

THIS DOCUMENT IS DEDICATED TO THE MEMORY OF
BRUCE B. McGUINNESS
ONE OF THE FOUNDERS OF THE NATIONAL ABORIGINAL
AND ISLANDER HEALTH ORGANIZATION,
FIGHTER FOR THE RIGHTS OF PEOPLE,
TOTALLY DEDICATED TO THE PRINCIPLES OF
COMMUNITY CONTROL, COMMUNITY INITIATIVE
AND COMMUNITY PARTICIPATION

Within it we are hopeful that you will find some of his
wisdom and all of his integrity

There is a collective of people, who have contributed to this document, all of whom subscribe to the philosophy described. We would like to thank them for their various contributions to its production.

They include Naomi Mayers, Alma Thorpe, Marj. Thorpe, Bruce McGuinness, Sol Bellear, Denis Walker, Graham Austin, Henry Councillor, Tony McCartney, Lyn Helms.

THE PHILOSOPHY AND SOME HISTORY OF THE RELATIONSHIP WITH GOVERNMENT OF THE NATIONAL ABORIGINAL AND ISLANDER HEALTH ORGANISATION.

The relationship between Aboriginal health status and land possession becomes patently clear, once we examine the true history of the last 200 [now 215] years of oppression.

To ignore that history clouds the perception of the underlying causes of disease and early death amongst Aboriginal peoples throughout Australia as the invasion progressed.

The breakdown began with the first alien intrusion into our communities and the subsequent disturbance in the relationship, both physical and spiritual, which Aboriginal peoples had and continue to have, despite obstructions, with the land and the seas. This intrusion (euphemism for invasion) brought death and destruction to our communities – it ranged from direct genocidal killings by various means across the spectrum of domination and dependency, brought about by policies of deliberate family “break-ups”, assimilation, integration and paternalism.

The latter continues in its many forms and is commonly more difficult to combat than racism in its many guises, because it is the unwitting tool of well-meaning “do-gooders”, who can be equally and even more effectively destructive to family and community. All of the foregoing contribute to and form the basis of denial of culture, deprivation and destruction of language, removal of identity, and total physical dispossession from our land, our spiritual heritage. Figuratively we bleed internally, often consciously, always sub-consciously.

The substitutes we received in the first place, apart from "baubles, bangles and beads" were white flour, white sugar, tea and tobacco and then alcohol, all of which contributed to the breakdown of our physical health and ultimately our mental and spiritual health, and at the same time creating increasing dependencies.

They denied that we possessed a culture, they denied our spiritual beliefs, they denied our use of language, they denied us our performance of ceremonies, they denied our law, and they denied family and skin relationships.

White Experts

The "expert" white invaders were sponsored by Church and State and many of our problems were initiated and perpetrated by these "experts", who imposed their "solutions" to the problems, which their presence and decisions had brought among us.

At best they were insensitive to Aboriginal mores and values, at worst they opposed our right to our own customs and value-system, and consequently to any semblance of self-management let alone self-determination.

PLEASE NOTE: A more extensive presentation of the historic reality is printed in the Forward to the National Aboriginal Health Strategy titled 'ABORIGINAL AUSTRALIA – THE REALITY AND NOT THE MYTH' (Pp. i-viii)

Necessary Requisites for Good Mental Health and Survival

Despite this history, we survived, but, at great cost – suffering fragmented identity, great mental stress and disturbance, severe physical illness, and gravely decreased life expectancy.

For the continued mental health of each individual, specialist psychiatrists and psychologists stipulate four requirements are necessary:

1. To have an assured identity.
2. To have a belief beyond one's immediate concrete experiences – a spiritual basis to life.
3. To have a language for specific communication within a group, i.e. tribe, extended family, nation exclusive to that group.
4. To have viable acceptable options for survival.

In view of the loss of one or more of these requirements by all of us, the miracle is that we have survived at all.

Assimilation on the Cheap or at a Price

We have survived despite the denial of these requisites, but with great losses and continuous mental stress.

The policies of assimilation and integration, which followed the directly genocidal policies of the first 140 odd years continued overtly until the beginning of the nineteen seventies– such policies provided financially speaking “on the cheap solutions” to the “Aboriginal problem” for governments of all flavours.

From 1972, partially because Australian Governments in that period saw the need to present a better “world image” to some developing countries and at the United Nations, they introduced “stated” policies of self-management and even alluded to self-determination. In reality, they have continued many policies, which are primarily assimilationist.

The difference from the pre-1972 policies was that they were now prepared to pay us virtually token monies to assimilate.

We know however that this policy will fail. If we did not succumb to seizures of our land, bullets, poisoned water holes, poisoned flour, imprisonment, and removal from our families, we will not succumb to Government money on Government terms.

Therefore, despite the increasing affluence within white Australia, if we are to maintain our identity, restore our dignity and not live in a constant state of oppression, we will need the help of trustworthy peoples of goodwill within and without our communities and Australia, who believe in peace and justice for all.

We see an acceptance of assimilation as an acceptance of obliteration.

The Spectrum

There remained in the early nineteen eighties, a unique situation in Australia, where we, the indigenous people, spread across this country, were in various stages of domination and dependency –

Some communities (fewer and fewer in number) in some nations, relatively untouched by the invasion;

Communities living on their traditional land, but suffering destruction as the invasion proceeds with the exploitation of what are in reality our natural resources;

Communities dispersed and removed from their traditional lands living in reserves or on the fringe of mining camps or pastoral stations or outside remote white settlements, and suffering from all of the illnesses, which such deprivation and oppression brings;

Other Aboriginal people, who have been born away from their traditional lands and communities, who are in the process of being de-nationalised, being stripped of their true identity, but retain some knowledge of their traditions and customs;

Others who have been removed from families, placed in foster-families (most commonly white) or in ward-ship or institutions – they have been pushed to the depths of dispossession (later to be called the Stolen Generations).

The total spectrum of the historical rape and dispossession of Aboriginal Australia remains with us.

The Regeneration Process

The hope lies with the re-generation, which is also present. This is the Aboriginal Australia, which is so often ignored, but the re-generation is a growing force – a black snow-balling force - a paradox, because it arose from those Aboriginal peoples across Australia, who had supposedly lost everything, who had apparently reached the depths.

In the early 70's, following close upon the opening of the first Aboriginal Legal Service in Australia, established by community initiative, and consequently community-based and community-controlled came the establishment of the first community controlled Aboriginal Medical Service in Redfern.

This new Aboriginal initiative was the forerunner of the wider community health services, which were then established during the period of the Whitlam Government. The Redfern initiative was soon followed by Aboriginal communities in Fitzroy (Victoria), Brisbane, Bairnsdale, Perth and Townsville.

Here were services being initiated without a cent of Government funding, by urban and provincial Aboriginal peoples. They were peoples, who had suffered all of the oppression and dis-possession and indignities of the previous 190 odd years. Despite this, from the depths, they sought to begin to meet the gross health needs of their people – gross needs brought about by the racist, colonialist and paternalistic deeds of the invaders.

They began a system of health care delivery, which was then unique in the world.

The Vital Nature of History

It is of the greatest importance to examine the history of our peoples up to the point of their total dis-possession and their apparent loss of their identity and traditional values. Then, we must examine with equal fervour, the history of their re-generation.

It is herein that an oral tradition has proven vital. Our immediate ancestors, our elders retained some lore, and varying elements of their own traditions and customs, despite removal, rape and the disbanding of their traditional family, community and national relationships. Sometimes they consciously held this knowledge until it was safe to hand on, sometimes it was in the sub-conscious and required a spark to ignite the memory of the knowledge.

The struggle to regain some rights, some recognition as human beings with at least the same intellect and intelligence as the invaders (more in reality), was fought strongly from the period of World War I, throughout the 30's, 40's, 50's, and 60's until the victory of the 1967 Referendum.

This was the spark for the revelation of the way forward in the 70's. The establishment of community-controlled services, and in particular health and allied services, acted as a springboard for community development, community growth and community co-operation across Australia – urban, rural and traditional.

This, in turn, will take us through the full cycle back to land re-possession and indeed land retention as witnessed by the homelands movement.

The Same but Different

The beginnings of these community initiated, community controlled health services varied of course. Each community had similar, if not exactly the same motivation for starting up a health facility, namely the gross deficiencies in existing public or private services to meet Aboriginal needs coupled with the grave state of each community's health status.

The common factors were recognition of a need, commitment and dedication by a number of community members to meet that need, and the good will and dedication of some health professionals to be part of the action.

It was soon recognized that clinical health provision, while relieving the immediate illness problem, was "band-aiding". Prevention, health education and promotion needed to go hand-in-hand with the clinical. As interchange took place and communications grew between the existing health services, there was an obvious need to meet together on a regular basis.

The Role of Governments

Up to this point, bureaucrats from the various State and Territory Health Departments, together with the Federal Department of Health met twice yearly on Aboriginal health matters. No Aboriginal community members were involved, invited or consulted – nor were the discussions ever revealed.

Then, Australian Department of Health set up a three-day Workshop on Aboriginal Medical Services from 5th -7th July 1974. As well as Federal and State Health bureaucrats, members of the then National Aboriginal Consultative Committee (N.A.C.C.) and representatives of the five existing Aboriginal community controlled medical/health services.

This was a surprising event and a significant one, as shown by Recommendation No. 1, which we reproduce verbatim:

*That this Workshop on Aboriginal Medical Services adopts the following structure of a National Aboriginal and Islander Health Organization (N.A.I.H.O.) as a concrete and positive step towards self-determination of Aboriginal and Islander people, to enable them to formulate and **implement Medical and Health policies and priorities** which are directly and indirectly related to the immediate needs and aspirations of the Aboriginal and Islander people.*

The structure of the National Aboriginal and Islander Health Organization would enable easy two-way communication at all levels. It would also provide the ways and means to tackle the immediate and pressing Aboriginal health problems at the local Aboriginal community level.

The planned tasks of the National Aboriginal and Islander Health Organization are briefly outlined:

Local Community Groups

- *Define the problems and needs in each specific area.*
- *Disseminate information to local indigenous people on all health matters*

Regional Assemblies

- *Collate, identify and program priorities.*

State and Territorial Assemblies

- *Communicate with relevant State and local government and other non-government organizations including all indigenous groups.*
- *Formulate State budgetary policies*
- *Allocate financial grants*

National Aboriginal and Islander Health Organization (N.A.I.H.O.)*

- *Formulate national policies for the permanent and rapid improvement of the health status of all indigenous people.*
- *Provide a direct link with Federal Government Ministers, Australian Government departments and other instrumentalities concerned with Aboriginal health.*
- *Receive and allocate all forms of financial assistance for Aboriginal and Islander Health programs.*

It is necessary to spell out some definitions on each level of the National Organization:

Local community group is defined as any indigenous community group involved in matters of Aboriginal health.

The regional assemblies will comprise indigenous people elected by the local community groups. The regional assembly will constitute that area designated by the N.A.C.C. boundaries.

The State and N.T. assemblies will comprise one elected member from each regional assembly within the State or Territory.

The National Aboriginal and Islander Health Organization (N.A.I.H.O.) * will comprise one elected member from the State and Territorial assemblies as well as one from Torres Strait Islands.

*This is the first known use of the term.

Proposed by: Denis Walker (Q.A.I.C.H.S.)

Seconded: Bruce McGuinness (N.A.C.C.)

Motion Carried.

The Aboriginal and Islander community representatives decided to meet alone for a period during the Workshop, and operated in unity.

Remembering that this was mid-1974, Aboriginal Medical/Health Services had only been in existence less than three years, and there were only five across the country, and they had never formally met prior to this Workshop, what remarkable foresight was shown by these community representatives!

They came back to their Services and communities with high hopes. Nothing happened with Governments, all was as before.

State Governments continued to take a varying degree of interest in Aboriginal Health, together with the Commonwealth Department of Health. Much of this was window-dressing and tokenism. As indicated above, these bureaucrats met together once or twice yearly over a number of years to "plan" initiatives in Aboriginal health – community representation were not allowed. It must also be noted that not one of the bureaucrats at these meetings was of Aboriginal or Islander descent.

A good summation of community attitudes is provided by a quote from a Victorian Aboriginal Health Service submission:

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"We will welcome government co-operation and collaboration, but your history and our history demand that such takes place **On Our Terms.**"

The Emergence of a National Community Controlled Health Organization

Then in 1976, the representatives of seven of our nine existing community-controlled services gatecrashed one of meetings, and sought to point out a number of important facts, which included:

- i) Aboriginal peoples must have appropriate representation at all meetings concerning their life-ways,
- ii) Our people were those, whose health was being discussed,
- iii) We were the representatives of the only Aboriginal and Islander community health services, who were developing a holistic approach to health-care delivery.

The above meeting dispersed immediately, and after some unofficial negotiations, the bureaucrats agreed to meet further with us the next day.

This exercise of solidarity by our services, together with recognition of the need to regularly meet, wherein each of the services retained their own community control and autonomous status, was recognized by all existing services.

Examining the history of each Medical/Health Service shows an evolutionary process of development in response to need and increasing knowledge and practice. This is mirrored in the history of the national body, which formed over several years and then formalized as a Congress during 1980-81.

Over these early years we reached an understanding of health as a condition of wholeness on both the personal and societal level; as a state of complete physical, mental, social and spiritual well being. What occurs within the individual has repercussions on the entire community and its environment. It is a question of the life in abundance of which the Christian Gospels, the Koran, Buddhist teachings and indeed most indigenous communities followed before invasion and colonization.

The NAIHO Experience Evolving to the NAIHO Congress

Each of our existing Health Services subscribed to the concepts of community initiation, community participation and community control. This philosophy was pursued and practiced relatively easily, so long as Government was not involved, whether in terms of funding, evaluation or shared programs. There were occasions when this was compromised, once there was State or Federal Government involvement at any level. This was a large part of our ongoing battle, i.e., to stave off Government meddling and interference and to avoid compromise.

Coming together on a regular basis led each service to recognize the advantages of a singular approach to Government, and enabled us to expose the inconsistency of rules and regulations by the petty bureaucrats in various Government departments, but particularly in the Federal Department of Aboriginal Affairs. This occurred consistently despite change of Minister or Government. We were also able to expose the common practice by Departments of playing off one Service against another.

In the development and formation of a national body, three principles were seen as paramount:

- a) Each service remained completely autonomous.
- b) Each service or community seeking to establish a service had equal representation and equal voting rights.
- c) All resolutions were passed by consensus. If consensus was not achieved after negotiation, motion was shelved until next full meeting.

The following is a reproduction of the outline of NAIHO Congress as accepted in 1982:

National Aboriginal & Islander Health Organization Congress

The Congress is the decision-making, policy development and program-planning body. It is open to all Aboriginal community-controlled Health Services and Health Committees/Councils.

New community-controlled health committees have equality of input and decision-making with the long-established Health Services. Essentially decisions are arrived at by traditional Aboriginal methods of consensus.

The State and Territory boundaries of Australia do not relate to traditional Aboriginal Nations' "boundaries", and so we have evolved regions (currently in 1982, twenty one), which have been drawn up the Aboriginal people within their immediate region and the adjacent ones.

The Health Services and Committees/Councils within a region meet on four occasions per year. They operate on the same basis as the national body with like representation. They elect a Regional Coordinator*, who becomes a member of the N.A.I.H.O. Executive.

The N.A.I.H.O. Executive consists of the 21 Regional Coordinators, together with the National Coordinator and the Specific Area Coordinators*2, who are annually elected by the Congress, together with the President, Chairperson, Secretary and Convener

[*1 Responsible for specific communities within community chosen geographical regions.

*2 Responsible for specific need areas of health-care delivery.]

Each and every Coordinator works in full co-operation with each other, responding to communities' requests to meet particular needs.

The Specific area Coordinators are elected with the following areas of responsibility:

Mental Health

Women's Health

Public/Environmental Health

Preventive Health

Health Worker Education

Dental Health

Justice

Finance/Resources

Physical Fitness/Recreation/Sport

Information/Publicity

Homelands

Eye Health/Trachoma

All Coordinators, with one exception, were employees of member Services, and their work for the National Organization was supported by their member Service. This reflects the commitment of member Services to the extension of community controlled health facilities to those communities who sought to establish such.

The National Coordinator was an elected full-time position, who worked in co-operation with the National Executive to carry out the decisions of the Congress. The position was funded by private donations, together with subsidies from longer-established member Services.

*** It is important to note that the National Aboriginal and Islander Health Organization received no funding for its operations and personnel. It had to fight to receive adequate funding for its twice-yearly Congress. Member Services commonly assisted with travel and accommodation for Community Health Councils and Committees from across Australia to attend Congress, as Government did not recognize their existence.

NAIHO EXECUTIVE

National President
National Chairperson
National Secretary
National Convener
National Coordinator

And

Twelve Specific Area Coordinators

Twenty-one Regional Coordinators

As we evolved, this broad representation on the Executive was seen to be very necessary in order to have an appropriate level and spread of community representation and participation across our peoples.

The Executive made all decisions in accord with Congress decisions, and over-viewed implementation of these.

It could draw up recommendations for a future Congress, and bring recommendations to Congress, as well as representations on behalf of particular communities, who were unable to represent themselves at a particular Congress

TERMS OF REFERENCE

FOR NATIONAL COORDINATOR, REGIONAL COORDINATORS

AND

SPECIFIC AREA COORDINATORS

1. Collate all material/information relevant to Aboriginal Health
2. Separate such material into:
 - (a) Direct relevance to Aboriginal Health
 - (b) Indirect relevance to Aboriginal Health
 - (c) Direct relevance to Specific Area Coordinators
3. Ascertain by consultation and experience, the importance of direct material/information on Aboriginal Health in terms of priority. Such priority should be determined by a number of factors:
 - (a) Human life at stake
 - (b) Human suffering
 - (c) Causes of health problems e.g., racism, obstructionism, mining interests, isolation, policy, careerist and elitist Aboriginals and non-Aboriginals.
4. Detail lists of priorities and proposed actions.
5. Detail list of resources (both personnel and material) needed.
6. Detail list of resources available.
7. Liaise with and utilize existing resources.
8. Establish new resource sources whenever necessary.

9. Appropriate member(s) of the National Executive for its reliability and authenticity should check all material/information.
10. All direct material/information should be channeled into the NAIHO grapevine, information flow, newsletter, phones, word of mouth, wherever applicable.
11. All indirect material/information should be channeled to the relevant Aboriginal organizations with proposed action recommendations.
12. Local community members from trouble areas should be stimulated and encouraged to participate in all areas of proposed action, both at discussion and action levels.
13. Most of the planning for action usually occurs at Executive meetings with recommendations from the National Coordinator, National Convener or relevant Specific Area Coordinators.
14. Priorities are usually set at Congresses with recommendations from the National Coordinator, National Convener and/or Specific Area Coordinators and where appropriate Regional Coordinators.

These Regional Coordinators and Specific Area Coordinators work in close co-operation with the National Coordinator who would in turn initiate the necessary steps in programs of actions, which incorporated community knowledge, community development and consequently community advancement from priority to action.

By 1982-83, twenty-six community controlled services had been established, and N.A.I.H.O. had identified over sixty other communities, which had recognized their own need of a community controlled Medical/Health Service.

As has been indicated throughout this document our community controlled Services, of necessity developed and evolved, according to individual community needs and the growing experience of the Service, together with an expanding vision.

Likewise, it was important that the National Organization evolved and developed in response to the most developed of its member Services

If N.A.I.H.O. was not to be impositional, it could not operate in advance of its member Services. That did not mean that N.A.I.H.O. would not gather the most advanced, appropriate information and knowledge of health resources and material to be distributed to its member Services.

While the following document, adopted by N.A.I.H.O. at Minto (N.S.W.) in 1984 will contain some repetition of the foregoing, it provides a very precise description of where N.A.I.H.O. principles and philosophy had arrived. Any repetition will only re-enforce the importance of particular principles.

(The document is reproduced separately on the next pages, as some may like to copy it apart from the whole)

Community Initiative, Participation and Control

The concepts within this document have formed the basis of our operations from the beginning, and we see it as the most valuable reference point for judging the quality of community activities and decision-making.

We believe it most closely reflects traditional methods of community, and is a most appropriate vehicle to carry our communities forward in the regeneration process, and in their progress towards full health.

COMMUNITY CONTROL is basic to the philosophy of Aboriginal health care delivery as exemplified by Aboriginal community initiated, community based health services throughout Australia. This philosophy of Community Control of necessity is reflected in the structure and workings of the national support organization of Aboriginal Health services, which is known as the National Aboriginal and Islander Health Organization.

COMMUNITY CONTROL means that each independent and autonomous health service is controlled by the community it serves, in order to provide that community with health care delivery to meet its health needs as defined by that community. The solution to each community's health is in the hands of each particular community.

To ensure the highest level of community control, there must be participation by the community as a whole in the decision making process. This process, for practical reasons, varies from urban to rural to traditional communities but participation remains a key element.

PARTICIPATION is a process in which a community or group of communities exercise initiative in taking action, stimulated by their own thinking and decision making, and over which they exercise specific control.

PARTICIPATION has been described as the collective effort by the people concerned in an organized framework to pool their efforts and whatever other resources they decide, in order to attain objectives set for themselves.

It is through action generated by community thinking and initiatives that men and women give expression to their creative faculties and develop them and thereby develop further the personalities of those community members, who participate. It is for this reason that participation is a basic human need.

(It is important to note that it is a basic human need still being denied to our peoples today by Federal, State and Territory Departments, even by some Aboriginal bureaucrats)

Membership of the Service should be open to all Aboriginal and/or Islander people in the community, so that they may contribute to the selection/election of the office bearers of a Board/Committee/Council of the Health Service. The selection/election process should take place at regular intervals as determined by the community.

To guarantee ongoing community control, this selected/elected group of people must be accessible to community opinion, and should ensure that Health Service staff respond to community health needs and that the administrative staff in particular, convey to the Office Bearers their assessment of the evolving health needs of the community.

COMMUNITY CONTROL means the community's control of the health care delivery service, NOT the control of the community by the Service or its Office Bearers.

These principles must be reflected at the national, regional and local levels.

In order to ensure that a national organization reflects community control of Aboriginal Health affairs across Australia, PARTICIPATION must be maximal, the community checks and balances must be in place at all times. This demands that the National Organization must not interfere in the decisions of the communities but rather be ready to respond to community requests for support and development. That is COMMUNITY CONTROL. This means that there must be a constant free flow of information to and from all levels.

This builds trust, builds community and will ensure protection against the forces in Australia, which are opposed to Aboriginal real community development and Aboriginal real community self-determination.

The talents and abilities of each individual in a community in a community must be encouraged, so that every individual can develop their full potential. With community support, this is possible and, in turn, those talents and abilities can be applied to help the community develop and to meet its needs.

Individual decision-making breaks down community, and so breaks down the support system for individual development. An individual in isolation cannot understand the total needs of his/her community, and therefore both the desire and the ability to meet those needs are lacking. This does not mean that the talents of each individual are not valued, but rather that they are valued as part of the sum total of talents within the community. They are of most value to each person, when they are devoted to the development of community initiatives, in co-operation and consensus with the total community.

The essence or essential element of community control that distinguishes the process of community control from all other methods of control, rule or governance is the coming together of the minds of the community – the use of all the talents within the community – to come to consensus. Consensus meaning agreement, concord reached after feeling together, perceiving together, and thinking together, best described as the sum of pooling together of the individual talents.

COMMUNITY CONTROL is like a living, developing, evolving tree, which is the sum total of the individual elements of the seed, the soil, the sun and the rain.

Community Control means that we have control in the face of Governments and institutions, which continue to seek to oppress us, to make us dependants, to satisfy us with 'hand-outs', to perpetuate a welfare mentality – a mentality which is a total contradiction of:-

ABORIGINAL COMMUNITY INITIATIVE, PARTICIPATION AND CONTROL OF ABORIGINAL BUSINESS