigenous people. At times the Tiwi people were viewed as insular and conservative in their approach to working within the Indigenous health sector, not wishing to develop partnerships outside their own people. The capacity of government staff to manage relationships with the Tiwi people was also questioned, with government staff not knowing how to manage cross cultural relationships in a sensitive yet confident approach, and not wishing to offend Aboriginal people: possibly under the misconception of maintaining cultural security.

Whilst this meeting with government staff occurred four years after the demise of the THB, I felt that it provided staff the opportunity to debrief from their experiences of working with the Tiwi people. The impact of the failure of the THB in 2003, felt like an incredible burden that government staff had also carried and their feelings of contributing to its failure and the on-going distress of the Tiwi people.

Capacity, Who’s Capacity?

Once Territory Health had agreed to Katherine West [CCT], they found that there was no-one within the department that had the skills or expertise to then go and do the consultations, to go and sell that proposal to the communities.

(Katherine West Health Board, 2003, p 44)

We now need technically effective programs to overcome Indigenous disadvantage.

It is time to apply technical solutions to technical problems. Under the new approach we need people with the technical capacity to bring about substantial and sustainable improvements. The people with the necessary skills may not be Aboriginal and no doubt this will horrify the old guard.

(Wesley Aird, The Australian Monday 28 April 2008)

These two examples by the Katherine West Health Board (KWHB, 2003) and Aird (The Australian Monday 28 April 2008) of both government staff and Indigenous people lacking capacity are at the heart of this argument. Governments and their agencies, usually proffer these arguments when wanting to increase the capacity of Indigenous people to undertake the core governance, management or service delivery functions. Literacy and numeracy are argued as the major areas where capacity building is needed in Indigenous communities, but little thought has been given to how non-Indigenous people can work better with Indigenous

people.

Too often, the challenge is for Indigenous people to increase their knowledge and capacity to improve outcomes. I found little or no commentary about government staff improving their capacity to work with Indigenous people and implement programs that are not only culturally appropriate but also achieve improved health outcomes. Katherine West Health Board, (2003) and Aird, (The Australian, Monday 28 April 2008) challenged both Indigenous and non-Indigenous people to increase their technical capacity to bring about substantial and sustained improvements.

Aird's (*ibid*) key argument was about "technical effectiveness" and how its implementation is essential to improve policy and program effectiveness. Technical effectiveness relates to **how** a policy or program is implemented; the skills, expertise and knowledge to achieve agreed goals and objectives within a defined context. Aird (*ibid*) argued for achievable and measurable goals, ones that Indigenous people and communities can aspire and relate to:

Under the new approach we need to hold accountable Aboriginal leaders of communities and organisations. Within their membership or geographic area there must be performance outcomes in the fight to overcome disadvantage. There should be no latitude when people attempt to hide behind or exploit culture while spending taxpayers' money.

The accountability within governments and their agencies is about understanding the issues associated with the power relationships and meanings of subject and citizen, of dominant groups over Indigenous people and communities, the ability to work with different cultural groups at different stages along the capacity building continuum aware of the risks, and risk management issues so as to avoid creating more harm and dysfunction. The key risk for future work is the impact that any intervention may have on the Tiwi people, as cited at the introduction of this Section – "*Primum non nocere, ... above all else, do no harm*". This research with the THAC identified unresolved shame of the Tiwi people with resultant continuing stress and illness. The breach of the psychological contract between governments and communities, and between health providers and individuals has the potential to compound the long-term and negative impacts on community members, people already harmed through decades of inappropriate interventions and approaches to engagement. The research of Hyatt (1997, p 228) identified that inappropriate interventions resulted in greater personal and community breakdown and dysfunction.

Hence the impassioned plea from a member of the THAC, "*we must be working with governments, ... not for governments*", (THAC, 15 February 2008).

Summary and Conclusion

The predicament of governments is how to best use their power and mandate to achieve outcomes for the Tiwi and Indigenous people as a whole. Governments cannot, and should not, abrogate or avoid accountability for their actions when working in partnership with Indigenous people and communities: particularly communities suffering from decades of both structural disadvantage and policy failure. Governments have at their disposal, significant power to influence and implement a range of policies and strategies. Governments can also choose to work with individuals and communities, in a power-sharing arrangement, to develop and motivate these people towards community control. Within the context of

Indigenous health, governments need to work with Indigenous communities to determine what interventions are needed, where and how should they be implemented, to achieve the dual goals of “closing the gap” and moving Indigenous people towards self-determination. Governments must also be aware that interventions may do more harm than good, and may only serve to create further distress and dysfunction.

The THAC has a long history of working with governments and experiencing the outcomes, both successes and failures. This review of the THB and the THAC identified that governments have enacted interventions expeditiously, with little consultation and engagement of Indigenous people in the process. Yet, the Tiwi as with most Indigenous people have lived with decades of neglect, structural disadvantage and with policy failure. I found that the THAC want to see long-term and sustainable solutions that involved the Tiwi people in a meaningful way. I also identified that the immediate action needed to address the engagement of and coordination by Tiwi people, is the development of business rules with external stakeholders, Governments and advocacy groups. The business rules will provide certainty for the Tiwi people and for the stakeholders with whom they are developing business.

Finally, this research has provided a voice to the concerns and issues of the Tiwi people to governments and stakeholders, in relation to taking control of their own health services and developing approaches appropriate to their own needs; the primacy and legitimacy of concerns are for the Tiwi people: and not maintaining status quo, nor the current status of politicians, bureaucrats, health care providers or researchers.

Enabling Framework: Pathway to Community Control

Indigenous peoples are treated as problems to be solved, rather than as active partners in creating a positive life vision for current and future generations.

(Human Rights and Equal Opportunity Commission (2007) Social Justice Report, 2006, website accessed 14 June 2008).

... developmental, non-manipulative participatory process involving the whole community, linked to community action and decisions ...

(Moran, 2004)

Introduction

“*Enabling Frameworks*” are used to describe the core structures and processes for the advancement and empowerment of traditionally disenfranchised individuals, groups and communities. Enabling frameworks are dynamic social responses or instruments to a clearly defined community problem. Understanding the issue or concern (problem representation, Bacchi, 2003) along with community action directed towards achieving specific outcomes is reliant on capacity and commitment.

Tom Calma, the Aboriginal and Torres Strait Islander Social Justice Commissioner (Human Rights and Equal Opportunity Commission, 2007) argued that the Human Rights principles provided an effective “enabling framework” for active engagement and ones that support good governance in Indigenous communities. Calma in the Social Justice Report, 2006 (*ibid*) also argued that, “... *Indigenous cultures vary considerably across Australia, and as a result there is a diversity of governance frameworks that need to be respected, rather than subjected to a ‘one size fits all’ approach*”.

This theme defines what is meant by Indigenous governance enabling framework, describes and analyses the implementation of an enabling framework with the THAC and the outcomes so far. How the implementation of this framework may be improved for the next stages towards a community control health service will also be explored.

Defining the Indigenous Governance Enabling Framework

In 2006, the NT Aboriginal Health Forum, comprising membership from AMSANT, DHCS and DoHA developed an “enabling framework” for the establishment of ACCHS throughout the NT (Department of Health and Community Services, 2006). The key principles guiding this framework are: a shared commitment to community control as the most effective basis for Aboriginal health and community care service delivery; the planned and sequential movements towards community control through attainment of agreed milestones; the development of certainty regarding capacity for Aboriginal community control; and sustainability of Aboriginal community controlled health and community services through the planned development of governance and management capacity.

The framework for the development of ACCHS is based on three phases: engagement, consolidation and finally independence with related advancement characteristics (refer Table 7). The initial draft has been used for working with the THAC and the development of the staged approach to community control or Tiwi governance. This document was further developed in 2008 to, *Pathways to Community Control* (Department of Health and Community Services, 2008) and enhanced this first document in the areas of: describing the continuum of community participation and control; demonstrating the changing partnership responsibilities from government or public administration to community (referred to as the partnership matrix); describing the development of community governance competencies and capabilities to achieve a viable and sustainable community controlled health service; and building both Board of Governance (community) and system (government) functionality, to support the community controlled health service.

The maturation of this “enabling framework” is highlighted in the comparison and analysis of the two documents and approaches (refer Table 7).

Table 7: Comparing “enabling frameworks”, 2006 and 2008

Initial 2006 Framework	Revised 2008 Framework
Phase 1: Engagement <ul style="list-style-type: none"> ▪ no engagement ▪ information sharing ▪ health advisory committee formation 	<ul style="list-style-type: none"> ▪ continuum of community participation and control, the shift from government to community control
Phase 2: Consolidation <ul style="list-style-type: none"> ▪ developmental stage ▪ partial community controlled HS 	<ul style="list-style-type: none"> ▪ changing partnership responsibilities from public or government to community (referred to as the partnership matrix)
Phase 3: Independent <ul style="list-style-type: none"> ▪ full community control ▪ regional community control 	<ul style="list-style-type: none"> ▪ the development of community governance competencies and capabilities to achieve a viable and sustainable community controlled health service
	<ul style="list-style-type: none"> ▪ building both Board of Governance (community) and system (government) functionality

The initial framework (Department of Health and Community Services, 2006) described the developmental stages for the community to achieve community control, from processes of no-engagement, the consolidation of community control, through to full and regional community control. Specific roles and tasks were identified along with performance indicators and measures of achievement including IMCs, to be reached before the next phase could be considered and commenced. The revised and amended enabling framework views community control as a dynamic process between public administration (government) and the community, where the focus is on the relationship and capacity between the two entities. The continuum of community participation and control highlights this shift of power, or power sharing, from public administration to self-determination and management, where there is strengthened definition around the dual responsibilities, dual competencies and capacities, and finally the building of both community and system functionality, including government to support community control. The ongoing functionality of both the community and government and its agents are critical to the success of community control.

How community control can be best achieved is referred to in the revised enabling framework (Department of Health and Community Services 2008, p5) where the key principles, "... *drawing the parties together*" are clarified:

- Aboriginal community participation as the key element of sustainable, viable, effective and efficient delivery of primary health (care);
- a shared commitment to the development of a strategy to secure greater levels of Aboriginal community control in the delivery of PHC;
- a shared commitment to foster an effective partnership between governments, communities and providers that ensures best practice governance of services and optimal health gain; and
- a shared commitment to personal and community development as an integral contributor to improved levels of community participation and control.

I found that this revised framework highlighted the contribution and development of capacity of both parties, with a significant shift away from government's propensity to blame and, "... *set up, Indigenous communities to fail*", as happened with the THB in 2003.

The Social Justice Report, 2006 (Human Rights and Equal Opportunity Commission, 2007) by the Aboriginal and Torres Strait Islander, Social Justice Commissioner, Tom Calma reflected on a number of current, Commonwealth government policies and policy approaches, that impacted directly on Indigenous governance and their implementation. Four significant issues were identified by Calma:

- a 'compliance mentality' that had permeated Indigenous policy resulting in an increasingly punitive response with the "cherry picking", (the act of pointing at individual cases or data that seem to confirm a particular position, while ignoring a significant portion of related cases or data that may contradict that position) of issues and the neglecting of important characteristics for sound policy;
- government's failure to implement policy commitments and their lack of accountability for policy failures. Calma identified a disturbing trend and culture among the government to apportion responsibility for failed policy to Indigenous peoples;
- government's failure to engage with Indigenous people by using a "top down" imposition, with policy set centrally and unilaterally by government, confirmed in bilateral processes with state and territory governments (again without Indigenous input) and then applied to Indigenous peoples; and
- new government arrangements, such as the establishment of the Office of Indigenous Policy Coordination that had fostered a culture of control that was, perhaps unintentionally, disempowering Indigenous communities.

The Social Justice Report 2006 (*ibid*, 2007) was a critique of the Commonwealth Liberal Government that had been in power since 1996. With the change in the federal government on the 24 November 2007, judgment is yet to be made of the new Labor Government's response to Indigenous issues and policies. What is clear is that when governments: use punitive responses to non-compliance; implement a top down, centralised and once size fits

all, policy approach; and lack accountability for failed policies, these actions disempowered and continue to subjugate Indigenous communities whilst creating more social dysfunction.

Tiwi Governance and the Enabling Framework

I found the THAC struggled with the overall approach and engagement with the “*enabling framework*” for Indigenous governance. The Advisory Committee met monthly without a formal agenda, with the meetings coordinated and facilitated by staff from the THS. The focus of most meetings was on local and operational issues, where committee members continued to argue and advocate for increased access to health services for their communities. Strategic and community control issues were considered, and inspirational goals were expressed, but without the necessary action between meetings, or out of session to achieve these objectives or ends. The THAC fully supported the move towards community control, but without acknowledging the developmental processes needed to achieve this outcome.

On the 9 April 2008, at a meeting facilitated between the Director Remote Health, Chair of the THAC, Manager THS and myself, a Job Description and an Expression of Interest for the future health Board Project Officer were developed and circulated to the THAC members for comment. Letters to key political representatives and government staff were also written, that expressed the desire of the THAC to return to community control seeking their support and proposing meetings to discuss achieving community control. At this April meeting, an alternative name to the Tiwi Health Board was also proposed, to give governments and the Tiwi people a signal that a future Board would have a new focus and capacity. The Chair of the THAC proposed a Tiwi word, *Ngininawula* meaning “our” for the name of the health Board. It was agreed that the future health Board be known as the “*Ngininawula* Health Board”. The THAC members agreed with these documents and proposal on the 12 June 2008.

The recruitment of the Project Officer by the THAC will be an important appointment and one that will be able to work full time with the Tiwi people to progress towards community control. Key objectives of the Project Officer’s role will be to:

1. to establish the “*Ngininawula* Health Board”;
2. to assist develop a Health Plan for the Tiwi Islands through community consultations;
3. to access high quality and on-going training and development resources for the members of the new Board and THS staff;
4. to negotiate with the DHF and DoHA and secure adequate service funds to support the development of the THS;
5. to initiate Agreements and networks with AMSANT and other key stakeholders to support community control developments;
6. to develop and implement the agreed IMC; and
7. to establish a monitoring group on behalf of the NTAHF to oversee and support the THB developments.

The responses in the *Indigenous Community Governance Project: Year Two Research Findings* (Hunt and Smith, 2007) reinforced a number of the issues faced by the THAC with the shift towards community control and Tiwi governance of their health services. The authors argued for Board and governance procedures to be established that foster greater stability and capacity of Board leadership (Project Officer, key objective No. 1) with longer terms for Board members and partial re-election/nomination of all leadership positions on a rotating basis.

Hunt and Smith (2007, pp xii and xiii) also described Indigenous communities and community organisations as complex with a diversity of conditions and needs, and different in what they are trying to achieve. The community consultations (Project Officer, key objectives No. 2) will be a key activity to understanding this complexity and diversity in the Tiwi community. The authors (*ibid*, p xii) supported governance induction, capacity building and mentoring processes (Project Officer, key objective No. 3) at a minimum, to enable Indigenous groups and incorporated organisations to better understand the statutory implications and obligations, and to develop local workable options for their asset and funds management.

Hunt and Smith (*ibid*, p xii) strongly argued for an urgent policy review of funding mechanisms for Indigenous communities (Project Officer, key objective No. 4):

... to create a more streamlined funding mechanism that will generate outcomes on the ground, and alleviate the debilitating 'funds management' workload imposed on organisations by the current multiple-funding pathways.

As previously identified, the development of relationships with governments and external stakeholders is key to the implementation of the community controlled health service for the Tiwi people and THAC. Networked governance principles and mechanisms, are identified by Hunt and Smith (*ibid*, p xv) as encompassing layers of groups, organisations and communities, with decision making responsibility located at the, "*closest possible point of connection to the people affected*" (Project Officer, key objective No.5). The development of agreed and mutual, "*two way*" (*ibid*, p xvii) objectives will assist with the re-establishment of trust, so important for the THAC members (refer Appendix J, Project Officer, key objectives No. 6 and 7).

What this research identified was the lack of a "Tiwi road", with most of the development only "one way". The THAC has been working towards an already prescribed and established "*enabling framework*" agenda without their real understanding of the need for their cultural mediation: *two cultures, two roads*; a Tiwi road and a government road, so elegantly expressed by the KWHB (2003, p68),

It is not simply the transfer of information or "facts" from one head to another. Rather, it was a constant process of negotiation between different knowledges, with the outcomes being a hybrid which in effect mediated between two cultures. Probably the best example of this is a diagram of two roads to health which the Board developed as a way of illustrating such mediation. The "Two Roads" picture became the Board's signature document.

I have found that this "*two roads*" picture and analogy, has the potential to create opportunities for the Tiwi people, the THAC, governments and external stakeholders:

- "*two roads*"; maintains and strengthens separate cultures and knowledge systems

that enables community control and self-determination;

- “intersecting roads”; where the paths cross signifies the mutual priorities and where shared outcomes must be achieved together, where work *must* happen together in partnership, after which separate roads are again travelled; and
- “one road”; travelling the same road with shared goals and values, with the opportunity for the sharing of knowledge and for trust to grow.

Reconciliation Australia (2007a, 2007b) in partnership with BHP Billiton documented the outcomes of their “Sharing Success Workshops”, with a number of Indigenous communities throughout Australia; Port Headland in Western Australia and Penrith, Western Sydney in New South Wales. The workshops focussed on building governance for organisation excellence and how to achieve this through strong leadership. These workshops could provide the THAC with the next steps needed to achieve community control: the discussion of practical ideas to address governance challenges and to build stronger organisations; strengthen local networks with other Tiwi organisations to support each others governance initiatives; identify some of the local governance gaps or issues; and to start thinking about ways to plan and implement strategies for building leadership in their own organisations. Importantly, Indigenous people facilitated these “Sharing Success Workshops”, for ATSI people and organisations.

Summary and Conclusion

The Enabling Framework provided the research and the THAC the roadmap or pathway, structure and processes to achieving community control and Tiwi governance. The framework detailed the stages and developmental characteristics or criteria, against which achievement or progress can be benchmarked and measured, for the THAC, governments and stakeholders who are in partnership with and supporting the move towards community control. The partnership of governments and stakeholders should be within a shared accountability framework, along the continuum of community participation and control. The framework maps and highlights the roles and tasks for the development of community control of the THAC and the project officer who will assist the new health Board and Tiwi people towards self-determination. The framework is underpinned by partnerships and alliances with governments and key sector advocacy groups to achieve a sustainable and resilient organisation and system.

The THAC has only just commenced this journey to re-establish their health Board. The project, to date has identified and described a number of risks and barriers to achieving community control, but with the appropriate facilitation and support, funding and resources using this “*enabling framework*”, the outcomes are very achievable. The journey towards community control is dynamic and will be challenging for the THAC and governments. The “two roads” picture, challenges the THAC to find its own pathway. At times the roads will cross, so the THAC, governments and stakeholders will need to share resources and expertise to achieve mutual priorities and goals. At times, the road will be shared with parties working together for sustained periods, travelling together with the opportunity for the sharing of culture, knowledge systems and allowing for trust to grow and be re-established. The “*enabling framework*” is also about Indigenous peoples treated as active partners in creating a positive life vision for current and future generations.

Chapter Five: Discussion

The truth is: a business as usual approach towards Indigenous Australians is not working. Most old approaches are not working. We need a new beginning. A new beginning which contains real measures of policy success or policy failure. A new beginning, a new partnership, on closing the gap with sufficient flexibility not to insist on a one-size-fits-all approach for each of the hundreds of remote and regional Indigenous communities across the country but instead allows flexible, tailored, local approaches to achieve commonly-agreed national objectives that lie at the core of our proposed new partnership. And a new beginning that draws intelligently on the experiences of new policy settings across the nation. However, unless we as a parliament set a destination for the nation, we have no clear point to guide our policy, our programs or our purpose; no centralised organising principle.

... the time has come for new approaches to enduring problems. And working constructively together on such defined projects, I believe, would meet with the support of the nation. It is time for fresh ideas to fashion the nation's future.

(Prime Minister Kevin Rudd, Apology to Australia's Indigenous Peoples, House of Representatives, Parliament House, Canberra 13 February 2008).

Introduction

The research was challenging from the very beginning with the need for a flexible and local approach to meet the needs of the THAC and the Tiwi people: the essence of community control. The research context changed significantly over the term of the project, particularly with the introduction of the AGI (21 June 2007), and after the passage of the *Northern Territory National Emergency Response Act, 2007 (Cwth)* on the 17 August 2007. The research methods also changed significantly from Collaborative Action Research to an anthropological and organisational analysis approach in response for the need to gain a detailed understanding of the cultural and social elements that were assisting or preventing the move towards a Tiwi community control organisation. The principles and values for researching with Indigenous people and communities were challenged and overturned, with a significant change in the level of committee participation, information sharing, timeframes for action and shared decision making.

The research Aim and Objectives (Chapter 4) identified five questions that the project would answer using the CAR approach. The shift to a post-modern anthropological and organisational analysis epistemology and methodology was stimulated by the perceived unequal power relationships between the THAC and governments, an approach that used in-depth examination and analysis of the motivations and behaviours of the THAC to answer the research questions. The answers to the research questions were not derived from the proposed actions undertaken to achieve community control as planned in the CAR, but from detailed participation in, and observation of, the workings of the THAC. Whilst not achieving a desired community control outcome, nor significant progress along the continuum towards community control, the exploration of the cultural, organisational and social aspects of the daily lives and interactions of the THAC assisted in answering these research questions and elicited a more pragmatic research outcome: one that will assist to achieve a lasting and

resilient community controlled health organisation and system in the longer-term. The research questions are discussed using the Research Findings.

This Discussion Chapter will examine the core six research findings related to the five research questions.

What is Community Control for the THAC?

Community control or Indigenous Governance for the THAC is embedded in the four key expressions of traditional Tiwi culture in: ceremony; alliance building; dispute resolution; and in youth initiation, mentoring or capacity building. At present the THAC is focussed on their cultural processes that have left individual and formal governance and management outcomes lacking or not addressed. The THAC has remained, broadly speaking, a patriarchal oligarchy: a group dominated by male Traditional Owners and Elders; characterised by centralised and at times autocratic, “top down” decision making; involving ritualised and placatory behaviours, “going through the motions”, that has marginalised other members of the Tiwi community, especially the women and youth. There was, in addition, a lack of evidence of connecting with the community and “*dancing to the same goals*” that was advanced in the THS mission and values statement. This preservation of traditional processes reinforced the gap between their rhetoric, the desire for Tiwi governance and between the “realities” of achieving community control and self-determination.

The rhetoric of Tiwi governance was also evidenced by the ongoing conflicting agendas of the THAC, where pressing local and operational concerns dictated, and took, precedence over the strategic issues and any long-term planning. Also, this “wish list” of short-term priorities was not linked to ongoing action or implementation. The lack of control, wearing too many hats, and/or exhaustion were frequently the justification for “going through the motions”, the lack of action, withdrawal and resistance, symbolic consultation or the “top down” decision making. The THAC has remained an “advisory committee”, a western governance construct that denies the cultural status of Traditional Owners and Elders, and without the accountability or the resources to drive or implement community control.

Two key questions remain unanswered as a result of this research and for the THAC:

1. what is community control for Indigenous communities or organisations when the conditions and funding of the partnership are dictated by external agencies – governments, advocacy groups or when the local oligarchy overshadows community participation? and
2. what choice do Indigenous communities or organisations have in determining how their governance model is to be implemented? Grim (2006) and Cornell (2008) found significant benefit in providing choice, based on capacity, to the American Indian and Alaskan Native Health Services, between leading the health service, providing the health services or supporting the health service.

These questions remain due to the lack of: implementation of the enabling framework; the development of trusting relationships between fund holders and providers; and the delegation of accountabilities to the THAC. These questions are fundamental to how Tiwi governance will be implemented and achieved.

How is Community Control to be implemented by the THAC?

There are four components essential in the implementation of a community controlled health service by the THAC: integration and advancement of the contemporary Tiwi culture; consideration of the Tiwi leadership; use and further development of Tiwi capacity building and mentoring; and understanding the concept of governmentality and the impact of developing rigorous internal and external partnerships.

Culture

The Tiwi people are still heavily influenced by traditional culture in their daily lives. Most dominant amongst these cultural remnants are: ceremony, especially funerals (*Pukimani*) and smoking, to cleanse the land and country from dead or “bad” spirits; alliance building through debt and obligation, linked to *Pukimani*; dispute resolution, especially by the community elders; and the initiation of young men, though the timeframes for initiation are now significantly truncated. “Demand sharing” also among family and community members is still evident. The functions of these cultural expressions remain a means of social control and securing a future for the Tiwi households or families by the Tiwi Traditional Owners and Elders. Tiwi control is still very much with the hands of a few senior men; what Hart, *et al.*, (1988) described as a, “... primitive patriarchal oligarchy”.

Violation of these cultural traditions by the Tiwi people, especially the elders resulted in shame and the loss of reputation and influence within the community. This awareness of shame and the apprehension to take decisive action was evidenced in the failure of the THB and the tentative steps taken by the THAC to regain their position of influence in relation to the governance and management of health services across the Tiwi communities.

Yet, the THAC did not argue to, “go back” to traditional ways, but sought legitimacy of what has meaning for them in their culture; a resilient culture that is changing yet provides continuity. To progress this shift into the 21st century, to achieve a future community controlled health Board and secure a future for Tiwi people, the THAC saw that there was a need for a blend of traditional and western culture. This blend of traditional Tiwi and western culture was an acknowledgement of what the Tiwi people felt was important, incorporated with the evidence-based western practice that provided for, and improved, the health and wellbeing of Indigenous people in a sustainable way and in the long-term. “Both ways” has been previously cited, and is used, by the Batchelor Institute of Indigenous Tertiary Education (2006) to develop curriculum and practice that contributed to new and appropriate concepts of Indigenous knowledge and learning. The KWHB (2003, p 68) described “Two roads” as symbolising the parallel journeys of Indigenous people and western organisations and the interconnections between to two journeys. “Both ways/Two roads” acknowledged the differences, but also how the two systems could work together to produce innovative adaptations and solutions to this intractable health problem.

The “both ways/two roads” analogies, though providing a way forward that acknowledged the contribution of the past and the traditions of culture, contain conflicting principles and values that challenged the basic character of Indigenous behaviour; the emphasis on individual verses collective control. This way of thinking and representing the future was new for the Tiwi people and created a level of ambivalence. These conflicting principles were also compounded by new Commonwealth legislation, the *Northern Territory National Emergency Response Act, 2007* (Commonwealth of Australia, 2007) that challenged their traditional laws and Indigenous governance.

The conflict of values is evident in two particular outcomes for the THAC. The THAC sought to identify incentives to engage with and mentor the young Tiwi people, to involve the youth in positive health behaviours and in the management of the health service, in sound traditional but relevant ways. Yet, engaging with their youth remained a problem. The philosophy and concept of PHC is one that is highly compatible with Tiwi culture, reinforced in the “bottom up” development and implementation of the “Tiwi For Life” program. Though compatible, the “Tiwi For Life” program also succumbed to Tiwi apathy and lack of community engagement.

The challenge for the Tiwi people is to identify the core cultural elements that are still valued and relevant to addressing their future health concerns. Developing a culture that values and respects a broader and fuller community participation and involvement yet builds on the Tiwi capacity for alliance building, dispute resolution and mentoring, underpinned with ceremony could provide a secure foundation for a sustainable and resilient health service and community. The future community control strategies must also give real meaning to Indigenous “work”.

Leadership

Leadership provided by the “big man” was always a dominant feature of the traditional Tiwi household and community. Traditional leadership roles included: developing and coordinating ceremony, alliance building, dispute resolution and initiation or mentoring of the young men, all based on debt and obligation enacted within the cultural knowledge system, *Pukimani*. The leadership provided by the Traditional Owners and Elders maintained law, authority and control.

The transition to the new health Board will provide the THAC members many opportunities to demonstrate a new approach based on contemporary leadership values as articulated by the outcomes of the Reconciliation Australia workshops (2007a, and 2007b). The current THAC members with need to shift beyond the traditional leadership styles based on arbitrary and tokenistic decision making, to one that encompasses the needs and welfare of all community members. This research identified contemporary Indigenous leadership occurring at many levels for the THAC:

- the modelling of ethical and appropriate behaviours that blend traditional and western governance;
- the identification of community and organisation preconditions that promote Tiwi ownership and the employment of Tiwi people in the future health Board and management team;
- the identification of the communities health needs and concerns that enables the development of the future Tiwi health plans;
- the facilitation of community engagement to identify these health needs; and
- the engagement of the broader health sector through open and transparent partnerships, to advocate and support the future health Board.

Contemporary Indigenous leadership will need to be about the consolidation and/or development of “new ways”, whilst acknowledging the Tiwi traditions and culture and the legitimate meanings that these can contribute. The challenge of the future generation of health leaders is to provide for the health, welfare and security for all Tiwi people.

Capacity Building

My research uncovered many forms of capacity and social capital building activities and processes currently underway on the Tiwi Islands and being supported by the THAC. Examples of current successful capacity building included:

- the mentoring of Tiwi youth to contribute to community programs and organisations;
- the employment of Tiwi people in critical roles to oversee and monitor investment and decision making;
- the establishment of a forum to advise on issues and concerns related to the health of Tiwi youth;
- the development and implementation of the Tiwi for Life Program, a comprehensive PHC initiative;
- the setting up of the THS suicide prevention team;
- the formation of the Tiwi secondary college at Pickertaramoor outstation in 2008; and
- the celebrated achievements of the Tiwi football league.

Each in their own way has contributed to the building of capacity and social capital and resources of the Tiwi people that also tackled the social determinants of Indigenous health.

The definition developed and used by the Cooperative Venture for Capacity Building (2004) identified five critical characteristics essential for sustaining the building of capacity: co-learning amongst the people, organisations and communities involved; action taking as a consequence of the capacity building and learning; incentives developed and built onto or as a result of the process; participation of individuals, groups and businesses; and finally, facilitative leadership. All characteristics can be found to some degree in the example of Tiwi capacity and social capital building, but critical to their success being their sustainability. Each has within its core characteristics *“leading to learning”*: leadership, mentoring and systems of “whole of community” learning. The construct of capacity building and mentoring is embedded in the daily lives of the Tiwi people and the THAC used capacity building as a key strategy and resource to support health promotion and illness prevention activities.

A number of opportunities for capacity building and mentoring were also provided where Tiwi people could be employed or involved in research activities that use a “bottom up” approach and are supported by key alliances. Critical will be the development of the capacity building support mechanisms that will survive over years whilst literacy and living skills are enhanced in a range of core areas; not only reading, writing and numeracy, but also involving the broader literacy goals of finance, technology/computer, cultural, ecological, health and mental health, information and media, and health. These strategies have the potential for greatly benefiting Tiwi capacity and social capital and assets. Illiteracy in this context and in its many forms can be viewed as contributing to the social dysfunction in Indigenous communities and one that can only be solved through education.

Governmentality

How governments achieve the requisite outcomes through policy reform whilst addressing the structural disadvantage of Indigenous groups and communities is part of the “wicked

problem” and one that will continue to challenge the Tiwi people, governments and politicians, Commonwealth and Territory, at all levels, for years to come. Governments have at their disposal significant power and resources to influence and implement a range of policies and strategies yet, have in the past, lacked the resolve and continued to avoid engaging effectively or appropriately with Indigenous communities to achieve sustainable outcomes. The research raised the issue of government accountability and whether they can, or should, abdicate accountability whilst implementing self-governing and self-determination policies, as promoted by neo-liberalism. It begs the question: who should be held accountable for the implementation of community control policy reforms: governments or Indigenous people and communities?

Indigenous people, like all Australians have basic rights around freedom of choice, the ability to gain from enterprise and the autonomy of behaviour. The research again raised further questions related to concepts and implementation of community control: How does this translate into western concepts of self-determination and community control for Indigenous people? What degree of power sharing should exist between governments and Indigenous communities? Are Indigenous people subjects or citizens of governments? Does a fundamental conflict exist between what governments want for Indigenous people and communities and what Indigenous people want for themselves? Has this need and basic right been examined and explored by governments in collaboration with Indigenous people?

Governments have accountability for understanding the power disparity issues that exist with Indigenous people and should also be aware of the potential impact that any intervention may have; even the capacity to predict the “perverse” or unintended consequences or outcomes. Governments should also have the capacity to assess and predict the “readiness” of Indigenous people and communities, for the move towards self-determination and assist Indigenous groups continuously throughout the journey to community control. Governments must also be aware of the risks and risk management issues facing Indigenous groups as they move towards self-determination and above all else, do no harm.

This research found many examples whereby governments have failed the Tiwi people, the THB and now the THAC. Government have continued to focus on the “what” of Indigenous health, not “how” to implement the change agenda that has been missing for decades. The Tiwi people, along with all other Indigenous people have been exposed to ongoing policy change and failure driven by political agendas, rather than what is in their best interest. Research and program evaluations have documented the lack of definition around community control and associated risks, with governments still developing policies based on past assumptions, and without recognition of the partnerships (“both ways/two roads”) required or what, and how, Indigenous people can contribute. The research provides evidence of “lip service” to consultation by governments. The KHWB provides an exemplar of how consultation is undertaken and what outcomes can be achieved. Governments are still enforcing western bureaucratic structures and processes on the THAC (an advisory committee) that negates the role played by the Tiwi Traditional Owners and Elders, and their accountability to their community. This only reinforces apathy, resistance and/or withdrawal from these processes. Governments have also failed to provide the resources and appropriate funds to support the developed health programs based on Tiwi need.

The lack of engagement with the THAC is reinforced by a blame culture, yet the NT Government has ignored and failed to implement its own “enabling framework” promoted now, over several years. There is a lack of accountability by government for outcomes, where single solutions are implemented; the “single bullet” or “lowing hanging fruit” approach, within limited timeframes. In summary, governments have exploited the Tiwi people

increased Tiwi shame, dysfunction and exhaustion for their own political and economic gain.

The THAC, want at a minimum, to develop and implement “rules of engagement” with governments as a first step towards community control: to establish a central and coordinated contact point, for all issues related to health and the provision of health services on the Tiwi Islands along with the development of a mutually agreed strategic direction and shared competencies between the THAC and governments. A real partnership based on Tiwi and western governance values and principles.

What is the Pathway to Community Control?

The “Enabling Framework” (Department Health and Community Services 2006, 2008) provided the THAC with an opportunity for growth and development: a framework that is dynamic and flexible enough to respond to the individual community needs and changing circumstances. The framework initially developed and used with the THAC evolved over the time of the research with a shift from achieving specified outcomes to one more focussed on the dual relationships and capacities of communities and governments. The Enabling Framework had at its core, the development of functionality for the health Board governance and of the broader system in which the Board is operating; with the internal and external stakeholders, Indigenous community and key partnerships.

The journey for the THAC has just commenced and the “roads” to be travelled for both the Tiwi people and governments will be complex and challenging. The enabling framework will need to address the issues of Board sustainability and resilience: *as the “roads” will need ongoing repairs as they may be washed away or flooded, need resurfacing or sealing, require new bridges built or even new roads surveyed and developed.*

The “enabling framework” is about Indigenous peoples respected and valued as active partners, and providing them a voice in the future of their lives, now and for future generations.

What are the Key Implementation Issues and Risks for the THAC?

Tiwi governance was characterised by the continual and dynamic conflict between the rhetoric of the THAC and their limited capacity to achieve community control. Tiwi governance will require additional human and financial resources, the development of governance capacity and the promotion of internal and external partnerships, for the future health Board to operate effectively. The facilitation and implementation of the community controlled “enabling framework” will be critical to achieving these governance outcomes.

There are great risks around the shift towards community controlled health services that in the past have not been identified, acknowledged, assessed nor managed. What this research has identified as missing from this enabling framework is the “long-term” view and the establishment of safety nets, to strengthen the actions of both the Indigenous community and governments. The safety nets are needed to surround the enabling framework whilst supporting the structural and process elements, consolidating both the Board governance and systems functionality. There is also a need for an additional level of support for the enabling framework; similar to scaffolding that acts not only as a safety net, but also an early warning system that identifies or amplifies, assesses and initiates action to prevent policy failure and greater community disintegration and dysfunction. Scaffolds can be erected

internally and/or externally to the organisation, with different designs related to context, with safety standards developed and monitored that control for hazards and to reduce failures.

Another mechanism for reducing hazards and failures prior to the implementation of an “enabling framework” should be the development of health impact statements, similar to those undertaken prior to major developments in the building, engineering and mining sectors. The New South Wales Department of Health (2003), developed an Aboriginal Health Impact Statement that ensured that when new initiatives are being considered the following principles are acknowledged: whole-of-life view of health; a practical exercise in self-determination; working in partnerships; cultural understanding; with recognition of trauma and loss. The Impact Statement documented the purpose and need of the proposed action, identified the affected people and environment, and offered a range of alternatives to the proposed action, with an analysis of the impacts. Using such instruments with involvement of the affected people and community prior to the action recognised the status of the people and their contribution to addressing the need or purpose, ameliorating the collaboration between the Indigenous people, governments and stakeholders.

This research also uncovered a number of risks and barriers to the THAC achieving community control. The risks and barriers included: the conflicting agendas and priorities between THAC members and community members; the lack of human and physical resources to actively contribute to and take sustained leadership roles; the lack of transport and logistics to plan effectively and consult broadly and involve community members; the lack of effective partnerships with internal and external stakeholders, and the advocacy and leadership roles of the THAC not translating into outcomes.

There are risks also associated in moving towards a new leadership for the THAC and the future health Board. Achieving the “right” balance between traditional ways and culture verses new governance requirements will be critical. Addressing the number of key structural barriers to achieving a “new” governance will be challenging for not only the Tiwi leaders but also for government or funders. Appropriate funding is needed to provide access to basic resources and infrastructure, so there is not a reliance on the “too few”, as is the development of processes to address the conflicting community values and agendas.

But why has the building of capacity not been sustained and systems resilient? Unfortunately many of the identified strategies have not been adequately resourced and sustained in the long-term by governments. Frequently, the leadership and participation is dependent on too few people, all of whom already have many jobs and roles, who themselves are exhausted and ill. Examples have also been described where capacity building and enabling processes have been used for the benefit or advantage of others, and not necessarily the benefit of the Tiwi people. Strategies that are not based on the short and long-term requirements of the Tiwi people need to be questioned and revised and subject to an Indigenous Health Impact Statement.

Is there a Common Framework for Community Control?

An initial objective of this research was to identify whether a common framework of community control existed or was developed throughout the research process. With the shift from the CAR to the cultural anthropological and organisational analysis methodology, the focus of the research became the understanding of the unique motivations and behaviours of the THAC, where the concept of generalisability is not a desired research outcome.

The “enabling framework” is a concept and model that has been developed and used for disadvantaged or oppressed groups worldwide and one that has been proven to achieve outcomes. The NTAHF has invested significant time and energies into the development of the “enabling framework for Aboriginal community control” and this framework was used with the THAC to provide a template for working with them, using culturally appropriate and considered structures and processes. The framework has not been advanced sufficiently with the THAC to undertake an evaluation or make considered recommendations on its applicability to the Tiwi context. Nor did the research test this framework with other Aboriginal community controlled health services, again for generalisability, applicability or risks.

Reflecting on the lack of capacity within the THAC and government sector, recommendations have been advanced to strengthen the framework, to initiate Aboriginal Health Impact Statements, prior to commencing an intervention or course of action, and the development of additional supportive scaffolding for the framework along with safety nets at critical times and places throughout the intervention.

Summary and Conclusion

The research required a flexible approach that would allow for the emergence of community control for the THAC, and for me to maintain my stated research values of Spirit and Integrity, Respect, Equality, Responsibility, Survival and Protection and Reciprocity (refer Appendix C: Personal Statement of Research Values). The research methods changed from the CAR to a cultural and social anthropological and organisational analysis investigation of the motivations and behaviours of the THAC and why the move towards community control was successful or a failure.

The research identified that the THAC has the capacity to move towards community control based on their traditional and contemporary culture, with several successful programs and projects currently underway. These cultural elements will need to be built on to ensure strong Tiwi leadership, governance, organisations and systems. To work and to be sustainable, the solutions will need to be developed on the ground and driven by the communities that own them. Relationships with governments and key stakeholders will need to be enhanced through relationship building and cultural mediation.

The THAC and the future health Board will have access to the “enabling framework” for community control. The framework will need to be supported with adequate resources to address the entrenched inequality and disadvantage, but also appropriate risk management strategies need to be developed that may include a Tiwi Health Impact Statement and associated safety nets. The journey for both the Tiwi people and their collaborators will be challenging and long. There will be two roads travelled, coming together in one “Yoy” (dance), and living same journey.

Chapter Six: Conclusion

Introduction

This research was undertaken to assist in addressing a significant health, political and human rights issue and one that a developed country, Australia with an Indigenous population of less than 2.5% should be able to address; a country and legislature that has the capacity and hopefully willingness to reverse the entrenched inequality and disadvantage of the Tiwi population and all Indigenous people. The “wicked problem” to be solved?

The research also challenged the notion that, “*desperate times, call for desperate measures*”; that when you're in a serious and intractable situation, you have to consider doing things that you might otherwise think are unacceptable, but are then undertaken at the risk of creating greater inequality and dysfunction with poorer outcomes. Desperate times do call for desperate measures, but these measures should be considered, discussed and implemented with the involvement of those affected: the ATSI peoples.

This Chapter highlights the number of key research issues: researching with Indigenous people; defining community control, community and community participation; creating a Tiwi road to community control; working with governments to achieve self determination; and finally the role of the researcher. A number of recommendations emerging from the research are also provided.

Research in the Indigenous Context

This research has built on a number of Australian government agency and university frameworks and guidelines for undertaking research with Indigenous peoples and more importantly, the impact that the research has on Indigenous people. There has been a history and legacy of projects, only meeting the needs of the researcher or organisation, without established protocols and outcomes that benefited the Indigenous people, the “subjects” of the research. This research has highlighted the need to undertake research “*with*” Indigenous people, to identify and develop the research questions with Indigenous people; to acknowledge the traditional knowledge systems and cultures whilst undertaking the research in collaboration with Indigenous people. Issues of traditional knowledge and the ownership of the intellectual property and the research findings also must be explored and managed.

I also “experienced” the foci of this research change from a prescriptive CAR methodology on community control, to an understanding of the motivations and behaviours underpinning the aspirations of the Tiwi people to move towards to an Aboriginal community controlled health Board. Adaptive and flexible research epistemologies and methodologies were required to meet both the needs of the Tiwi people and the dynamic context in which the project was undertaken, yet with a rigorous approach to data collection and analysis. Detailed notes of meetings, interviews and group discussions, observations of interactions and the accessing of reports, projects and newspaper articles undertaken on the Tiwi Islands were made over a two year period and cross referenced against a number of emergent key

themes. The cultural anthropological and organisational analysis approaches emphasised cultural relativity and the use of findings to frame cultural critiques.

Defining Community Control

There remains within the Aboriginal community controlled health sector an emphasis on the rhetoric and political ideology verses the pragmatic reality when defining community control. The definitions of community control and what is meant by an Aboriginal community controlled health service remain ephemeral and have very different meanings for different people: for Indigenous people themselves seeking self-determination; for governments, bureaucrats and public servants who are seeking to achieve political and administrative outcomes; and the health providers who are trying to achieve improved outcomes with little or few resources within exceedingly challenging environments.

Whilst developing definitions of community control and Indigenous governance, community and community participation, an agreed nomenclature and classification of Indigenous communities based on a set of characteristics that underpin systems and organisational sustainability and resilience remains lacking. This is work still to be done.

Two key questions remain unanswered by this research: what is community control for Indigenous communities or organisations when the conditions and funding of the partnership are dictated by external agencies and what choice do Indigenous communities or organisations have in determining how their governance model is to be implemented?

Creating a Tiwi Road to Community Control

The journey for both the Tiwi people and their partners will be challenging and long. There will be two roads travelled: one by the Tiwi people through the expression of their knowledge systems and culture; and a second road travelled by governments, administrators, bureaucrats and the service providers. There is a need for the two entities to come together at key intersections or junctions in the journey and to work for the benefit of the Tiwi people, creating a Tiwi road to community control. As stated in the Tiwi Health Missions (2007), *“To make this happen we all need to Yoyi (dance) to the same goals”*.

The development of the Tiwi road will also need to use the lay knowledge of the Tiwi people, so that the values and experiences of the Tiwi people are built into the governance systems, the business rules, and the health policies and procedures to create a sustainable and resilient organisation and service. The use of local or lay knowledge is one way of connecting and further valuing the contribution of the Tiwi people. If lay knowledge is not used, this may further reinforce the health inequalities and individual and community dysfunction. This research has not revealed any evidence that suggests the emergence of a Tiwi Road, a road that was so important for the members of the KWHB (2003).

The research supported the development and implementation of an “enabling framework”, a systematic yet responsive approach and methodology in creating the Tiwi road to community control. The results corroborated the Department of Health and Community Services (2006), “A Framework for Development of Aboriginal Community Controlled Health and Community Services”. This enabling framework is supported by the development of strategies and actions involving Indigenous governance, leadership, and capacity building and mentoring.

The research also found that the Tiwi culture and people possess the knowledge and skills to achieve community control. The findings also identified that all future actions by those involved, need to assist in creating and supporting the appropriate motivations and behaviours of a larger group within the Tiwi community and to provide contemporary Indigenous leadership and guidance.

Role of Governments

A key research finding was an understanding of the power relationships and dynamics within governments, “*governmentality*” and the resultant impact on the Tiwi people. The functional and self-perpetuating behaviours of bureaucrats have already been alluded to: behaviours that create within governments, the ambivalence to take risks, and the hesitancy to act in both the short and long term to make a lasting impact. Whilst embedded within this climate of implementing ill considered and often misguided policies and strategies, and by ignoring the risks and playing “political upmanship”, the major losers will continue to be the Tiwi and Indigenous people through disengagement, resistance, confusion, apathy, exhaustion, fatigue and stress with the potential for greater community dysfunction and social breakdown.

A clearly defined role and action for governments is to develop and enact mutual Indigenous governance capacities and competencies and the development of shared and reciprocated learning strategies that bridge the cultural divide between Indigenous people and western administrative systems. There is also an opportunity for governments to become, themselves, “learning organisations” and to avoid the blame and shame ethos that has prevailed due to this cultural divide.

Inherent within the findings is the proposal for the development of an independent cultural mentor/mediator role or advocate; a trusted individual, work unit or organisation that can oversee the development of government policies and strategies between Indigenous people and governments and who has authority to challenge breaches of human rights and inappropriate policies. This would build on the work already commenced in the NSW Government with the introduction of Aboriginal Health Impact Statement when Indigenous issues and policies are being considered.

The final plea for governments, agencies, bureaucrats, health providers and any individual wishing to undertake an “intervention” to improve the health outcomes for Indigenous people is to consider the principle, “*Primum non nocere*”, above all else, do no harm.

Role of the Researcher

The research became a deep reflection and contemplation of how I responded to Tiwi culture and people where life, dreaming and land concepts are so very different from my own experience. The data collection and analysis became a journey of discovery of my responses around cultural awareness, behaviours, competency, safety and security. My journey of discovering cultural security was reliant on me, not the Tiwi people. It was how I choose to “enter and engage” in the “*Yoyi*” (dance), my motivations and behaviours.

I identified strongly with the words of Goodale (Hart, *et al.*, 1988, p 103) when she stated, “... *I also found it extremely difficult, but also very rewarding to play a dual role of both listener and adviser (when asked) in the various debates and discussions ...*”, affecting the Tiwi

people and the future of the THB. I had concerns about my inability to complete the Research Agreement with the THAC and to work more closely with the Tiwi people to achieve community control and increased the capacity in the area of research. I hope for some lasting legacy for the Tiwi people from my research. Finally, the research was also about giving voice, in a broader medium to the Tiwi people and the members of the THAC.

Recommendations

This research was unable to answer all questions that emerged and has identified further and supplementary questions. The recommendations following address the future key research agenda with Indigenous people and the outstanding issues from this research.

Recommendation 1

Future research is to be conducted from the Indigenous perspective of self-determination and empowerment, where they are both the researcher and the research subject. Reframing the research to a self-determination and empowerment approach supports the “enabling framework” for Indigenous development with strategies that will eventually assist to close the gap in Indigenous health inequality.

Recommendation 2

The development of agreed definitions of community control, community and community participation and Aboriginal Community Controlled Health Services, based on an enabling framework for organisation and system sustainability and resilience, for the Indigenous governance sector. Clarity of definition will assist Indigenous people, governments and stakeholders commence from an agreed understanding and starting point for policy development and implementation.

Recommendation 3

A strategy that develops governments’ capacities and competencies in response to the plight of Indigenous people’s substandard education, housing and health, unemployment, and limited transport and community resources, to be undertaken. The capacity for governments to understand the issues (the what), their interrelationships and co-dependencies, and how to engage (the how) and make improvements in the Indigenous sector, continues to be lacking.

Recommendation 4

That the future Tiwi Health Board engages with Reconciliation Australia for the facilitation of their “*Sharing Success Workshop: Good Governance means Good Business*”, along with the appointment of the project officer to assist initiate the enabling framework. The development of partnerships, both locally with AMSANT and nationally with Reconciliation Australia should assist in developing sustainable and resilience organisations and processes, and embed local Tiwi leadership.

Postscript

As previously stated, this is a “work-in-progress”. I have already referred to the release by the Commonwealth of the, “Northern Territory Emergency Response: Report of the NTER Review Board” (Commonwealth Government, 2008b), on the 14 October 2008. The Minister for Indigenous Affairs, Jenny Macklin in late October 2008, has decided to continue with income management and retain the suspension of the *Racial Discrimination Act* for a further 12 months despite the contrary recommendation of the NTER Review Board (*ibid*). The context within which this research was undertaken thus remains very dynamic, complex and controversial.

In late October also, the Centre for Aboriginal Economic Policy Research launched, “Contested Governance: Culture, power and institutions in Indigenous Australia”, (Hunt, *et al.*, 2008). Hunt, *et al.*, (2008, p 21) reaffirmed the contested space of Indigenous governance that includes: networked governance models; nodal networks and gendered realms of leadership; governance systems arising out of locally dispersed regionalism and “bottom-up” federalism; subsidiarily and mutual responsibility as the basis for clarification and distribution of roles, powers and decision making across social groups and networks; cultural geographies of governance; and an emphasis on internal relationships and shared connections as the foundation for determining the “self” in self-governance, group membership and representation. Contested governance, undeniable!

One final document, just accessed was the study of the, “The State of the Native Nations: Conditions under U.S. Policies of Self-Determination” (The Harvard Project on American Indian Economic Development, 2008, p 219). The report states:

By taking over the administration of health-care delivery systems from the IHS (Indian Health Service) through contracting and compacting, Native nations have been able to reduce regulation, increase financial flexibility, and redesign service offerings to create effective, quality appropriate health-care programs.

This U.S. example reinforced the gains that can be achieved when Indigenous people are supported by federal legislation through self-determination, consistently over decades and involved and engaged in processes that are meaningful for them.

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APPENDICES

- Appendix A: Aboriginal Community Controlled “Enabling Framework”, (Pathway to Community Control)**
- Appendix B: Commonwealth Laws Impacting on Indigenous People**
- Appendix C: Personal Statement of Research Values**
- Appendix D: Research Agreement**
- Appendix E: Project Plan and Timeframe**
- Appendix F: Information Sheet**
- Appendix G: Consent Form**
- Appendix H: Data Analysis Template and Example**
- Appendix I: Standard letter to Politicians and Government Agencies**
- Appendix J: Project Officer, Job Description**
- Appendix K: Project Officer, Expression of Interest**

Appendix A: Aboriginal Community Controlled “Enabling Framework” (Pathway to Community Control)

PHASES	DEVELOPMENT STAGE	DEVELOPMENT CHARACTERISTICS	PLANNED TIMEFRAME
	3.2 Regional Community Control	<ul style="list-style-type: none"> Services developed further to cover regional area and a number of communities. 	To be determined by the THB
	3.1 Full Community Control	<ul style="list-style-type: none"> Health Service Committee manages all PHC services and becomes an ACCHS. 	To be determined by the THB
3. INDEPENDENT			
	2.2 Partial Community Control	<ul style="list-style-type: none"> IMCs attained. Implementation of specific program contract. Pooled DoHA and DHCS funds to contract out PHC services to DHCS or existing ACCHS. 	November 2008
	2.1 Developmental	<ul style="list-style-type: none"> Committee part of the NT Aboriginal Health Forum to undertake transition to CC. Health Plan developed with indicators of management capacity (IMCs). Investment of new health funds under auspicing agreement. 	October 2008
2. CONSOLIDATION			
	1.2 Committee Formation	<ul style="list-style-type: none"> Committee developed with funding to provide for meeting costs, governance training and the employment of a facilitator. 	January 2008
	1.1 Information Sharing	<ul style="list-style-type: none"> Information sharing about services provided 	September 2003 to December 2007
1. ENGAGEMENT			
	No Engagement	<ul style="list-style-type: none"> Little information sharing Uncoordinated service provision Service duplication and gaps exist 	

Appendix B: Commonwealth Laws Impacting on Indigenous People

The following is a detailed list of the Commonwealth laws impacting mostly on Indigenous people and include (<http://www.austlii.edu.au/>, visited 30 September 2007):

- *Racial Discrimination Act 1975 (Cwth)*, gave effect to Australia's obligations under the International Convention on the Elimination of All Forms of Racial Discrimination (CERD) and is administered by the Human Rights and Equal Opportunity Commission (HREOC). This Act defined racial discrimination as less-favourable treatment based on race, which is unlawful, but allows for special measures, which are distinctions made for affirmative action;
- *Family Law Act 1975 (Cwth)*, section 60CC, statutory provision guided the court's determination of what is in the best interest of a child. Sub sections 60CC(3)(h) and 60CC(6), which replaced the old 68F(2)(f) and gave weight to the need for an Indigenous child to live in an Indigenous community;
- *Aboriginal Land Rights (Northern Territory) Act 1976 (Cwth)*, the first statute to recognise Aboriginal systems of land ownership, it resulted from the Woodward Inquiry's report on Aboriginal land rights. This Act provided for land grants as inalienable freehold, also established Aboriginal Land Councils and procedures for negotiating mining agreements;
- *Aboriginal Councils and Associations Act 1976 (Cwth)*, provided for establishment of Indigenous councils and incorporation of Aboriginal associations, and was repealed by Act No. 125 of 2006 on 1 July 2007;
- *Aboriginal and Torres Strait Islander (Queensland Reserves and Communities Self Management) Act 1978. (Cwth)*, established Councils with responsibility to their communities for governance and service provision in Aboriginal and Islander reserves and communities;
- *Aboriginal and Torres Strait Islander Heritage Protection Act 1984 (Cwth)*, was the first Act of its type since the Commonwealth was powered to legislate for Aboriginal people in 1967. This Act was intended to be used only where State or Territory laws did not adequately protect Aboriginal objects and sites;
- *Human Rights and Equal Opportunity Commission Act 1986 (Cwth)*, established the Commission (HREOC) to make determinations on complaints of discrimination, including the *Racial Discrimination Act 1975 (Cwth)*;
- *Australia Act 1986 (Cwth)*, removed British power to legislate for Australia and removed Privy Council as last court of appeal for Australia;
- *Aboriginal and Torres Strait Islander Commission Act 1989 (Cwth)*, established the Aboriginal and Torres Strait Islander Commission (ATSIC) as an elected Indigenous body responsible for Indigenous programs, services and input to government policy decisions;
- *Council for Aboriginal Reconciliation Act 1991 (Cwth)*, established the Council for Aboriginal Reconciliation (CAR) to promote formal reconciliation. The CAR ceased in 2001;
- *Native Title Act 1993 (Cwth)*, this major reform was the Keating government's response to the decisions of the High Court in *Mabo (No 2)*. It contained a scheme for obtaining a determination from the Federal Court as to whether native title exists

in relation to a defined area and an arbitration mechanism for processing development applications in relation to land which is the subject of a native title claim;

- *Native Title Amendment Act 1998 (Cwth)*, the Howard government released its 10 Point Plan in response to concerns that Wik would mean that Indigenous rights were too much in favour at common law, and it was enacted in this amendment. It included harder registration tests, less right to negotiate, easier approval for mines, easier extinguishment, increased power to states and territories and makes determination process more legalistic with new provisions for Indigenous Land Use Agreements;
- *Human Rights (Mandatory Sentencing of Juvenile Offenders) Bill 1999 (Cwth)*, this Bill was introduced by Sen. Bob Brown to override the mandatory sentencing laws in WA and NT. This led to a Senate Inquiry into mandatory sentencing and national and international attention being focussed upon the issue;
- *Aboriginal and Torres Strait Islander Commissions Amendment Act 2005 (Cwth)*, abolished the elected Indigenous representative body, the Aboriginal and Torres Strait Islander Commission (ATSIC), with services for Indigenous Australian now to be mainstreamed;
- *Aboriginal and Torres Strait Islander Act 2005 (Cwth)* after ATSIC was abolished, the old ATSIC Act 1989 was renamed, and provided for establishment of Indigenous Land Corporations (ILC) Torres Strait Regional Authority (TSRA) and Indigenous Business Australia (IBA); and
- *Aboriginal Land Rights (Northern Territory) Amendment Act 2006 (Cwth)*, this amendment made for easier and simpler processes for mining on Aboriginal land. It facilitated the leasing of Aboriginal land and the mortgaging of leases, and made provisions for long term 99-year leases over townships on Aboriginal land. It removed guaranteed funding for land councils, in order to improve accountability.

Appendix C: Personal Statement of Research Values

Throughout this research I will reflect on my responsibilities for the conduct of the project with the Tiwi people. I acknowledge the “rights” of the Tiwi people to participate or withdraw from the research, to address local health priorities, to negotiate a different focus for the research, to seek assurances of trust in me and to seek external advice at any time. I will also challenge taken-for-granted concepts and theoretical relationships of community control by asking how these relate to lay knowledge and researching with Indigenous people. This is what community control is about!

Central to undertaking this research with the Tiwi people is recognition of the values of ***Spirit and Integrity***: connectedness to the past, current and future generations and a connectedness to the land, skies, waterways and paths that bring everyone together, including non-Indigenous people. I have a responsibility to maintain these connections in all dealings with the Tiwi people as this embodies the values of integrity.

Respect: I will respect the dignity of the Tiwi cultures and in doing so build community strength and capacity. I view respect as about the recognition of diversity and how this strengthens relationships with the land and culture and also across cultures.

Equality: I will value equally all people who are involved in the research processes, as well as recognising differences.

Responsibility: The Tiwi people have obligations that include; country, kinship, caring for others and the maintenance of cultural and spiritual awareness. I will acknowledge and respect these obligations throughout the research and negotiate activities and methods to accommodate the needs of the Tiwi people.

Survival and Protection: I will protect Tiwi knowledge to enable the survival of the Tiwi culture throughout the research processes.

Reciprocity: using “both ways” philosophy and approach, I will share research knowledge and skills for mutual gain. The reciprocity will extend to culture and the environment to strengthen community.

Appendix D: Research Agreement

RESEARCH AGREEMENT²

between the Tiwi Health Service and Greg Rickard – Principal Investigator

TITLE: “Learning the Tiwi way to community control: what is community control for the Tiwi people and how do they wish to implement community control?”

The Tiwi Health Service (THS) agrees to conduct the research project as discussed with the following understanding:

1. PROJECT DESCRIPTION

The THS and the Department of Health and Community Services (the Department) have the long-term goal to re-establish community control to assist improve the health outcomes for the Tiwi people.

The aim of this research, using a Collaborative Action Research (CAR) approach is to work with, and learn from the Tiwi people by exploring their understanding of and defining what is meant by community control and how self-governance can be developed. It will also facilitate community decision-making for the governance of health services; what health and support services the THS will provide and how organisational support functions (finance, human resources, information technology, quality improvement and capital works) will be resourced. It is hoped that through understanding the factors that influence community control including the implementation issues and risks, improved health outcomes for the Tiwi people will be achieved.

The research also plans to identify a framework for community control that could be applied to other Aboriginal Community Controlled Health Services (ACCHS) to assist with long-term sustainable implementation and risk management. How this framework can be used with other community controlled organisations will be agreed with the THS, prior to use.

2. PROJECT SCOPE

This section details the key research questions, activities, participation by community residents and knowledge ownership (Intellectual Property).

Key Research Questions: the key research questions to be asked of the Tiwi Health Advisory Committee (THAC) and the Tiwi people are:

- What is community control for the Tiwi people?
- How community control would be implemented?
- What are the pathways (building blocks) to community control for the Tiwi health service? and
- What are the community control implementation issues and risks?

² This Research Agreement is based on a sample Agreement as proposed by the World Health Organisation (WHO) www.treatycouncil.org/about11.htm and recommended in the National Health and Medical Research Council (2005) *Keeping research on track: A guide for Aboriginal and Torres Strait Islander peoples about health research ethics*, Australian Government, Canberra.

The intended beneficiaries of this project are the THS and the Tiwi people. From these questions, it is planned that a comprehensive and generic community control pathway or framework can be identified and developed that can inform other ACCHS.

Research activities: the research will involve the THAC and Tiwi people in a range of data collection and validation activities - case studies, community consultations, in depth interviews and focus groups.

Community participation:

The research participants (community representatives) will be nominated by the THAC and will be acknowledged in the research findings. Information Sheets and Consent Forms will be provided by the Principal Investigator (PI) and used for all research activities, with the Health Service Development Officers (HSDO) providing interpretation and cultural liaison, as required. The anticipated duration of the research is from March 2007 to November 2008.

Knowledge ownership: Intellectual Property rights and the ownership of specific research products (proposed action and reports) will be developed with the THAC. The members of the THAC who contribute to the CAR and validation processes will be joint authors of all future papers and products of the research.

Three types of knowledge for ownership and disseminated are proposed for agreement by the THAC:

1. knowledge developed or owned by the Tiwi people;
2. knowledge developed or owned jointly by the Tiwi people and the PI; and
3. knowledge developed or owned by the PI.

3. RESEARCH METHODS

The Research Methods justifies the proposed activities and the number and purpose of interviews. Methods to be used, as agreed by PI and THAC, are:

1. Community (case) Study. The community study will involve a document review – an analysis of selected Tiwi Health planning documents – strategic and annual business plans, Annual Reports, meeting papers, policy documents, organisation structure, health status and service data, resource documents, reports and reviews. The documents reviewed will be identified and provided by the THS.
2. Community Consultations. Community consultations will focus on the Tiwi people's understanding and need for community control and how this may be translated into action based on their previous experience of having community control and why things went wrong. Tiwi people from each of the three major communities will be invited to attend consultation processes co-facilitated by THAC members and the PR.
3. In depth Interviews. Past and current employees of the THS will be interviewed as identified by the THAC and the THS. Once the initial data collection processes are underway, the THAC will identify additional Tiwi people, other key informants and ACCHS to be interviewed.
4. Focus Groups. Focus groups comprising Tiwi people with experiences of community control or having an interest in developing community control will be engaged as part of the data collection processes. The focus group will seek to obtain ideas and thoughts about the specific research objectives.

4. SKILL TRANSFER OPPORTUNITIES

Opportunities will be made available to THAC members and the HSDO with respect to training – research activities and project management. The HSDO will assist in the research as part of their employment with the THS and as members of the THAC.

The development of this project is based on communication between THAC members and PI. All efforts will be made to incorporate and address local concerns and recommendations at each step of the project. Identified community representatives and THS will be kept informed on progress and maintain communication links through email, fax or phone. At the end of the study, the researchers will participate in Tiwi community meetings to discuss the results.

5. DATA COLLECTION, CONFIDENTIALTY and CONSENT

Data collection will not identify individual community members, as the focus of the data collection is the processes and dynamics of community control. Anonymity and confidentiality will be maintained. The interviews will remain confidential and no names will be attached to records. A four digit code will be used to refer to individual participants.

Consent will be gained for participation in the research activities (signed and witnessed) with the inclusion of the interpreter, if used. Any documentation of written consent will be destroyed after the interviewers, PI or other supervisory levels have reviewed the results. Any lists containing household numbers or names will be kept in an agreed secure location by the research team during the project. These lists will be destroyed after all interviews are completed.

Consent by THAC or community members can be withdrawn at any time, including due to death. Research queries will be referred to the research supervisor.

The THAC will audit the consent procedures every three months to ensure compliance. Failure to comply with the consent procedures will be documented in the THAC minutes, with remedial action undertaken immediately.

6. INFORMATION SHARING AND STORAGE

Information collected will be shared, distributed, and stored in the following ways during the research:

- during the project, hard copies of the interviews and electronic data will be stored on the PR's personal laptop computer, that is password accessible. After each field trip and meeting with the THAC and/or Learning Group, data will be backed up onto a separate and secure file (external disc drive). This file will be kept in a lockable filing cabinet, in locked premises;
- the Primary Supervisor will also have access to the data and information stored on the PI external disc drive, in case of something happening to the PI.
- after the research is completed, all data will be kept for 5 years post publication. Formal archiving (for example: Menzies School for Health Research, Charles Darwin University, NT Archives) will be identified;
- a copy of the database in (state software) on CD will be provided to the community with instructions on retrieval and queries. A data set will remain in the possession of the PI; and
- any future use of the data requires the negotiation of a new Research Agreement.

Access to the data

- the PI will have access to the data from March 2007 to December 2008 and for 5 years post publication; and
- members of the THAC will have access to the data from March 2007 to December 2008 and for 5 years post publication.

Restriction on use of the data

The PI is restricted to using the data as outlined and agreed in the Research Agreement. This includes cultural information that is secret, restricted or otherwise confidential in the public domain. Any use of data and information beyond the immediate research must be approved by the THAC.

Assistance on use of the data

The PI will be available during and after the study to answer questions and assist THAC members in understanding, interpretation, and use of the data if the community decides to use the results for other purposes.

Dissemination of findings

A final report will be distributed after approval from the THAC. Before distribution of the final report, any publication of findings, or contact with the media, community agreement will be sought and obtained.

7. PROJECT PROGRESS

The PI will keep the THAC and all identified community members informed of the status of this project through a regular monthly update at the THAC or that will be faxed, emailed or mailed according to local preferences.

A final report containing the results of the research activity will be provided to the community by December 2008.

8. CONTACT WITH OTHER PARTIES

Prior consent from the THAC will be obtained before any information is released or communication with the media, funding agencies, and any other parties beyond those named in this Research Agreement.

9. STOPPING THE RESEARCH

The research will be stopped under the following conditions:

- community leaders decide to withdraw participation; or
- the research partners find, at any stage, that the project cannot provide the expected benefits to the community.

10. FUNDING, BENEFITS AND COMMITMENTS

1. Funding

The Remote Health Branch of the Department supports the research with all costs incurred by the PI or as part of the normal work of the THAC.

The PI has NOT acquired funding or any other forms of support for this research.

2. Benefits to both parties

a) Benefits to PI:

- the Final Report of the research will be used as a thesis for a Doctorate in Public Health;
- a final report will be presented to the THAC and Remote Health Branch by December 2008;
- scientific articles in peer-reviewed journals, conference presentations, and other types of publication will be made on the basis of these findings and include the THAC and HSDO as co-authors; and
- the final report will be reviewed by community members prior to any form of publication. Scientific articles and presentations will be published after discussion with identified community leaders.

b) Benefits to the Tiwi community:

- short-term:
 - defined pathway to community control for the THAC;
 - development of Tiwi knowledge about community control and self-determination;
 - education about community control;
 - development of governance and administrative decision making;
 - development of capacity building and research skills for the THAC and HSDO; and
 - co-authors of thesis and scientific papers.
- long-term:
 - health gains for the Tiwi community.

3. Commitments

a) agreed responsibilities of the THAC and HSDO. These include:

- facilitation and promotion of the research project;
- remaining well-informed about research progress;
- informing and gaining the cooperation of the community, including community organizations affected by the research;
- recruiting/recommending community members who will participate as researchers;
- ensuring agreed strategies for recruiting participants (convenience/non-random sampling); and
- leading the research project towards meaningful results.

b) agreed responsibilities of the PR include:

- incorporation of THAC and Tiwi input, knowledge and recommendations;
- fostering and maintaining the current and future research relationship;
- carrying out the research in a culturally acceptable and ethical manner;
- informing the THAC about the research in a clear, specific and timely manner;
- acting as a resource to the THAC for health related questions arising from the research; and
- providing funding as agreed.

Signed by:
(on behalf of the PI)

.....

Position: Principal Investigator

Date:

Signed by:
(on behalf of the community)

.....

Position: Director, Remote Health, Department
of Health and Community Services

Date:

Appendix E: Project Plan and Timeframe

Project Plan and Timetable

Phases	Activities	Outcomes	Timeframes
Phase 1	Project Initiation	Negotiate entry to and the Research Agreement with the THS.	August – December 2006
Phase 2	Aims and Objectives	Define problem statement with key aims and objectives identified and described.	August – December 2006
Phase 3	Project Plan	Project Plan developed and accepted by the THS and MSHR Human Ethics Research Committee.	August – December 2006
Phase 4	Literature Review	Literature Review undertaken and for updating throughout the research.	February 2007
Phase 5	Data Collection	Data Collection undertaken.	March 2007 – June 2008
Phase 6	Data Analysis	Data Analysis undertaken concurrently with the Data Collection using CAR. Findings validated.	March 2007 – June 2008
Phase 7	Meta-analysis	Generic framework of community control developed and validated.	February – June 2008
Phase 8	Report Writing	Thesis submitted.	July – November 2008

Phase 1: Project Initiation

The Project Initiation phase was finalised with the completion of a Research Agreement (NHMRC, 2005, p13) with the THS and the research ethics application, identifying the phases of the research and the roles and responsibilities of all participants in the CAR. The THAC guided the project and involved them as co-researchers and key informants. It is anticipated that all research activities will include the THAC.

Outcome

Negotiated entry to the THAC and completion of the Research Agreement with the THS and THAC.

Phase 2: Aims and Objectives

The research aims and objectives resulted from an Organisational Analysis of the THB (Rickard, 2006 unpublished) and were further developed and refined through consultation and feedback with the THAC and with faculty from the Public Health School, Flinders University.

Outcome Problem statement, key aims and objectives identified and described.

Phase 3: Project Plan

The Project Plan was finalised with input from the project collaborators – the THAC, Director of Remote Health and Manager, THS. The Project Plan scheduled all research activities: Literature Review, Data Collection, Data Analysis, Meta-analysis and Final Report.

The Project Plan and Timetable scheduled the research over a two year period. The Project Plan will be monitored and revised according to community need and changing organisational issues. Any changes to the Project Plan will be documented and justified.

The application to the Human Research Ethics Committee of the DHCS and Menzies School of Health Research, in April 2007 completed the Project Plan.

Outcome Project Plan and Timetable developed and supported by the THS and accepted by the Ethics Committee.

Phase 4: Literature Review

The literature review supporting the research context and methodologies explored:

- definitions and meanings of Aboriginal Community Control Health Services;
- best practice in Primary Health Care; and
- lay knowledge.

Each area was researched over the breadth of the literature, nationally and internationally. An initial review of the literature was undertaken for Research Proposal, and will be updated throughout the research and finalised prior to submitting the thesis.

Outcome Literature Review developed and updating throughout the research period.

Phase 5: Data Collection

The methodology used a qualitative approach to gain an understanding of the issues impacting on the THAC and to plan for a sustainable community controlled health service using CAR. The CAR will progressively identify the key problem or tasks and through iterative steps and developed a future vision and actions to improve health outcomes of the Tiwi people. Data collection will occur progressively throughout the CAR cycle and involve the following major methods:

- Participant Observation: documenting the issues discussed and raised during the THAC meetings with observation of behaviours. The THAC became the primary informants of the research;

- THS Case Study: reviewing selected THS documents and literature, identified and provided by the THS and THAC;
- Community Consultations: focussing on the Tiwi people's understanding and need for community control and how this was translated into action, based on their previous experience of having community control and why things went wrong. Tiwi people from the three communities were invited to attend consultation processes co-facilitated by the THAC members and the researcher;
- In depth Interviews: past and current employees of the DHCS Remote Health Management, THS and THAC were interviewed as identified by the THAC and THS. Once the initial data collection processes are underway, the THAC will identify additional Tiwi people, other key informants and ACCHS to be interviewed; and
- Focus Groups: comprising Tiwi people with experiences of community control or having an interest in developing community control were engaged. The focus group will seek to obtain ideas and thoughts about the specific project objectives.

Data was reviewed and validated with the THAC.

Outcome Data Collection completed according to timeframe.

Phase 6: Data Analysis

The interpretation of data and identification of findings occurred concurrently with the data collection (Phase 5). The analysis of data involved what Holliday (2007, p 90) calls "*developing a sense of argument*":

- the analysis of the raw data collected through observation and minute taking of the THAC, discussions with the Advisory Group, document review and interviews with identified key informants;
- asking questions of the raw data (what is this about?) and searching for natural clusters or divisions;
- the creation of themes and headings (labels) that suit each cluster or division. The raw material was again interrogated and coded using these labels, for internal consistency and rigor, this being an iterative process; and
- using the confirmed themes as headings, where arguments to support the findings are extracted from the coded, raw data.

The data analysis sought to uncover the lived experience, or "lessons learned" by the Tiwi people. The lessons were both predictable and unexpected. The analysis captured these lessons and assessed their impact on the current and future organisational and community structures and processes. The analysis also reflected on the changing research context occurring within the communities.

Outcome Data Analysis undertaken based on the findings with analysis validated.

Phase 7: Meta-analysis

Once the data collection and analysis (Phases 5 and 6) were completed, findings were compared with the findings of the in depth interviews with the urban, regional, rural and remote ACCHS to identify a common framework of community control. The NTAHF "enabling framework" was used as the

source document for the confirmation of the “common framework”. The framework identified the range of variables that impact on ACCHS; strengths and weakness, opportunities and threats.

Outcome Generic framework of community control developed.

Phase 8: Report Writing

The final phase involved the documentation of all stages in the research that was reviewed by the THAC and Advisory Group.

Outcome Thesis submitted November 2008.

Appendix F: Information Sheet

INFORMATION SHEET

“Learning the Tiwi way to community control: what is community control for the Tiwi people and how do they wish to implement community control?”

What is the research about? The project is about finding out what the Tiwi people want of community control and how self-governance can be undertaken.

How will the Tiwi people benefit from the research? It is planned that this research will assist in improving the health outcomes for the Tiwi people and identify a framework for community control that could be applied to other Aboriginal communities in a sustainable way. Also, it is planned that members of the Tiwi Health Advisory Committee (THAC) and the Tiwi Health Service Development Officers (HSDO) will develop research and project management skills over the time of the project.

How will the Tiwi people be involved? **The Tiwi people will be involved through community meetings and interviews, assisted by the HSDO. Major questions to be asked of the Tiwi people are:**

- What is community control for the Tiwi people?
- How can community control be undertaken?
- What is the pathway to community control for the Tiwi Health Service (THS)?
- What are the community control issues and risks? and
- Is there a framework of community control that could be used by other Aboriginal and Torres Strait Islander communities?

Who has approved the research? THS and the THAC have agreed to this project. The HSDO have agreed to assist me with all the research activities.

How can I find out about the research results? The results of the research will be provided to the Tiwi people. The results may be published in the Tiwi newspaper, project information sheets or other ways as suggested by the THAC. Feedback on the results will also be sought from the Tiwi people. Final reports and any publications will also be made available.

What if I don't want to be involved in the project? You can refuse to answer any or all of the questions and ask the researcher to leave at any time.

How will the information be used? Any information collected will not identify individual members of the Tiwi community and will be stored for up to five years after the research has been completed. The information can only be used with agreement from the THAC. The Manager of THS or the HSDO will answer any questions you may have about this project or will refer you to the research supervisor and ethics secretary, whose contact details are shown below:

RESEARCH SUPERVISOR

Dr Kate Senior
Menzies School of Health Science
8922 8007
kate.senior@menzies.edu.au

ETHICS SECRETARY

Menzies School of Health Research
8922 2722
ethics@menzies.edu.au

Who is doing the research? **My name is Greg Rickard and I am a doctoral student with Menzies School of Health Research. I am a nurse and have worked in health for over 20 years. I can be contacted on:**

- Phone: 8922 7161
- Mobile: 0412 553 949
- Email: greg.rickard@nt.gov.au.

I understand that the participant retains the ownership of Aboriginal knowledge and cultural heritage, and this will be acknowledged in research findings and in the dissemination of the research.

January 2007

Appendix G: Consent Form

CONSENT FORM

“Learning the Tiwi way to community control: what is community control for the Tiwi people and how do they wish to implement community control?”

All of the things listed below about this project have been explained to me by Greg Rickard, the Principal Investigator with help of _____ (interpreter’s name) as interpreter.

- **Purpose of the Project;**
- **Anticipated research outcomes;**
- **Research procedures and methods;**
- **Time for the interview or community consultation; and**
- **Information provided - use, storage, confidentiality, period of time data retained, access to feedback and project progress.**

If I choose to withdraw from the project, all information that I provide will be returned to me with all data removed from the research database by the Principal Investigator.

I know I have the right to withdraw from the project at any time, refuse to answer any or all questions and ask the researcher to leave. The Tiwi Health Service Development Officers (HSDO), or Manager, Tiwi Health Service will answer any questions you may have about this study or will refer them to the research supervisor, Dr Kate Senior of the Menzies School of Health Research. Kate can be contacted on 8922 8007 or by email kate.senior@menzies.edu.au.

I agree to participate in this interview or community consultation.

Signed on _____ (day), of _____ (month), 2007.

Participant’s name _____

PARTICIPANT’S SIGNATURE _____

Witness’s name _____

WITNESS’S SIGNATURE _____

A Health Service Development Officer (HSDO) was an interpreter for this consent process:

Interpreter’s name _____

INTERPRETER’S SIGNATURE _____

“I understand that the ownership of Aboriginal knowledge and cultural heritage is retained by the informant and this will be acknowledged in research findings and in the dissemination of the research”.

Greg Rickard
Principal Investigator
January 2007

Appendix H: Data Collection Template and Example

Developing a sense of argument (Data Analysis)

Holliday, A (2007) *Doing and Writing Qualitative Research, 2nd Ed. Sage Publications, p 90*

The analysis of the raw data has led to the creation of a number of initial themes. The themes are coded as follows:

- Indigenous Governance (**IG**), an alternative descriptor of community control;
- Contextual Issues (**C**), that reflect to “environment” in which IG is occurring – historical, political, etc;
- Culture and governance (**CG**), impact of the Tiwi culture on the development of community control;
- Leadership (**L**) issues, and again the impact of Tiwi principles and values on community control;
- Mentoring and Capacity Building (**MCB**), to develop in individuals and the community itself, sustainable and resilient systems and processes;
- Governance of Governments (**GG**), acknowledging the systems and processes need to be developed to manage relationships with external stakeholder, the most dominant being governments;
- Enabling Framework (**EF**) – how this agreed model can be implemented with the THAC with government endorsement and support; and
- The Principal Investigator (**PI**) – the impact of the research process on the researcher.

Raw Data Interviews, observations, etc	Data Analysis What is this about?	Creation of Themes Label it and define (unpack) Use definitions as codes	Text of data discussion
<p>Developing the Research Proposal</p> <p>17 July 2006, meeting with THAC</p> <p>Engagement with the Tiwi Health Advisory Committee (THAC) formally commenced on the 17 July 2006 where at an initial meeting I presented the concept of the research in response to the Tiwi people and the DHCS desire to progress toward community control (IG) of their health services. I was surprised at this initial meeting when the Advisory Committee agreed</p>	<p>G: Motivation for community control based on an urgency and native approach (aspiration)</p> <p>Context: History of the THB</p>	<p>Indigenous Governance (IG)</p> <ul style="list-style-type: none"> ▪ Community Control – definition from Lit review and emerging definition from research ▪ “Aspiration to reality” – huge gap with between ▪ Motivation for IG, what is behind the aspirations and the shift towards IG? even the very small step ▪ What of IG in health? the 	<p>IG - Aspiration for community control.</p> <p>Need to find a Tiwi metaphor (the first subject can be economically described because implicit and explicit attributes from the second subject are used to enhance the description of the first) for IG – maybe Australian Rules football that is so huge on the Tiwi Islands.</p> <p>The metaphor also needs to</p>

Raw Data Interviews, observations, etc	Data Analysis What is this about?	Creation of Themes Label it and define (unpack) Use definitions as codes	Text of data discussion
<p>immediately (within 5 minutes) of their support and willingness to work with me (IG).</p> <p>Immediate aspiration to progress toward community control of their health services (IG).</p> <p>Detail was not important, how to achieve (IG) CC not discussed. The move to (IG) CC was what was important.</p>		<p>vision/plan, doing (service delivery) and support functions</p> <ul style="list-style-type: none"> ▪ IG is about the “how” governance as the tool: the strategy, the rules, the training, the team work and involvement. <p>Context of community control (Context)</p> <ul style="list-style-type: none"> ▪ THB ▪ Failure, hurt, shame ▪ Distrust ▪ Set up to fail ▪ Lack of support ▪ blame <p>Principal Investigator (PI)</p> <ul style="list-style-type: none"> ▪ role, with an Indigenous group ▪ waiting and allowing ▪ motivation to emerge, desire to build ▪ impact on methodology – mainly observational, THAC discussions, level of participation, advice and meeting outcomes ▪ early stage minimal direction /facilitation 	<p>acknowledge the governance “field” – from forcefield analysis (Lewin) The “field” is very dynamic, changing with time and experience. The “interplay” in governance, seems to be very important.</p>

Raw Data Interviews, observations, etc	Data Analysis What is this about?	Creation of Themes Label it and define (unpack) Use definitions as codes	Text of data discussion
<p><i>22 August 2006, meeting with THAC</i></p> <p>I again visited the Tiwi Islands on the 22 August 2006 with a more complete list of questions that I thought could assist the THAC work towards community control. I presented these questions and after some discussion sought the Advisory Committee's response.</p>	<p>PI issue of engagement and allowing Tiwi processes to unfold. Research methods put on hold.</p>	<p>Principal Investigator (PI) questions mainly about the underpinning assumptions for community control – what is community control, how to implement CC, etc.</p>	<p>PI did not understand the underpinning issues of culture and governance (CG), leadership (L), mentoring and capacity building (MCB), and governance of government (GG)</p>

Appendix I: Standard Letter to Politicians and Government Agencies

12 June 2008

The Hon XXXX XXXXX MP
Minister for
PO Box
Parliament House

Dear Minister XXXXX,

The purpose of this letter is to bring to your attention the aspirations of the Tiwi Health Advisory Committee (THAC) to move towards Community Control of our health services on the Tiwi Islands. The Tiwi Health Board managed the provision of health services from 2000 to September 2003, after the highly successful Tiwi Coordinated Care Trial. Since September 2003, the health services have been jointly managed by the THAC and the Northern Territory, Department Health and Community Services (DHCS).

Over the past 18 months, the THAC has been working with a PhD student from Menzies School of Health Research, to move towards community control. At the December 2007 meeting of the Advisory Committee, it was agreed that a new Future Health Board be established from October 2008. The THAC is using the NT Aboriginal Health Forum's "enabling framework" for the development of Aboriginal Community Controlled Health Services, a framework jointly endorsed by the Commonwealth Department of Health and Ageing (DoHA), the NT DHCS and the Aboriginal Medical Services Alliance, Northern Territory (AMSANT) in 2006.

This "enabling framework" outlines the stages, processes and outcomes to be achieved for Aboriginal Community Control of our health services. These are being explored with risks identified with the Remote Health Branch of the DHCS and the Menzies' researcher. Our next steps are to appoint a Future Board Project Officer and gain the funding necessary for further governance and management training.

The THAC is aware of the need to move forward and engage with the Tiwi youth so as to achieve a sustainable health Board. As a symbol of these aspirations, we are also proposing that a future Board be called the Ngininawula Health Board, the Tiwi translation meaning, "Our Health Board". The THAC members would like to meet with you to progress this important initiative for our people and as a key step to improving the health outcomes for the Tiwi people.

Yours sincerely

Marius Puruntatameri
Chair, Tiwi Health Advisory Committee
cc: Ms XXX XXXX

Appendix J: Project Officer, Job Description



Northern Territory Government

Department of Health
and Community Services

JOB DESCRIPTION

Job Title:	Project Officer
Designation:	To Be Determined
Work Unit:	Tiwi Health Service
Position number:	
Responsible to:	Tiwi Health Manager and the Ngininawula Health Board

Primary Objective

The aim is achieve a sustained Aboriginal Community Controlled Health Board through the planned development of governance and management capacity using the NT Aboriginal Health Forum's (NTAHF) "enabling framework" by the THS and the Project Officer.

Key Responsibilities

- to establish the "Ngininawula Health Board (NHB)";
- to assist develop a Health Plan for the Tiwi Islands through community consultations;
- to access high quality and on-going training and development resources for the members of the TNHB and THS staff;
- to negotiate with the DHCS and DoHA and secure adequate services funds to support the development of the THS;
- to initiate Agreements and networks with AMSANT and other key stakeholders to support community control developments;
- to develop and implement the agreed Indicators of Management Capacity (IMC); and
- to establish a monitoring group on behalf of the NTAHF to oversee and support the THB developments.

Selection Criteria

Essential

1. Experience in a Primary Health Care setting working with Indigenous people and a multidisciplinary team.
2. Demonstrated experience in Project Management and achieving agreed outcomes.
3. Possess well-developed communication & interpersonal skills to allow for effective project outcomes to be achieved with an ability to manage conflict and mediate desired outcomes.
4. Ability to negotiate the pooling of funds from both Commonwealth and Territory Health Departments, to meet the health needs of the Tiwi population.
5. Ability to negotiate with external providers, education and training in governance and management.

6. Develop monitoring systems to assess performance using the agreed Indicators of Management Capacity (IMC).
7. Ability to effectively organise and prioritise own workload with minimal supervision.
8. Demonstrated professionalism and awareness of the issues of confidentiality.

Highly Desirable

1. Previous experience in developing and implementing new health systems.

<i>Additional Information</i>

For additional information, contact Marius Puruntatameri, Chair, Tiwi Health Advisory Committee on (08) 8978 3669 or Miriam Heath, Manager Tiwi Health Service on (08) 8922 8526.

Approved

Director, Remote Health

(Date)

Appendix K: Project Officer, Expression of Interest

Tiwi Health Service and the Department of Health and Community Services

EXPRESSION OF INTEREST

Project Officer: Future Ngininawula Health Board

Expressions of Interest are sought from people with the knowledge and experience to work with the Tiwi Health Service to re-establish the **Ngininawula** Health Board, a Community Controlled Health and Community Service.

Background

The Northern Territory, Aboriginal Health Forum (NTAHF) in 2006 developed an “enabling framework” to assist communities develop the appropriate structures and processes to achieve community control. The Tiwi Health Service (THS), along with the Department of Health and Community Services (DHCS), Commonwealth Department of Health and Ageing (DoHA) and the Aboriginal Medical Services Alliances of the NT (AMSANT) have a shared commitment to community control as the most effective basis for Aboriginal health and community services.

Aim

The aim is achieve a sustained community controlled, health and community services through the planned development of governance and management capacity using this “enabling framework” by the THS and the Project Officer.

Objectives

- to establish the “Future **Ngininawula** Health Board (TNHB)”;
- to assist develop a Health Plan for the Tiwi Islands through community consultations;
- to access high quality and on-going training and development resources for the members of the TNHB and THS staff;
- to negotiate with the DHCS and DoHA and secure adequate services funds to support the development of the THS;
- to initiate Agreements and networks with AMSANT and other key stakeholders to support community control developments;
- to develop and implement the agreed Indicators of Management Capacity (IMC); and
- to establish a monitoring group on behalf of the NTAHF to oversee and support the THB developments.

Timeframe

The Tiwi Health Advisory Committee has expressed a commitment to establish the TNHB by October 2008. It is anticipated that a minimum of two years is required to achieve the specific goals and IMCs.

Contact Persons

If you like to seek a job description and further information about this important and significant role please contact Marius Puruntatameri or Miriam Heath from the THS. Contact details are:

- Marius Puruntatameri: 8978 3669
- Miriam Heath: 8922 8526

June 2008