Talking it Up! Project Report

‘Aboriginal voices in the formulation of health policy that works’
Acknowledgement of Country

We acknowledge and respect the Traditional Custodians of the Land, the Wurundjeri peoples of the Kulin nations on whose land this report was produced; and Elders past and present. As we share knowledge, learning and research within this report, we also pay respect to the knowledge embedded forever within the Aboriginal Custodianship of Country.

Acknowledgements

This report was made possible by contributions from many people. Firstly and most importantly, we thank the participants for taking part in the focus group discussions, attending community forums and providing feedback in later phases of consultation, without which this research would not have been possible. Participation was confidential, so we are not naming all of the participants here, but to everyone who took part we say: Thank you. Your ideas, stories and suggestions were sincerely appreciated and highly valued. We hope you like the final report.

The research was funded by the VicHealth Discovery grant program (Grant Number 2008-0077), and we thank them for funding research into Aboriginal health in Victoria.

Co-investigators

The research was carried out by:

Aunty Shirley Firebrace, community Elder and co-investigator. Aunty Shirley conceptualised the original idea for the project and facilitated the first round of community consultation, as well as providing editorial insight for the report.

Uncle Reg Blow, community Elder and co-investigator. Uncle Reg facilitated the second round of consultation and provided vital editorial input for the report.

Sarah Pollock, Wesley Mission Melbourne. Sarah is the lead investigator and submitted the grant application to VicHealth. Sarah provided the main analysis of the focus group and community elements of the project, and produced the majority of the material in the focus group chapter of the report. Sarah supervised the policy review at Wesley, and set up the criteria against which the policies were summarised.
Ann Taket, Deakin University. Ann is a co-investigator and provided research training for co-researchers. Ann developed the material for the introductory chapter and produced the stimulus questions for the second round of community consultation.

Sarah Barter-Godfrey, Deakin University. Sarah is a co-investigator and acted as liaison between the three parts of the project. Sarah provided research training for co-researchers and supervised the Deakin students. Sarah carried out the third stage of the policy analysis, including the ‘heat mapping’ and development of the policy chapter. Sarah developed material for the report and, together with Samantha Furneaux, provided the administrative support for the project.

Researchers (in alphabetical order)

Sandy Barber, community researcher. Sandy took part in the research training and facilitated focus groups discussions at the community forums.

Neil Bo Barney, community researcher. Neil took part in the research training and facilitated focus groups discussions at the community forums.

Troy Blow, community researcher. Troy took part in the research training and facilitated focus groups discussions at the community forums. Troy also assisted in the second round of community consultation and provided feedback on the interim report.

Andrea Gough, Deakin University student. Andrea carried out an initial scoping of health policy during her undergraduate health promotion placement, producing a report that informed the full policy analysis.

Peta Farquhar, Wesley Mission Melbourne. Peta identified, sourced and collated the policies used in the policy review. Peta produced the policy summaries for the first stage of the policy analysis and mapped the relationships between them in the second stage of the analysis, producing the materials presented in the document ‘Mapping relationships between parties’ available in the full report.

Samantha Furneaux, Deakin University. Samantha was the research assistant for the project and provided administrative support for the production of the report and discussion materials. Samantha carried out the literature review, and produced the diagrams used in the policy review to summarise the relationships between the policies, and the map to illustrate participants’ countries in the focus group study. Samantha completed the meta-synthesis analysis and diagrams presented in the introductory chapter.

Chris Halacas, Wesley Mission Melbourne. Chris took part in the research training and facilitated focus groups discussions at the community forums. Chris also assisted in the successful grant application.

Mary Hassall, Artist. Mary produced the artwork for the Talking it Up project. Mary also transcribed the group discussions, providing a careful record of the focus groups that was used to guide the analysis.

Danielle Thomson, Deakin University student. Danielle took part in the research training and assisted with the community forums.
**Artwork**

The artwork for Talking it Up was produced by Mary Hassall, and copyright remains with her. The artwork cannot be reproduced elsewhere without her permission.

Artist statement:

“I am an Australian artist, in my 50s, born and brought up in various locations around Victoria, currently living and working in Darebin. My work reflects my interest in the way human beings relate to our landscapes, our backgrounds, both at home and away from home. I believe that in our creative endeavours, both as individuals and in groups, that we have the power to heal ourselves as people and to heal our relationships with all the Living Being of Earth.”

**Full Project Report**

A second version of this report has been produced which contains full details of the policies analysed in Chapter 3 of this report. The full report can be accessed at www.deakin.edu.au/dro/ or at www.wesley.org.au.

| Enquiries, comments and feedback |

If you have questions or suggestions, please contact:

Sarah Pollock, Wesley Mission Melbourne: spollock@wesley.org.au
Aunty Shirley Firebrace: sfirebrace@yahoo.com.au
Uncle Reg Blow: regblow@yahoo.com.au
Ann Taket, Deakin University: ann@deaking.edu.au
Sarah Barter-Godfrey, Deakin University: barter@deaking.edu.au

Media enquiries should be directed to:
Grant Thomas, Executive Manager, Community Relations, Wesley Mission Melbourne
P: (03) 9666 1215  E: gthomas@wesley.org.au

ISBN 978-1-875146-30-7

© Wesley Mission Melbourne 2009
This publication is copyright. Apart from fair dealing for the purpose of private study, research, criticism or review, as permitted under the Copyright Act, no part may be reproduced without written permission from the publisher.

Wesley Mission Melbourne ABN 81 098 317 125
# Table of Contents

**TALKING IT UP: INTRODUCTION**
4 - 18

- Where the project idea came from
- Evidence of need for the project
- Project design
  - Project strand 1 Participant forums
  - Project strand 2 Literature review
  - Project strand 3 Health policy
  - Project strand 4 Formulating project recommendations
- Project findings
- Holism
- Identity
- Cultural respect
- Collaboration
- Power and control
- Health sector and services
- Reconciliation
- Project recommendations
  - Health policy
- Expanded service delivery
- Advocacy partnerships for systemic change
- New knowledge and understanding
- How to read the report

**Chapter 1: COMMUNITY GROUP DISCUSSIONS**
20 - 30

- Introduction
- Method
  - Fig 1.1 Participants’ countries
  - Fig 1.2 Map of participants’ countries
- Findings
  1. Effects of the Past in the Present
     a) Sickness is everywhere
     b) The family is the site for sickness and healing
     c) Lack of respect and its connection to ill health
     d) Dispossession is linked to ill health
     e) Living in ‘no man’s land’ affects health
     f) The build up of past and present racism
  2. Identity and Voice
     a) Loss of cultural identity and role
     b) Feeling invisible
     c) Loss of voice is about loss of respect, and vice versa
     d) The invisibility of urban Aboriginal people
     e) The need for a new story to be accepted
  3. Service Quality and Gaps in Provision
     a) Service system problems
     b) The need for service models which draw on Indigenous knowledge systems
     c) Inequitable access to services: the ‘elephant in the room’
  4. Promoting Healing
     a) Talking and listening as acts of healing
     b) The importance of being in control
     c) Dialogue and reparation
  5. Warriors and Tiddas
- Relationships between themes
- Fig 1.3 Thematic diagram from focus groups
Chapter 2: LITERATURE REVIEW

1. Introduction 33
2. Method 34
3. Literature Overview 35
   Fig 2.1 Thematic Diagram from Literature Review 36
4. Tension between statistical equality and valuing difference and diversity 37
5. Measurability: culturally appropriate evidence base, measures, benchmarks, targets and timeframes within the context of increased power and control for Indigenous people 39
   Data Quality 39
   Absence of Data and Incomplete Data 39
   Cultural Appropriateness 40
6. Policy does not address structural inequities and determinants 41
7. Recognition of historical and cultural context, social settings: Collaboration as Reconciliation 42
   Legacy of Colonisation 42
   Self Determination 44
   Collaboration as Reconciliation 45
8. The Policy Cycle: Process and Delivery 46
   Collaboration and Partnerships 46
   Policy recommendations from research in urban Aboriginal communities 48
   Research with urban Aboriginal communities 48
   Policy Design 49
   Policy Implementation 50
   Evaluation of services, programs and policy 50
9. Conclusions 52
References 54

Chapter 3: HEALTH POLICY

Introduction 57
Method 57
Limitations 59
Findings 60
Conclusions 62
Fig 3.1 Policies included in the analysis 63
Fig 3.2 Documented participation in the development of policies 64
Fig 3.3 Descriptions of participation 65
Fig 3.4 Influence of the National Strategic Framework 66
Fig 3.5 Influence of the 1989 National Strategy and the current Victorian Framework 67
Fig 3.6 Policies not clearly related to other policies in the analysis 68
Fig 3.7 Other policies related to the policies in the analysis 69
Policy Review 70
Fig 3.8 Criteria for policy review 70
References 71
TABLE OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Participants’ countries</td>
<td>22</td>
</tr>
<tr>
<td>1.2</td>
<td>Map of participants’ countries</td>
<td>22</td>
</tr>
<tr>
<td>1.3</td>
<td>Thematic diagram from focus groups</td>
<td>30</td>
</tr>
<tr>
<td>2.1</td>
<td>Thematic diagram from literature review</td>
<td>36</td>
</tr>
<tr>
<td>3.1</td>
<td>Policies included in the analysis</td>
<td>63</td>
</tr>
<tr>
<td>3.2</td>
<td>Documented participation in the development of policies</td>
<td>64</td>
</tr>
<tr>
<td>3.3</td>
<td>Descriptions of participation</td>
<td>65</td>
</tr>
<tr>
<td>3.4</td>
<td>Influence of the National Strategic Framework</td>
<td>66</td>
</tr>
<tr>
<td>3.5</td>
<td>Influence of the 1989 National Strategy and the current Victorian Framework</td>
<td>67</td>
</tr>
<tr>
<td>3.6</td>
<td>Policies not clearly related to other policies in the analysis</td>
<td>68</td>
</tr>
<tr>
<td>3.7</td>
<td>Other policies related to the policies in the analysis</td>
<td>69</td>
</tr>
<tr>
<td>3.8</td>
<td>Criteria for policy review</td>
<td>70</td>
</tr>
</tbody>
</table>

TABLE OF APPENDICES

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Poster used to advertise the first round of community consultation</td>
<td>75</td>
</tr>
<tr>
<td>2</td>
<td>Invitation to second round consultation</td>
<td>76</td>
</tr>
<tr>
<td>3</td>
<td>Nine Principles from National Strategic Framework ATSI Health, 2003-2013</td>
<td>77</td>
</tr>
</tbody>
</table>
Talking it up Introduction

Where the project idea came from

The motivation for the Talking It Up project arose directly out of an earlier project that was being undertaken in collaboration between Wesley Mission Melbourne (Wesley), Aboriginal elders at Maya Healing Centre and Deakin University School of Health and Social Development (DU). The existing project, entitled ‘Healing Stories: experiences of the health system by Aboriginal and Torres Strait Islander people living in NE Melbourne’ set out to examine the experiences of Aboriginal and Torres Strait Islander people living in NE Melbourne when they accessed or attempted to access the health system. Like Talking It Up, this project was participatory in that the need for the project was identified by the Aboriginal elders through many years of working with Aboriginal and Torres Strait Islander people and their families, and in its design and execution, where control over data collection, data analysis, and reporting remained with Aboriginal and Torres Strait Islander people.

A strong and trusting relationship grew between the three parties. This was an important factor in the identification of need for the Talking It Up project described in this report. Aunty Shirley Firebrace (Women’s Program Co-ordinator at Maya at the time of the project) identified a lack of voice as a significant issue for the women she worked with. Many of these women experience a range of social deprivations that impact on their health and the health of their families.

Compounding the situation in which they find themselves is the sense that they have no say in what is happening to them, in particular, no say in identifying the problems and issues that do the most damage to their own and their families’ health, and no say in coming up with strategies to address these problems. Likewise, Uncle Reg Blow (CEO of Maya at the time of the project) was working to assist men to work through the difficulties that many experienced by talking about their health and the things that impact on health, whereby having a voice could become a significant part of their healing.

As a result of many conversations within the frame of the Healing Stories project, the project partners formulated the design for the Talking It Up Project, and successfully submitted to VicHealth for a small discovery grant to fund the project.

Evidence of need for the project

Research evidence shows that Aboriginal and Torres Strait Islander people are over-represented in the populations experiencing chronic ill health, particularly in relation to heart disease, stroke and diabetes, as well as suffering poor dental care. Additionally, alcohol and drug abuse afflicts many Aboriginal and Torres Strait Islander people and families. Research on health promotion suggests that strategies that work for non-Aboriginal and Torres Strait Islander populations do not work for Aboriginal and Torres Strait Islander people. Efficacy is also impacted by poverty.
Finally, there is a general paucity of research on health and health-related issues amongst Aboriginal and Torres Strait Islander people and families living in metropolitan areas. Where research does exist, it tends to be at the level of population trends and generally does not seek Aboriginal and Torres Strait Islander people as actors in the research process and as agents of their own destiny through research projects with a participatory design (Jackson Pulver et al, 2007).

**Project design**

Initially, there were three separate strands to the work of the project: a series of forums involving group interviews/discussions with community members; a policy analysis that reviewed policies relating to Aboriginal health at federal and state level; and a literature review. Each of these is described in turn below. The results of these three separate strands of analysis were then brought together in a fourth strand to the work, a process involving community members to discuss and agree the overall recommendations contained in this report. This process is also described below.

Through this structure, the project employed a participatory methodology as the basis for individual and collective empowerment in relation to health outcomes. As mentioned above, the need for the project was identified by Aboriginal people, through their own processes of healing. The need was presented by appropriate figures within their communities, namely community elders.

They invited other Aboriginal people to take part through their own communication channels, thus ensuring that responsibility for engagement in the project, and in formulating action for improvement, remained with Aboriginal people and their families. However, the project design also recognised that Aboriginal people exist within broader structural and policy constraints which impact on their ability to manage their own lives successfully or otherwise.

Thus the project sought to combine indigenous and non-indigenous knowledge through bringing together the three strands of work in the way described.

A Community Reference Group guided the work of the project at all stages, endorsed the findings and drafted the recommendations. The two elders who had identified the need for the project formed the core of the group, and worked on the project from start to finish. At different times during the project, other community members joined the group to assist in its work, including training Aboriginal researchers, letting others know about the forums, discussing findings and drafting recommendations.

The Aboriginal researchers were included in the group, attending meetings and providing input whenever they were able. It was important that the membership remained open and flexible, enabling people to take part in aspects that were important to them in a way that allowed them to attend to other commitments and events in their lives, as they arose. The group chose to work at Maya, as a safe space for themselves, and for the people who took part in the forums. The group framed the partnership with the non-Aboriginal researchers in the project in terms of ‘reconciliation work’, Aboriginal and non-Aboriginal people working together to create change.

This spirit was articulated by Aunty Shirley and Uncle Reg at the start of the project, and informed the design and development of everything that took place subsequently. In practical terms, the work involved a sharing of expertise and knowledge between the Community Reference Group and the non-Aboriginal researchers, regardless of the specific tasks that the various members of the broader ‘team’ undertook at any given stage of the project.

Research ethics clearance for the project was obtained through Deakin University Human Research Ethics Committee, as a modification to the existing Healing Stories project (EC 228-227).
**Project strand 1: Participant forums**

The project included four participant forums which were held to identify and discuss issues impacting on health and strategies to address problems. On the advice of the Community Reference Group for the project, the forums were structured to include opportunities for women’s business, men’s business and family business. To this end, four groups were held, two men-only (7 and 12 participants), one women-only (18 participants) and a mixed group (30 participants: all participants in the mixed group had attended one men’s/women’s group). In all, 35 people took part in the groups.

Participants were recruited through a range of existing channels within the community, a process controlled and undertaken by the Community Reference Group. Forums were held at Maya, a space which Aboriginal participants were familiar with and frequently used for other purposes.

Participation was self-selected, that is people chose to identify themselves as Aboriginal and over 18, and chose whether or not they wanted to take part. The standard pro-forma for consent asks participants to identify themselves by name and where they are “of”; for these participants the “being of” element was broadly responded to as which land or mob with which they identified. There is great diversity within a geographically local urban or metro Aboriginal community, diversity of culture and language, and a range of countries with which people are affiliated. It is important not to assume that everyone is from the land on which the research is carried out, or that people are only affiliated with one land or mob.

The sample self-identified as being from countries across Victoria, New South Wales, Queensland and Western Australia – a diversity that would not be adequately captured by traditional items asking people where they live now or where they were born. Seven out of the 22 people who responded to “being of”, identified two countries, both of these are included in the summary of where the participants are “of”. As these are fairly small numbers, frequencies have been grouped into 1-3, 4-6 or 7 and more to protect the privacy of the participants.

Figure 1.1 below presents a list of the countries that participants identified themselves as “being of”, including spelling variations.

1-3 participants
- Bundjalung
- Dainggatti
- Gumbainggir
- Gunu (Gunai)
- Gunditjmara
- Murray (Murri)
- Ngarrindjeri
- Noongar
- Tjapwurung (Djabjawurung)
- Waka Waka
- Wimmer
- Yagara (Yuggera)

4-6 participants
- Wamba Wamba (Wemba Wemba)

7 or more participants
- Yorta Yorta
Participants were encouraged to identify the individual and social issues impacting on their health and ill-health, and had a large degree of control over the direction that the discussion took within this broad framework. Each of the forums was facilitated by Aboriginal researchers drawn from the community and trained within the scope of the project. They were assisted on the day of each forum by the non-Aboriginal researchers, who provided support in any way that the Aboriginal researchers required.

Each forum was recorded and transcribed for analysis; during transcription, any statements that potentially identified the speaker were de-identified. The data was then coded, and reconstituted under different categories representing the emerging themes. Following this, the data was re-analysed to consider the relationship between the various categories and themes.

The transcripts revealed that participants both described and offered explanations for the situations they found themselves in. This was a complex, interlinked articulation of their social situation which forms the basis for an emergent theory of urban Aboriginal health from the perspective of Aboriginal people living in the metropolitan area.

A summary of issues and strategies from the combined forums was made available to all participants that had provided postal contact details, and were discussed at a second community forum which was attended by interested participants. The data from these forums formed the basis of the community evidence base, presented within the next chapter of this report.

Project strand 2: Literature review

The research team conducted a literature review which focused on the policy implications of existing research relating to the health of, and health promotion for, Aboriginal and Torres Strait Islander people in metropolitan communities. This review sought focus on the part of the literature that can be applied to Aboriginal people living in Victoria, a predominantly urban or metropolitan population, geographically embedded within multi-cultural cities and towns (ABS 2007).

The review takes a human-rights based position, which emphasises the importance of social justice, and an essential need for the autonomy of, and engagement with, Aboriginal people in the governance and improvement of their/our communities. Where possible, we sought to take a holistic approach to Aboriginal health policy; in terms of both a holistic notion of health and a holistic, or intersectoral, notion of policy and health governance.

Three types of research literature were sought. Firstly, evaluations of specific policies identified in the policy review section of the Talking It Up project; secondly, primary research around health and health promotion from urban Aboriginal communities that had policy implications; and thirdly, secondary research or commentaries that critiqued the evidence base and/or policy outcomes for Aboriginal health.

A search for empirical research around specific Aboriginal health policy, as well as current research around health and health promotion for urban Aboriginal communities was conducted using all databases available through EbscoHost, including Academic Search Premier, CINAHL, Global Health and Medline. * Search terms were: Aborigin* or Indigenous AND health AND Australia* (where “**” is a truncation term that allows for multiple variations of the root word, for example Australia* would identify Australia and Australian and Australians).
A sub-set of the search was limited to urban or metro areas, to filter out research only conducted within very remote communities. The publication date was limited to 2000 onwards, in line with the earliest year of introduction of current Aboriginal health policy, as identified in the policy review. Grey literature was searched for using Google Scholar, and the titles of existing policies (identified in the policy review) were used as search terms through the main Google search engine, to identify other commentaries or evaluations available through grey or other non-peer reviewed sources.

Articles identified by the search strategy were read and thematically analysed, identifying key themes in the literature. These are reported in the chapter on the literature review later in this report, and summarised in Figure 2.1 (page 36).

**Project strand 3: Health policy**

This part of the project sought to review current Aboriginal health policy, applicable to Victoria. Health policies are the decisions, announcements and documents that guide and govern health delivery. These include health-related frameworks and strategies, which give direction to health service providers and regulators. Policies articulate how health should be delivered, regulated and accounted for and it is important to consider the policy environment as this is one of the most important points of communication and negotiation between those in control of health delivery, those responsible for delivering health, and their clients. For the purposes of the policy review, only published documents that come from health related departments at the Federal or Victorian state level are included.

Policies that do not extend beyond announcements or decision-making, i.e. are not implemented or disseminated sufficiently for others in the health sector to follow, are not included. Therefore this review seeks to analyse the policy documents that form the shared policy environment for the health sector, its workers and its clients.

The policy review was a detailed process of collecting and documenting the policies that govern and guide Aboriginal health in Victoria. This includes national policies and frameworks, as well as those specifically from Victoria. The first part of the process was to identify the policies that govern Aboriginal health.

It was not possible to find a single-site summary of health policies relevant to Aboriginal health, so policies were collated from a range of sources. These included Australian Policy Online (www.apo.org.au); Victorian Government Online (www.vic.gov.au); Department of Health and Aging (www.health.gov.au); and Department of Families, Housing, Community Services and Indigenous Affairs (www.fahcsia.gov.au).
Policies were included if they were: current, specified a remit for Indigenous or Aboriginal health; existed in a policy document as a policy, framework, strategy or guidelines. Policies were excluded if they were only applicable to states or territories outside of Victoria, or if they did not have a remit or a specific and substantial policy for Aboriginal or Indigenous health. In total, 15 Federal/National policies and nine Victorian/State policies were identified.

An additional policy, the National Framework for Aboriginal Health 1989, was initially excluded because it was not current implemented, although it became useful in later stages of analysis as it remains influential in the policy environment. A complete list of the policies included in the review is presented at the beginning of the chapter on health policy.

The analysis was carried out in three stages. The first stage was an initial analysis, summarising the policies, frameworks and strategies against a criteria that aimed to identify key aspects. The criteria covered the extent to which the policy governed Aboriginal health (which level of government, its jurisdiction and who it applies to, its longevity and for how long it applies, its level of impact as guiding or obligatory); its aims and rationale (what it sets out as its objectives and why); what outcomes it seeks and whether these will be monitored; how it proposes to implement its aims; how much money has been allocated to achieving its aims; and additional key points about what actions will be done and by whom. The full criteria are presented in Figure 3.8 (page 70).

The second stage of the analysis was to identify the relationships between the policies. Sometimes this was very clear, where policy documents state that they are guided by or build upon the principles of existing frameworks; or where later strategies are the implementation plans of earlier frameworks. Sometimes the relationship was less clear.

These relationships were mapped and a full, but somewhat complicated, database was produced which located each of the policies presented here and their stated inter-relationships. To simplify the presentation of this analysis, each policy has its own relationships presented in a diagram at the start of its policy sub-section.

The third stage of the policy analysis was to compare the policies against each other, along dimensions of interest identified by the literature review and community forums. These dimensions included: the extent to which Aboriginal people and communities had been involved or consulted in the policy process; the extent to which policies indicated an integrated policy environment; and the extent to which policies were informed or guided by principles of good practice for Aboriginal health (specifically the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013).

This analysis used a variation of the ‘heat mapping’ technique, where coding is represented visually by using a gradient of shading; deeper shading represents a greater extent. Heat mapping has the advantage of using categorical data in a way that is indicative of a gradient without needing to use numerical data, and therefore supports comparisons across a variety of data sources.

The fourth stage was the period of community consultation, where co-investigators and community members contributed to revisions and interpretation of the policy analysis.

Findings from all stages of analysis are presented later in this report. For a full description of each of the policies and frameworks analysed in the health policy chapter, related to the review criteria, please see the long form of this report, available at www.deakin.edu.au/dro/ or www.wesley.org.au.
Project strand 4: Formulating project recommendations

Following the completion of each of the three strands described above, the researchers developed a summary report which contained key findings from each of the strands. They discussed the emerging findings with the two elders in the Community Reference Group, and developed a set of questions which could inform the development of recommendations for the project. A second round of community consultation, facilitated by the community Elders, was arranged for participants to discuss the interim report and to draft recommendations.

It was intended that all original participants would be invited, and although it was not possible to make contact with them all prior to the session, everyone who had provided a postal address at the first participant forums was invited to attend. Five people attended the session, and worked on the interim report and recommendations.

Subsequently, as further contact was made, all participants who had provided a postal address were sent a copy of the summary report and offered a variety of ways in which to provide feedback to the research team. All feedback received prior to October 23rd 2009 was incorporated in to this final project report.

Project findings

The policy review identified that health policies tend to be focused on health outcomes (related to specific disease/s) and rarely demonstrated holism in their conceptualisation or measurement of health and wellbeing. There is varied and sporadic explicit connection between different policies and strategies, and the interrelationship between the different strategies is confusing.

The project identified tensions around the best ways to approach policy work with indigenous communities:

- Tension between statistical equality and cultural diversity, where the goal of normalising Aboriginal people fails to recognise or celebrate cultural differences in health patterning within the Aboriginal population and between Aboriginal and non-Aboriginal populations;

- Tension between the need for Aboriginal-specific health policy and the realities of integrated, urban communities, and the way in which Aboriginal health policy tends to segregate Aboriginal from non-Aboriginal people and broadly fails to recognise the role of non-indigenous Australians in the improvement and delivery of Aboriginal health, and

- Tensions across the policy process, with calls for greater consultation and engagement with the community at all phases of the planning, policy-
making, implementation and evaluation cycle. The focus on health outcomes fails to incorporate a historical perspective, which would allow for greater recognition of and emphasis on historical and structural determinants of health. Gaps between policy intention and implementation also exist, and require greater engagement with the broader social and structural context within which Aboriginal health exists.

The policy analysis undertaken as part of the project reveals that Aboriginal health policy is often formulated without the incorporation of indigenous knowledge systems, which would situate policy in a culturally appropriate context. Specifically, the project finds that the development of policy which is informed by the best knowledge from both indigenous and non-indigenous knowledge systems is an emerging area for further study and policy development work. This raises particular issues for Aboriginal people living in urban areas, where the notion of ‘community’ is marked by diversity of cultures and knowledges. One of the outcomes of this situation for urban Aboriginal people is inequitable access to services and supports, where some people are shunned by the Aboriginal Controlled part of the system because of their particular associations with mob and country.

The three chapters of the report present different types evidence for Aboriginal health, as part of a coherent whole which understands Aboriginal health from a community, research and policy perspective. Each chapter presents a different set of arguments to explain Aboriginal health and healing. While there are no active contradictions between the three chapters, aspects of health and healing are presented with different emphasis, in different lexicons and to differing extents.

Within each chapter there are themes identified in the material discussed (see thematic analysis of the participant forums; thematic summary of the literature; and the themes presented in the policy review). Strikingly, the themes raised by the participants’ voices were strongly endorsed by the evidence in the literature and the ‘gold standard’ of Aboriginal health policy, the nine principles of the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (see Appendix 3).

To explore this further, a brief meta-synthesis was carried out at the end of the project to identify the common themes that emerged from the project as a whole.

The meta-synthesis involved grouping together key themes from the three strands of the project, to identify common ideas or ‘meta’ themes. Seven meta-themes were identified: holism; identity; cultural respect; collaboration; power and control; health sector and services; and reconciliation. These are displayed in the following diagrams over page.
Key

**Orange** themes come from the participant data

**Blue** themes come from the literature review

**Purple** themes come from the nine principles of the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013
Identity

- Homogenisation of Indigenous communities
- Living in "no man's land" affects health
- Loss of cultural identity and role
- The invisibility of urban Aboriginal people
- Identifying people as Aboriginal
- Identity and Voice
- Feeling Invisible
- Warriors and Tiddles

Cultural Respect

- The build up of past and present racism
- Equality and difference
- Culturally appropriate policy
- Cultural Respect
Collaboration

Dialogue and reparation

Working together

Engagement with Aboriginal communities

Consultation & partnerships

Power and Control

The importance of being in control

Loss of voice is absence of respect, and vice versa

Irresolvable access to resources - the elephant in the room

Poverty and Powerlessness

Accountability and transparency

Self-determination

Plans agreed by Aboriginal people

Community Centralization of Primary Health care services

Localised decision making

Accountability

Talking it up - Aboriginal voices in health policy that works
Project recommendations

These recommendations were drafted initially with the researchers and Aboriginal elders working together. They were then considered in detail and revised through the community feedback process. As such, these are the recommendations of the Aboriginal people who took part in the project, on the basis of the shared understanding of their health and healing that they developed as a result of taking part in the project.

Health policy

1. A revision of Victorian health policy should be undertaken so that it integrates the past and the present, through explicitly addressing the effects of dispossession and discrimination, and providing access to the pre-requisites for health (housing, education, employment etc), as well as focusing on disease reduction.

2. Victorian health policy should explicitly call for the incorporation of indigenous knowledge systems into service delivery, enabling the funding of forms of non-clinical healing services which focus on the development of consumer and community autonomy for health.

3. Policy should be accompanied by two sets of outcomes measures: the first relating to the impact of dispossession in spiritual, emotional and physical domains; and the second relating to increased longevity and disease reduction.

4. The voices of Aboriginal service users (as opposed to the voices of Aboriginal organisations) in the formulation of health policy should build on the good practice that exists for some policies at national level. Implementation should be strengthened by ensuring that Government health plans are explicit about their processes for Aboriginal service user participation.

5. Aboriginal participation in policy formulation should be strengthened by a program of community education aimed at Aboriginal service users, and through access to culturally appropriate supports for participation (e.g. family-member advocate system to aid network participation).

Expanded service delivery

6. New forms of service should be developed and funded which enable Aboriginal people to come together to share their experiences of past abuse within a culturally appropriate framework for spiritual healing. These services should be supported by standards and protocols, explicitly based on indigenous knowledge, which can apply within and across agencies, to ensure that spiritual healing is a component of all health service delivery.

7. Service delivery should focus on integrated models of provision which link services in different life domains, including services which are focused on building individual and community capacity building (e.g. literacy, numeracy and vocational and general education).

8. Data collection systems should be developed and implemented that enable the state bureaucracy to accurately determine the coverage of health services in relation to the Aboriginal population. Data collection needs to be located within an independent, centrally controlled body which comprises Aboriginal and non-Aboriginal representation, and implemented across all health service provision, including the Aboriginal Controlled and mainstream sectors.
9. Aboriginal people should have access to a service which protects their rights as consumers, which builds on existing structures within Consumer Affairs Victoria, by actively using Aboriginal consumer rights workers to work within ‘grass roots’ organisations and distribute information on rights in and across all relevant health service providers in Victoria.

10. Aboriginal people working in Aboriginal Controlled Health Organisations (ACHOs) should have access to funded, professional supervision, as well as ongoing professional development, to ensure that they are supported in their work and to build capacity within the ACHO sector. Professional development should reflect cultural protocols and rituals.

11. The implementation of the newly developed Cultural Competency Framework (in the Child and Family Services sector) should be extended and linked to service delivery in all policy areas that impact on the lives of Aboriginal people, including existing and new policy.

Advocacy partnerships for systemic change

12. VicHealth, supported by Consumer Affairs Victoria and Aboriginal Affairs Victoria, should lead the way in brokering conversations about the ‘elephant in the room’ (the reported ‘shunning’ of some people by some services within the Aboriginal Controlled Health sector, resulting in inequitable access to services and supports and/or poor treatment). The conversation should be framed within the business of consumer rights, and relate to access and choice for Aboriginal consumers.

13. VicHealth, in collaboration with Deakin University (DU), should advocate for the inclusion of Aboriginal health within health and allied health courses taught in all Victorian education institutions. The School of Health and Social Development will advocate within DU and other universities to start this process.

14. Wesley Mission Melbourne (Wesley) will review its own service delivery and implement measures that make services more accessible for Aboriginal consumers. Wesley will share its experiences with other community sector organisations, and advocate for organisational and systemic change which improves access for Aboriginal consumers to mainstream services.

15. Community education/campaign (like the recent Reconciliation Australia campaign to tackle discrimination) around the racism that Aboriginal people historically and currently experience should be provided, and funding sought by VicHealth and the Talking It Up partnership from a philanthropic source to undertake this.

New knowledge and understanding (further research)

16. More work needs to be done to understand what a successful life looks like for Aboriginal people, situated within an understanding that talking about stories of success is an important part of healing, and including stories from the individual, family and community levels, as well as those that focus on what Aboriginal and non-Aboriginal people have done together.

17. More work needs to be done to identify and understand what Aboriginal people need to feel safe when they are living away from their country, with the aim of creating new ways of feeling safe that are community-generated and community-supported, rather than through a reliance on Government.
How to read the report

The report comprises three sections:

- The evidence base for Aboriginal health that was developed from the community forums;
- A review of the literature on Aboriginal health; and
- A review of relevant policy.

Each of these can be read as a stand-alone summary of community views, key arguments from existing literature and an overview of the policy environment. However, when put together, they form a developing evidence base of good practice and directions for reforms for effective and healthy Aboriginal health policy.

A second version of this report can be accessed at www.deakin.edu.au/dro/ This longer version contains a description of each of the policies and frameworks referred to in this document, against criteria for analysis contained in Figure 3.8 (page 70). It also contains additional appendices (a summary report used for the community consultations and mapping of the relationships between the various policies and frameworks). Otherwise, the two reports are identical.
Chapter 1: COMMUNITY GROUP DISCUSSIONS

Introduction 20

Method 21

Fig 1.1 Participants’ countries 22
Fig 1.2 Map of participants’ countries 22

Findings 23

1. Effects of the Past in the Present 24
   a) Sickness is everywhere 24
   b) The family is the site for sickness and healing 24
   c) Lack of respect and its connection to ill health 24
   d) Dispossession is linked to ill health 24
   e) Living in ‘no man’s land’ affects health 25
   f) The build up of past and present racism 25

2. Identity and Voice 25
   a) Loss of cultural identity and role 25
   b) Feeling invisible 25
   c) Loss of voice is about loss of respect, and vice versa 26
   d) The invisibility of urban Aboriginal people 26
   e) The need for a new story to be accepted 26

3. Service Quality and Gaps in Provision 27
   a) Service system problems 27
   b) The need for service models which draw on Indigenous knowledge systems 27
   c) Inequitable access to services: the ‘elephant in the room’ 27

4. Promoting Healing 28
   a) Talking and listening as acts of healing 28
   b) The importance of being in control 28
   c) Dialogue and reparation 28

5. Warriors and Tiddas 29

Relationships between themes 30

Fig 1.3 Thematic diagram from focus groups 30
Chapter 1: Talking it Up with the Community

Research findings from community forum focus group discussions

Introduction

The first and most important strand of the Talking it Up project was a focus group study with participants from the local Aboriginal community. The group discussions, held at community forums, sought to ask people about the things that influence their health and their access to healing to begin to explore the policy needs of Aboriginal health in Victoria.

Discussions explored the individual and social issues impacting on health and ill-health, across issues which impact on chronic ill-health and those which bring about positive health outcomes.

Research evidence (discussed further in the literature review chapter) shows that Aboriginal and Torres Strait Islander people are over-represented in the populations experiencing chronic ill health. Health promotion strategies that work for non-Indigenous populations are not necessarily effective for Aboriginal and Torres Strait Islander people, and efficacy of strategies and policies is also impacted by poverty.

Health policies tend to create ‘additional’ strategies that supplement mainstream policy (explored further in the health policy chapter), and research tends to focus on rural or remote Aboriginal communities rather than metropolitan areas (although population patterns suggest that the majority of the Aboriginal population resides in urban/metro areas).

Where research does exist, it tends to be at the level of population trends and generally does not seek Aboriginal and Torres Strait Islander people as actors in the research process and as agents of their own destiny through research projects with a participatory design (Jackson Pulver et al, 2007). This study was therefore designed to engage with local community members, drawing participants from urban, metro communities, and with discussions facilitated by community members as trained co-researchers.
Method

Data was collected via a series of community forums with Aboriginal people, aged over eighteen years, and currently living in metropolitan Melbourne. The forums were advertised through the distribution of a flyer and by word of mouth through the ‘Koori grapevine’.

Members of the Community Reference Group in particular used their networks to let other services know about the forums. Participants self-selected to be part of the project, and no attempt was made at specific representation.

On the advice of the Community Reference Group for the project, the forums were structured to include opportunities for women’s business, men’s business and family business. To this end, four groups were held, two men-only (7 and 12 participants), one women-only (18 participants) and a mixed group (30 participants: all participants in the mixed group had attended one men’s/women’s group). In all, 35 people took part in the groups.

Participants were recruited through a range of existing channels within the community, a process controlled and undertaken by the Community Reference Group. Forums were held at Maya, a space which Aboriginal participants were familiar with and frequently used for other purposes.

Participation was self-selected, that is people chose to identify themselves as Aboriginal and over 18, and chose whether or not they wanted to take part. The standard pro-forma for consent asks participants to identify themselves by name and where they are “of”; for these participants the “being of” element was broadly responded to as which land or mob with which they identified.

There is great diversity within a geographically local urban or metro Aboriginal community, diversity of culture and language, and a range of countries with which people are affiliated. It is important not to assume that everyone is from the land on which the research is carried out, or that people are only affiliated with one country.

The sample self-identified as being from countries across Victoria, New South Wales, Queensland and Western Australia – a diversity that would not be adequately captured by traditional items asking people where they live now or where they were born.

Seven out of the 22 people who responded to “being of”, identified two countries, and both of these are included in the representations, below, of where the participants are “of”. As these are fairly small numbers, frequencies have been pooled into 1-3, 4-6 or 7 and more.

Figure 1.1 over page presents the list of countries that participants identified themselves as “being of”, including spelling variations. To represent the geographic diversity of the participants’ identities (all of whom presently reside in Victoria), the countries were located using a detailed map of Aboriginal and Torres Strait Islander lands (available online at: http://yolngu.net/yolngu.html).

One of the countries listed in Figure 1.1 (Murri) was not included in the our geographic map as it was possibly associated with more than one region.

The map of participants’ countries is presented in Figure 1.2 over page.
Figure 1.1 Participants’ countries

1-3 participants
- Bundjalung
- Dainggatti
- Gumbainggir
- Guna (Gunai)
- Gunditjmara
- Murray (Murri)
- Ngarrindjeri
- Noongar
- Wiiman
- Tjapwurung (Djabjawurung)
- Waka Waka
- Yagara (Yuggera)

4-6 participants
- Wamba Wamba (Wemba Wemba)

7 or more participants
- Yorta Yorta

Figure 1.2 Map of Participants’ Countries

Map of Participants’ Countries

22 Talking it up - Aboriginal voices in health policy that works
The project researchers provided training in group facilitation to Aboriginal community members. The training included the development of the schedule (or questions) that the groups were to consider – this process was undertaken by the Aboriginal facilitators. Each group was convened and lead by one of these facilitators, with the non-Aboriginal researchers present on the day of each forum to assist their Aboriginal colleagues in any way that was required. Formal consent was obtained from all participants by the non-Aboriginal researchers, prior to the commencement of the group session.

Each forum was audio recorded and transcribed, including de-identifying any potentially identifiable statements. The data was then coded, and reconstituted under different categories representing the emerging themes. Following this, the data was re-analysed to consider the relationship between the various categories and themes. A summary of issues and strategies from the combined forums was made available to all participants that had provided postal contact details, and were discussed at a second community forum which was attended by interested participants.

Participants were contacted by post if they had provided a postal address and through word of mouth, facilitated by the Community Reference Group. Details of the project materials are available in the appendices, including: a poster used at Maya to advertise one of the community forums (Appendix 1); the invitation to attend the second consultation (Appendix 2); and the summary report circulated to participants at the second consultation and subsequently by post to those who had provided a postal address (available in the full report).

The transcripts revealed that participants both described and offered explanations for the situations they found themselves in. This was a complex, interlinked articulation of their social situation which offers an exploratory at theorizing urban Aboriginal health from a grounded perspective.

Findings

Emergent themes have been arranged into four groups, which are discussed in turn:

1. Effects of the past in the present
2. Identity and voice
3. Service quality and gaps in provision
4. Promoting healing
5. Warriors and tiddas

The fifth theme winds its way throughout the other four themes, but has been selected out for separate comment. The separate experiences of men and women, their interpretation and the meaning each gender group placed on them are worthy of comment, and in keeping with the ‘men’s business’ and ‘women’s business’ structure of the forums.

This section of the report concludes with a consideration of the relationships between these themes, which forms the basis for an emergent theory of urban Aboriginal health from the perspective of Aboriginal people living in the metropolitan area.
1. Effects of the past in the present

a) Sickness is everywhere

“There’s so much hopelessness...what’s the use”

“People are sick with worry”

Sickness is everywhere: individuals, families, and communities are all sick. It is a hard way to live, and hard to know how to heal oneself and others. Alcohol, drug addiction and violence are responses to the frustration and hopelessness. This perpetuates, or creates, an intergenerational aspect, which is mutually reinforced by current policies, e.g. child protection.

c) Lack of respect and its connection to ill health

“How do I find ways of feeling good about myself?”

“Whitefellas always looking down their nose at us”

Lack of respect, experienced personally and communally, within communities, within families, and between black and white Australians, is strongly connected to ill health and an inability to heal.

d) Dispossession is linked to ill health

“Blackfellas need their land”

“The dreamtime was love, peace and justice...this is gone for blackfellas”

The effect of dispossession, and its linkage to ill health, needs to be understood at personal, infrastructural, and legal levels. At the personal level, the loss of land (and therefore culture) impact on self-esteem and mental health, and is linked to poor choices which perpetuate dysfunctional life circumstances.

At the infrastructural level, a lack of housing and support services (in particular, services for people in and leaving jail, and for women fleeing family violence) contribute to an ongoing experience characterised by rootlessness, instability and transience. At the legal level, the lack of real land rights, the failure of native title in Victoria, and difficulties with proving aboriginal identity mean that basic structures for well-being are lacking.

b) The family is the site for sickness and healing

“We need to focus on healing and looking after each other, so you don’t get bitter about how dysfunctional things are”

“How do I find ways of feeling good about myself?”

“We need to focus on healing and looking after each other, so you don’t get bitter about how dysfunctional things are”

“Men and women are both unwell – why aren’t we helping each other instead of fighting all the time?”

The family is the site for sickness, and also contains the possibility for healing. For this to happen, strategies and supports for people to identify with, and connect to, culture, land (home) and community are needed.
2. Identity and voice

a) Loss of cultural identity and role

“You had your place in the law and in the family”

In the past, culture provided people with a role, place and social system that allowed them to flourish as families and communities, including processes for dealing with events that disrupted the social fabric. For many people who now live in an urban area, this has disappeared within a generation. For the men (for whom this appeared to be particularly important), this was portrayed through nostalgia for an idyllic past, which they set against descriptions of a dysfunctional present.

b) Feeling invisible

“We are treated like children in our own country”

“There’s nobody out there to listen to us, because everyone knows everything”

Experiences of racism carry forward from the past, and exist independently in the present, with a compounding affect. The impact of growing up with constant, overt discrimination has a massive impact on individual identity and self-esteem, leaving people feeling that they would “never be good enough”, only ever be “second-place”, having “no place or role”. Contemporary and continued experiences of racism, especially those felt within the service system, leave people feeling degraded and worthless. This has an impact on people’s ongoing engagement with services. 

25
c) Loss of voice is about loss of respect, and vice versa

“Health is a big industry... aboriginal people are perfect clients”

“And then, as you got older, we started thinking about taking responsibility and who you wanted to be, making a spear, a boomerang”

Having a voice and being respected are connected. They talk about the ways in which they have been problematised and commodified, as “dysfunctional clients”, a disempowered and disempowering position in which other ‘experts’ come and ‘know about’ and ‘do things to’ them. There is the sense that they risk becoming identified with a pathology e.g. sexual assault, drug and alcohol, violence, or criminality. Counter to this is a view of themselves as guardians of the land and holders of knowledge, both in relation to the environment, and in relation to healing their own communities.

d) The invisibility of urban Aboriginal people

“Tourists get told we’re not blackfellas...well, what are we?”

“We got people out there that say they’re black, but they’re not black...they’re taking the system for a ride”

As urban Aboriginal people, perhaps with pale skins, they feel particularly invisible. This is reflected in the repeated difficulties of proving Aboriginality and in the feelings of rejection that come with not being counted.

e) The need for a new story to be accepted

“I could kill everybody all of the time – it’s just not healthy”

“People didn’t want to hear the bad stories, just the nice feeling stuff – it’s important to hear the impact the past has had on people”

A return to visibility would involve recognition of past wrongs and an acknowledgement of history on their terms, as well as effective mechanisms for representation. Men associate unfair treatment within the legal system, both historically and currently, with powerlessness and frustration. They feel let down by the legal system, and not sure where how to get redress. Combined with the overt racism that they have experienced, this is a strong feature in their description of their own poor health, violent reactions to their invisibility and recourse to drugs and alcohol.

For these men, the value of the social circle in healing (see section 4a, page 29) lies with its capacity to function as a safe place in which to share unjust experiences and the anger and hurt that these give rise to. As such, talking and sharing is an alternative to more destructive and alienating courses of action.
3. Service quality and gaps in provision

a) Service system problems

“What I really need is a carer where I live, someone to keep an eye on me and speak on my behalf. Coz I dunno what to say half the time on my behalf. I leave home to go to the doctor’s surgery. By the time I get to the doctor’s surgery I’m in another world, know what I mean?”

“More [healing] circles…I believe that everyone has a voice and that through times gone by our voice has been…stopped. These circles are imperative for us to get stronger and listen to and hear each others’ stories”

Women, in particular, focused on problems within the service system, and what is needed to fix it. There are two key areas for service development. The first of these relate to social services, in particular, family violence and housing, and services for people in and coming out of prison. Integrated services, particularly those which have a mental health dimension, are important. It is important that service design and staffing are capable of responding to the complexity and multi-dimensionality of experiences and issues that people have.

b) The need for service models which draw on indigenous knowledge systems

“We know what the problems are, because we’ve experienced them – we know what needs to be changed to make things better”

“Women need to talk about it, what they’ve been through – not bear it alone”

There needs to be a focus on preventative services, including child care and women’s programs, and programs to teach people how to stay out of prison. Participants in the women’s group talked about the need for service models which draw on communities’ knowledge (for instance, strengths-based approaches). The women also questioned the competencies required to work with people who had experienced complex and entrenched disadvantage. They recognised the precarious position of relying on workers from the communities in question, with their expert and first hand knowledge of the problems that service users face, and the need to ensure that those same workers were supported in their own healing journeys.
c) Inequitable access to services: the ‘elephant in the room’

“An industry has been made out of our misery”

“There is a lot of discrimination...even in our own orgs...they can get a bit toffee, not compassionate enough”

The major issue in relation to service provision and quality, however, concerned divisions within the Aboriginal population in Victoria, where some people found themselves unable to access particular services, despite being eligible. In the words of one participant, ‘there is a division in the community between the rich black bureaucrats and the little group that are suffering down there’.

This phenomenon is closely related to nepotism in the non-Aboriginal community. One female elder described this as the act of ‘shunning’, where one individual or family will ‘shun’ or turn their backs on another, leaving them out of the circle through which Aboriginal business, including healing, can be done.

Examples of shunning included discrimination towards some individuals and families, depending on who is on the board or staff of the service providing organisation. It covers difficulties with proving aboriginality. And it raises questions about where do people go when they are turned away from these organisations. The discrimination from within the community is felt all the more painfully, and whilst it is clear that it needs to stop, is not clear how this is going to happen. Because of the difficulties of discussing this experience with actors in the service systems, it can be regarded as ‘the elephant in the room’ of Aboriginal services.

Although the participants talked freely about this issue in the safety of the spaces that the project provided, there is a great deal of reluctance to talk more publically. Moreover, the non-Aboriginal researchers noted that it is also difficult to find a way to talk constructively about it within the broader health and community services system. In particular, they contemplated the outcomes of dismissing it as ‘Aboriginal politics’, and considered that this was a form of abrogation of responsibility of the part of the mainstream system.
4. Promoting healing

a) Talking and listening as acts of healing

“Healing is about having someone to talk to, so that you can feel you’re important to someone”

“We need to stick together and remain proud of our families, despite the violence and death”

Healing and well-being were not expressed in relation to curing disease, but in terms of having a voice to talk to each other, the healing experience of being listened to, and feeling cared for. Talking is central to the healing process. Talk and sharing experience are seen as acts of healing, active experiences that are constitutive and productive. Talk is the carrier and shaper of culture, it is a means of showing care for self and others, and thus a means of healing individually and communally.

c) Dialogue and reparation

“We have a strong knowledge base here”

“We could be included and respected for our input into debates”

Dialogue is seen to be important as a means of reparation and progress, and is the means of bringing together talk and control. Dialogue is needed at a range of levels: interpersonal, family and community, between different aboriginal communities and between aboriginal and non-aboriginal communities. Dialogue needs to occur within a recognised set of structures, which would include a treaty and a system of representation linked into broader governance arrangements. In particular, women expressed the desire for a voice of their own, recognising their strength in numbers, and expressing their desire for control of their own resources.

b) The importance of being in control

“We’d like people to look at Aboriginal systems of living and environment, and learn from that”

“The importance of spiritual continuity – even if we are physically changed”

A second aspect of healing was about feeling in control of their own lives, through the provision of services in which they had a say, and the means of being represented in decision-making at all levels of governance.
5. **Warriors and tiddas**

Whilst the themes were common to both men and women, there were differences in their expression, emphasis and interpretation. The men, who referred to themselves as ‘warriors’, showed greater concern with the loss of their traditional role as protector of family and land, and that the impact of this cultural dispossession had on their health and well-being. The women called themselves ‘tiddas’ (sisters), and talked largely about what was needed to support and protect their families.

This appears to reflect a shift in the protector/guardian role from men to women, a cultural disruption which is damaging for both genders. The men were able to offer an analysis that centred on their double dispossession, first by the failure of modern urban society to ‘reconstruct’ a role for them, and secondly by the loss of their role to their women. The women didn’t talk in terms of their liberation from their traditional role, but about the heavy burden of this shift, which required them to care for their men as well as their families, in order to carry their cultural traditions forward for future generations.

This leads to the need for spaces in which Aboriginal men can talk to and share their experiences with each other, and likewise, spaces where Aboriginal women can talk to each other. The women, in particular, articulated the need for a representational voice to ensure that women’s experiences and issues are included in broader governance structures. The women talked about the link between family violence and loss of voice, which made it ‘hard to find my way out’. Women did not turn their backs on the men who were violent, but talked about their need to have separate, safe spaces in which they could share their experiences and regain their self-respect and pride in their culture and who they are.
Relationship between the themes

The diagram in Figure 1.3, on the next page, was developed and refined in conjunction with the Aboriginal co-researchers to show the interrelationships between the emerging themes. Themes have been grouped into three main strands: factors impacting on health and well-being; interventions that promote healing; and, collaborative advocacy for reconciliation and healing.

In the first strand (factors that influence health and well-being) the vertical arrows show how the factors that influence health and well-being are causative and cumulative, resulting in widespread, even ubiquitous, sickness. In the second and third strands, the vertical arrows show how the different forms of intervention (including advocacy) build on each other to promote good health.

Within each strand, thematic elements have been grouped together to show strong relationships between those themes. Horizontal arrows indicate relationships across the three strands. Thus, themes relating to dispossession and loss are grouped in the first strand, are best addressed by interventions to tackle racism and discrimination in the second strand, and require health policy which tackles the effects of the past and the present, shown in the third strand.

The interventions to promote healing are related to the various factors impacting on health and well-being, and combine to suggest an integrated approach to health and healing for Aboriginal people which addresses the concrete and symbolic aspects of their lives.

Although the exploratory theory presented in this diagram has come from the unique experiences of the people who have participated in this project, it is endorsed in the boarder literature relating to Aboriginal health. This is explored in detail in the next section of this report.
# Chapter 2: LITERATURE REVIEW

1. Introduction
2. Method
3. Literature Overview
   - Fig 2.1 Thematic Diagram from Literature Review
4. Tension between statistical equality and valuing difference and diversity
5. Measurability: culturally appropriate evidence base, measures, benchmarks, targets and timeframes within the context of increased power and control for Indigenous people
   - Data Quality
   - Absence of Data and Incomplete Data
   - Cultural Appropriateness
6. Policy does not address structural inequities and determinants
7. Recognition of historical and cultural context, social settings: Collaboration as Reconciliation
   - Legacy of Colonisation
   - Self Determination
   - Collaboration as Reconciliation
8. The Policy Cycle: Process and Delivery
   - Collaboration and Partnerships
   - Policy recommendations from research in urban Aboriginal communities
   - Research with urban Aboriginal communities
   - Policy Design
   - Policy Implementation
   - Evaluation of services, programs and policy
9. Conclusions

References
1. Introduction

This literature review seeks to identify and discuss the policy implications of existing research around health and health promotion for urban Aboriginal communities. There is a broad and vibrant body of literature that explores and debates Aboriginal health and health policy in Australia and in other First Nation countries, much of which is focussed on rural and remote communities and those living apart from ‘mainstream’ society (Pyett et al 2009). This review does not seek to summarise the whole of this literature, but seeks to narrow the field to that which can be applied to Aboriginal people living in Victoria, a predominantly urban or metropolitan population, geographically embedded within multicultural cities and towns (ABS 2007).

The available literature is diverse, with multiple points of convergence and divergence, and as such most policy arguments can be supported by at least a fraction of the overall body of research and commentary, as Lutschini cautions: “policy makers have to navigate and interpret a diverse health literature and assemble disparate messages into saleable policy options... policy makers can justify any answer based on the diversity of the literature, subsequent themes and range of meanings” (Lutschini 2005 pp 2-7).

With that in mind, it is important to highlight the limitations of this review early in our discussions: this is not an exhaustive analysis of all available positions and beliefs within the field of Aboriginal health and health policy. Neither is it without assumptions or bias: we take a human-rights based position, which emphasises the importance of social justice, and an essential need for the autonomy of, and engagement with, Aboriginal people in the governance and improvement of their/our communities. Where possible, we seek to take a holistic approach to Aboriginal health policy; both an holistic notion of health and also as an holistic, or intersectoral, notion of policy and health governance. On this latter point however, we are pragmatically limited by the structure and organisation of the health field.

Indigenous social and health disadvantage have been well documented (see for example ABS/AIHW 2008), and health policy makers in Australia face a broad range of entrenched public health problems, particularly as Aboriginal health disparities and inequities widen (Gleeson 2009). Notions of holism within Aboriginal health are widely recognised, and relatively well established within mainstream policy machinery, for example a government-level definition of Aboriginal health from 1989 states that: “Health is not just the physical well-being of the individual, but the social, emotional, and cultural well-being of the whole community.

This is a whole-of-life view and it also includes the cyclical concept of life-death-life” (Department of Aboriginal Affairs 1989). However, “there is no definitive source providing a comprehensive grounding framework to enable effective engagement with the concept of Aboriginal health” (Lutschini 2005 p2).
A lack of detailed or applied understanding of the notions of holistic Aboriginal health is evident in both the social and political environment, which renders “cultural differences either invisible or too visible and something to be eliminated” (Altman 2009 p14).

This invisibility is amplified in urban, metropolitan and ‘mixed’ areas, where Aboriginal culture is submerged within, as well as subjugated by, ‘mainstream’ dominant cultures. It is therefore important that there is “recognition that Aboriginal culture exists and is important in urban areas” (Kelly and Luxford 2007 p17). A need for recognition of urban Aboriginal communities, culture and health-needs is both a rationale for this review and also a finding drawn from the policy environment: urban Aboriginal people are affected by health policies, but rarely are they adequately recognised within the policy process.

The discourses of the public policy environment will shape emergent policy, and those who participate in the discourse will influence policy content (Aldrich et al 2007), therefore it is important to recognise, engage with and facilitate the participation of Aboriginal communities within commentary and advocacy for policy change.

While there is a large body of literature that points to the failure of policy, “there are few examinations of policy, [or] the policy process of political decision-making for policy concerning the health of Aboriginal and Torres Strait Islander peoples” (Aldrich et al 2007 p125). This review therefore aims to draw from a diverse but acknowledged incomplete evidence base, to identify implications from existing research through a thematic analysis of literature relevant to current and future Aboriginal health policy in Victoria.

2. Method

Three sources of data were sought. Firstly, evaluations of specific policies identified in the policy review section of the Talking It Up project; secondly, primary research around health and health promotion from urban Aboriginal communities that had policy implications; and thirdly, secondary research or commentaries that critiqued the evidence base and/or policy outcomes for Aboriginal health.

A search for empirical research around specific Aboriginal health policy, as well as current research around health and health promotion for urban Aboriginal communities was conducted using all databases available through EbscoHost, including Academic Search Premier, CINAHL, Global Health and Medline.

Search terms were: Aborigin* or Indigenous AND health AND Australia* (where “*” is a truncation term that allows for multiple variations of the root word, for example Australia* would identify Australia and Australian and Australians). A sub-set of the search was limited to urban or metro, to filter out research only conducted within very remote communities.

The publication date was limited to 2000 onwards, in line with the earliest year of introduction of current Aboriginal health policy, as identified in the policy review. Grey literature was searched for using Google Scholar, and the titles of existing policies (identified in the policy review) were used as search terms through the main Google search engine, to identify other commentaries or evaluations available through grey or other non-peer reviewed sources.

Articles were included in the literature review if they were evaluations of specific policy, evidence-based commentaries on specific policies, empirical research into Aboriginal health with a policy focus or commentaries on the general Aboriginal policy environment. At the outset of the literature search, there was an anticipated hierarchy across this
Articles identified by the search strategy and included for review were read and thematically analysed, identifying key themes in the literature. These are discussed in the following sections of the literature review.

3. Literature Overview

Five themes were identified in the literature:

1. Tension between statistical equality and valuing cultural difference and diversity
2. Measurability: culturally appropriate measures, benchmarks, targets and timeframes within the context of increased power and control for Indigenous people
3. Policy does not address structural inequities and determinants
4. Recognition of historical and cultural context, social settings: Collaboration as Reconciliation
5. Policy Cycle: process and delivery

These are summarised in Figure 2.1 on the following page, and discussed in more detail in the following sections. An earlier version of this diagram was included in a summary report circulated to the community for feedback and community comment.

A full copy of the draft literature review was available in the interim report discussed at the second round of consultation. Feedback was generally supportive, but minor revisions have been made to improve the clarity and appearance of the diagram. Conclusions were reformulated to frame tensions in the evidence-base as questions for practice.
What are the policy implications of existing research around health and health promotion for urban communities?

**Equality and difference**
- Remedialism, bringing Aboriginal people 'up'
- Recognition of unique and 'good'
- Over-emphasis on bio-medical indicators, lack of holism
- Homogenisation of indigenous identities

**Culturally appropriate policy**
- Plans agreed by Aboriginal people
- Identifying people as Aboriginal
- Use & misuse of data

**Social structures and inequities**
- Poverty and powerlessness
- Equal opportunities
- Social determinants

**Policy making and doing**
- Engagement with Aboriginal communities
- Consultation & partnerships
- Evaluation & research
- Policy vs practice
- Workforce & services

**Reconciliation and history**
- Self determination
- Legacy of colonisation
- Context: historical, social and cultural

**Equality and difference**
- Remedialism, bringing Aboriginal people 'up'
- Recognition of unique and 'good'
- Over-emphasis on bio-medical indicators, lack of holism
- Homogenisation of indigenous identities

**Culturally appropriate policy**
- Plans agreed by Aboriginal people
- Identifying people as Aboriginal
- Use & misuse of data

**Social structures and inequities**
- Poverty and powerlessness
- Equal opportunities
- Social determinants

**Policy making and doing**
- Engagement with Aboriginal communities
- Consultation & partnerships
- Evaluation & research
- Policy vs practice
- Workforce & services

**Reconciliation and history**
- Self determination
- Legacy of colonisation
- Context: historical, social and cultural

**Equality and difference**
- Remedialism, bringing Aboriginal people 'up'
- Recognition of unique and 'good'
- Over-emphasis on bio-medical indicators, lack of holism
- Homogenisation of indigenous identities

**Culturally appropriate policy**
- Plans agreed by Aboriginal people
- Identifying people as Aboriginal
- Use & misuse of data

**Social structures and inequities**
- Poverty and powerlessness
- Equal opportunities
- Social determinants

**Policy making and doing**
- Engagement with Aboriginal communities
- Consultation & partnerships
- Evaluation & research
- Policy vs practice
- Workforce & services

**Reconciliation and history**
- Self determination
- Legacy of colonisation
- Context: historical, social and cultural
4. Tension between statistical equality and valuing difference and diversity

There are several strong voices within the literature that express a tension between statistical equality and valuing cultural difference and diversity within policy. These voices stem particularly from commentary around the Close the Gap policy.

Often policy broadly aims to bring Aboriginal health ‘up’ to the standard of White or non-Indigenous Australian health, providing evidence of the “persistent white/western faith in the power of the scientific method to heal social ills” (Pholi et al 2009 p9). This goal of normalising Aboriginal people has an inherent threat of assimilation and fails to recognise or celebrate cultural differences in health patterning.

The pursuit of statistical equality “reduces Indigenous Australians to a range of indicators of deficit, to be monitored and rectified towards government set targets…illustrating a substantial imbalance of power and control over the Indigenous affairs agenda in Australia” (Pholi et al 2009 p1).

Current Aboriginal health policy is dominated by the idea of statistical equality, and whilst at face value there should be no gap between Indigenous and non-Indigenous Australians, these commentators argue that effective Aboriginal health policy should accommodate and value diversity and difference rather than emphasising statistical equality (Altman 2009; Pholi et al 2009).

Altman (2009) suggests that the pragmatic politics of equality is over-determining Aboriginal health policy, while the more complex and subtle politics of difference and diversity is being excessively subordinated (Altman 2009).

In order to measure progress, Close the Gap relies on comparable data and therefore anything that may be uniquely positive about being an Aboriginal or Torres Strait Islander person is of little relevance to the ‘evidence base’ as there is no comparable data set within the non-Indigenous population (Pholi et al 2009).

The politics of the gap have swung heavily towards remedialism and the imposition of authoritarian solutions, with frustration and intolerance of the long-standing tension between equality and difference (Altman 2009; Pholi et al 2009). There are a number of arguments against this approach.

Altman (2009) highlights these specifically, and these include the post-development theory that interprets the Close the Gap framework as “just an antiquated form of imposing a top down modernisation approach on Indigenous subjects” (Ferguson 2006 as cited in Altman 2009 p7).

Anthropologies of development are critical, seeing such “universalistic top-down approaches as disruptive of local solutions and cultures, and fundamentally reflecting a discourse of power” (Escobar 1995 as cited in Altman 2009 p7). Culturalist/relativist critiques state that the approach “only uses the social norms of the dominant society, and so fails to value different life worlds and social norms whether in remote or metropolitan Australia” (Peterson 2005, Cowlishaw 2009 as cited in Altman 2009 p7).

Humpage 2005 (as cited in Altman 2009) states that the Close the Gap approach is used “as a means to legitimise state intervention, to define Indigenous difference as in need of remedy, to mainstream non-Indigenous standards, and to avoid acknowledging Indigenous notions of outcomes that might include self-determination, autonomy and self governance” (Humpage 2005 as cited in Altman 2009 p7).
Whilst Altman (2009) and Pholi et al (2009) focus their commentary on Close the Gap, there are similar arguments within commentary on Indigenous Drug and Alcohol policy. Brady (2007 p762) states that current drug and alcohol policies have seen “a retreat from the recognition and endorsement of the special, different needs of Indigenous people, and a return to notions of equal treatment and integration with the Australian collectivity”. This argument is supportive of those situated within commentary of the broader Close the Gap framework.

Alongside these arguments are critiques that describe how social indicators can be culturally inappropriate, and whilst this will be more specifically discussed in the following section, the statistical indicators with which progress in closing the gap will be measured represent Indigenous Australia not as a society, but as a population comprised of individuals.

Statistics focus on averages of individuals, and so present a statistical fiction of subjects as independent of kinship or community social settings and the dynamics within Aboriginal and Torres Strait Islander societies, as well as the structural conditions, and relationships of power and control between Indigenous and non-Indigenous Australia (Taylor 2008 as cited in Altman 2009; Pholi et al 2009).

It is with this in mind and the ambiguous interpretations of statistical data that Altman (2009) asks the question of what is it that we are seeking to measure within the Close the Gap framework, and is it a sound basis for policy?

Altman (2009 p6) states that the statistical goals of Close the Gap “become somewhat rhetorical and hollow if they are not matched by effective policy action or analysis of the causes of socio-economic difference, and if such goals do not reflect Indigenous aspirations”.

The poor recognition of socio-economic and structural determinants of Indigenous health must also be examined, and there is a compelling argument throughout the literature for greater emphasis on and recognition of these factors within the policy environment. A more detailed discussion of this is presented in future sections.

To summarise, this theme identified in the literature reflects a small number of firm voices that call for a policy framework that does not sacrifice either equality or difference. Altman (2009 p15) articulates that this policy framework would be “based on more coherent and inclusive notions of equality and difference”, and is somewhat comparable to the Indigenous policy environment that exists in New Zealand. Recommendations for this policy framework include the notion of equality however this refers to equality and equity, “although difference in outcomes is inevitable” (Altman 2009 p15).

Secondly, the framework needs to encompass the notion of difference, with “Indigenous-specific programs negotiated on social justice and human rights principles. Such rights should countenance the option for voluntary exclusion as strategic choice” (Altman 2009 p15).

Thirdly this policy framework needs to incorporate the notion of historical legacy, and that should involve compensatory measures. Altman (2009 p15) acknowledges that this policy framework would be challenging and difficult to sell politically, but that “it is essential if we are to transcend the insidious homogenisation embedded in the Close the Gap approach, and instead seek to pursue a kind of multiculturalism that can seriously accommodate and value Indigenous diversity and difference”.

As outlined in the next section, the tension between statistical equality and cultural diversity and difference is most clearly articulated in the limited benchmark targets that are utilized within policies: highly individualised and with an emphasis on socio-economic status and biomedical data points to the exclusion of Aboriginal understandings of health and wellbeing.
5. Measurability: culturally appropriate evidence base, measures, benchmarks, targets and timeframes within the context of increased power and control for Indigenous people

Measurability was identified as a persistent theme within the literature, and incorporates a number of strands and tensions. Specifically these include problems associated with data quality, the absence of data and measurability and the cultural appropriateness of data, measures and benchmarks, each of which are discussed further.

**Data Quality**

National data remains flawed in relation to Aboriginal and Torres Strait Islander people and the accurate identification of Indigenous status. The problems associated with data quality “limit our ability to accurately establish and monitor comparative secular trends between populations” (Brown 2009 p97).

There is concern surrounding the difficulties in collecting, and thus the completeness, quality and accuracy of Aboriginal and Torres Strait Islander statistical data, particularly in mortality, hospitalisations and health datasets, and across and within jurisdictions with the largest Aboriginal populations (Anderson 2006a; Anderson 2006b; Brown 2009; Jackson Pulver and Fitzpatrick 2004; d’Abbs and Brady 2004; Mak 2008).

Anderson (2006b p21) notes that the ability of the Aboriginal and Torres Strait Islander Health Performance Framework, which was designed to measure the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health, will “be limited by the availability of appropriate quality data for reporting, a major factor of which is the inconsistent recording of Indigenous status/territories, although this is improving”.

**Absence of data and incomplete data**

The policy-making process is complex and politicised, however when the opportunity for policy reform arises, public health research and evidence has an important place (Nutbeam and Boxall 2008). Whilst most policy change is incremental and based on a mix of influences, increased value placed on evidence will be most likely if evidence is “available when needed, is communicated in terms that fit with policy direction, and points to practical actions” (Nutbeam and Boxall 2008 p748).

As a consequence of poor data quality surrounding Aboriginal and Torres Strait Islander people, much of the policy commentary points to an avoidance of data altogether, thus influencing the measurability of Aboriginal health policy. The success of Aboriginal health policy requires improved data collection and the ongoing development of shorter and longer term action plans and benchmarks that are agreed to by Aboriginal people (Jackson Pulver and Fitzpatrick 2004).

Aboriginal health policy typically lacks benchmarks or measures, but is also influenced by the quality and appropriateness of the evidence base. However, as identified by Altman (2009 p2) in commentary on Close the Gap, even when policy articulates specific objectives such as reducing the gap in mortality rates for children under five; reading writing and numeracy levels; year 12 attainment rates; and employment outcomes, the term “closing was used a little loosely, if realistically, to mean halving”.


Despite having objectives, there are questions of their measurability and ability to be monitored over time, and the appropriateness of reducing but not eradicating disparity or disadvantage of Indigenous populations.

Policy recommendations relating to the National Drug Strategy Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan focus on better compilation of coronal data from different jurisdictions in order to provide a national collection of statistics on the impact of petrol sniffing and other inhalants on morbidity and mortality given the paucity of data in this area (d’Abbs and Brady 2004).

There are problems identified within the evidence base used to inform the National Drug Strategy Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan. d’Abbs and Brady (2004 p259) recommend that the evidence base, particularly relevant to petrol sniffing, could be increased by “utilising one or more of the existing national drug research centres” and that this would highlight the difficulties in collecting such data and provide the basis for a formal national collection of statistics on the impact of petrol sniffing and other inhalants on morbidity and mortality.

Similarly, there is some commentary around Aboriginal health policy that targets drug abuse, and it is noted that there is a lack of fit between funding and evidence-based interventions for substance misuse (Gray et al 2006). It is also noted that evaluation of Indigenous-specific policies, programs and interventions is limited, and that those that have been conducted are of variable quality (Gray et al 2006; Dance 2004).

In the absence of reliable data, and limited benchmarks and targets for Indigenous health policy, what data is relied upon is not always culturally appropriate. Altman (2009 p14) highlights that there has been “no negotiation of agreed objective and no evidence that the policy juggernaut is countenancing ‘flexible tailored local solutions’”.

**Cultural Appropriateness**

There is widespread acknowledgement and acceptance of holistic definitions of Aboriginal health within the policy literature, however “there is little general or specific detail about what this means and the implications for the health system” (Lutschini 2005 p2). As discussed in the previous section, there is a tension between statistical equality and valuing diversity, which results in conflict and tensions in other areas of the literature.

The tension between reductionism and holism, and benchmarking versus experienced equity, is evident in the literature body. AIHW data is weighted heavily towards risk factor reduction and health service provision, and the statistical orientation of closing the gap reduces Indigenous Australians to a range of indicators of deficit, and does not allow for the enormous complexity of diverse, Indigenous, culturally-distinct, ways of being (Altman 2009; Pholi et al 2009; Nutbeam and Boxall 2008).

There is tension between the collection of health performance indicators to facilitate health policy and planning and the role of indicators in fiduciary accountability (Anderson et al 2006b). The evidence base that guides Indigenous health policy is typically quantitative and is based largely on biomedical and socio-economic indicators, and as such “is the starting point and the guide to action, to the point where action may only be undertaken where there are data available to support it” (Pholi et al 2009 p3).

Policy makers must engage with holistic notions of Aboriginal health in order to set culturally appropriate benchmarks that reflect community aspirations whilst ensuring human rights provision and accountability (Lutschini 2005; Jackson Pulver and Fitzpatrick 2004).
The targets identified will require significant commitment and investment in implementation, and a key strategy for reducing the disparities in Indigenous health would be to address structural power imbalances, increasing Indigenous control over their circumstances (Brown 2009; Pholi et al 2009; Ring and Brown 2002). “The framework for monitoring progress would include a substantial suite of indicators measuring the degree to which power and control increase and is collectively exercised within Indigenous Australia” (Pholi et al 2009 p5). This notion of collective voices will again be picked up in later sections.

6. Policy does not address structural inequities and determinants

Indigenous health disparities are predominantly related to other ‘diseases of poverty’ and it is the familiar principles of ‘equal opportunity’ that compels governments to ensure that no ‘category’ of citizen suffers worse life chances than other categories (Couzos 2004; Rowse 2009). “Indigenous Australians, as a category, do suffer worse average life chances, so public policy must respond” (Rowse 2009 p3).

Aboriginal people in Australia are “on the negative extreme of basic indicators of health and well-being, such as life expectancy, educational attainment, and incarceration rates” (Johnston et al 2007 p490). However, Australian health policy does not typically address the social determinants of health (Nutbeam and Boxall 2008).

Whilst it is recognised in previous sections that Aboriginal health policy must include targets, funding and timeframes that are culturally appropriate, it is also recognised in the literature that data has become both the means and the ends. It is the statistical gaps within inappropriate measures that define the targets for policy action (Altman 2008).

Such a policy approach, though ‘evidence based’ is virtually devoid of theory and exists outside of historical, social and cultural context, measuring what is reducible and feasible rather than measuring determinants of health or health outcomes (Calma 2007; Pholi et al 2009; Anderson et al 2006b).

It is imperative that policy attention is directed towards areas such as health, education, housing, welfare reform, and employment, and that these policy areas are addressed with both short and longer-term strategies (Jackson Pulver and Fitzpatrick 2004).

Research conducted by Lloyd et al (2008 p181) that explored the role of the health workforce in implementing Aboriginal health policy, states that “addressing the social determinants of health and community development were seen as the most important aspects to improving Aboriginal health”.

There are broad calls for a greater focus on the structural inequities and social determinants influencing Indigenous health outcomes, and these broad principles have also been highlighted in commentary surrounding a few select policy documents and policy areas.

Specifically, the importance of the social determinants and broad structural inequities has been highlighted in three Aboriginal policy areas: Close the Gap, the National Drug Strategy Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan and the National Strategic Framework for Aboriginal and Torres Strait Islander Health, the details of which are outlined below.
Commentary surrounding Close the Gap emphasises its failure to acknowledge that poverty is a symptom of powerlessness, and hence fails to address the structural sources of inequality and how they might be rectified (Li 2007 as cited in Altman 2009).

Other commentary indicates that it is the absence of a critical focus on structural inequities, collective power and control, and the dynamics of the relationship between Indigenous Australia and the rest of the nation, that means the policy will be “unlikely to achieve healthy Indigenous Australian societies, adequately equipped to manage and sustain the health of its members” (Pholi et al 2009 p6).

Literature that examines the National Drug Strategy, with a particular emphasis on sniffing and inhalants states specifically that petrol sniffing is “too complex an issue to be addressed through short-term pilot and project funding; it requires, rather, longer-term interventions that address the multiple risk and protective factors present in communities, and that build on programmes that have been shown to be effective” (d’Abbs and Brady 2004 p259).

There are parallels with The National Strategic Framework for Aboriginal and Torres Strait Islander Health, which has been described as being “measuring what is feasible as opposed to measuring determinants of health or health outcomes” (Anderson et al 2006b p7).

This theme highlights agreement within both broad and specific policy commentary that the structural, social and historical determinants influencing Aboriginal health are omitted from the policy process, and that this must fundamentally inform future policy, as discussed further in the next section.

7. Recognition of historical and cultural context, social settings: Collaboration as Reconciliation

“Sickness, expatriation from ancestral land, and poverty are all manifestations of the collision of worlds and cultures” (Johnston et al 2007, p489) and there are a number of voices in the literature that argue for the importance of recognition of this historical context and social settings.

The current Aboriginal health policy environment does not sufficiently target or acknowledge upstream determinants and causes, and symptomatic of this is the downstream, post-diagnosis service focus within the policy environment. Three particular issues are noted as particularly embedded within the current context of Indigenous affairs and yet inadequately addressed by policies: colonisation, self-determination and reconciliation.

Legacy of Colonisation

As discussed in the previous section, the social determinants and structural inequities influencing Aboriginal health must be recognised; however these cannot be viewed as a “technical problem with no history” despite the preference for doing so by the settler-colonial state (Altman 2009 p14). It is broadly recognised that Aboriginal health is holistic, and that it encompasses mental, physical, cultural and spiritual health (NACCHO 2003).
It is important that there is historical openness about the concept of Indigenous rights (Rowse 2009), and more specifically, “to recognise the link between Aboriginal and Torres Strait Islander people’s burden of illness and the anxiety, anger and grief resulting from separation from country, cultural destruction and genocide is the first step towards significant and lasting change” (Jackson Pulver and Fitzpatrick 2004 p193).

A number of authors within the literature recognise the importance of the historical and cultural context, and argue that our shared history must be acknowledged within the broader community and within the policy environment (Jackson Pulver and Fitzpatrick 2004; Johnston et al 2007; Altman 2009).

This shift in focus to the broader, non-Indigenous community is central to the arguments around recognition of structural and social determinants. It forms the idea that the focus should be on the wider community and society, rather than directing all attention at Indigenous community groups and their ‘problems’. Pholi et al (2009) provides a pertinent argument that there is no measure of the prevalence of racism or discrimination towards Indigenous people within the broader Australian population. Pholi et al (2009 p5) goes on to state that “because no broader social problem or structural inequities are measured, there is no evidence of a broader problem to be addressed”. This is linked to the implications of measurability as highlighted in the previous section.

Rowse (2009 p2) states that because of the circumstances of the settler colonial nation-state, Indigenous Australians have suffered systematic abuse and that our “unfortunate history has given their human rights a distinct content and pertinence”. He goes on to state that “they are the colonised, not the colonisers and justice demands that the colonised and colonisers negotiate a relationship of consent”.

Given these circumstances, it is recognised within the literature that there must be a shift in community attitudes along with the acknowledgement of our shared history, otherwise the current experiences of racism or low sense of control over life circumstances for Indigenous individuals remains just that, an individual problem (Pholi et al 2009; Jackson Pulver and Fitzpatrick 2004).

Kaplan-Myrth (2005) argues that while some non-Indigenous Australians experience guilt and shame as a result of shared history, they are not willing to go much further than that. This perspective, in which the broader, non-Indigenous community is the focus, is supported by Edwards and Taylor (2008 p32) who state that policy must be critiqued for potentially disempowering language and practices, and thus require “non-Indigenous people to change their responses”. Edwards and Taylor (2008) highlight that decolonisation would require an examination of ‘us and them’ language division, and that this would provide an opportunity for social justice within policy and practice.

Therefore this argument for a shift in attitudes is required not only in the broader community, but within the health and policy environments and would require “an unpacking of history and preconceptions, and recognition that our professions, healthy policy and services, are founded upon and privilege western cultures and world views” (Edwards and Taylor 2008 p32).

The literature includes broad calls for the recognition of historical context. However, this theme is also recognised more specifically in a small number of research studies, critiques or commentary papers surrounding specific policy, as outlined below. Research surrounding the National Oral Health Plan highlighted that participants portrayed how “ongoing cultural adaptation was required to cope with the social and emotional impact of colonialism, living in missions, the stolen generation, loss of land, processes of assimilation and sustained disempowerment” (Jamieson et al 2007 p54).
Community members felt that historical legacy impacted on the health, including oral health, “mainly through continued practices of being told what to do, where to live, how/when/if they would receive government money and what health services were available to them” (Jamieson et al 2007 p54). Participants felt they had “little power over their oral health or oral health care decisions” (Jamieson et al 2007 p54). Recommendations from this research are that strategies must incorporate the “influence of historical legacy/cultural adaptation, and the downstream factors resulting from this” into the provision of Indigenous health services and health education/promotion programmes (Jamieson et al 2007 p58).

Systematic and sustainable improvements in Indigenous health and social disadvantage require self-determination for Indigenous people, and collaboration as reconciliation within the context of recognition and responsibility for our shared history. This is discussed in the following two sections.

Self Determination

A number of strong voices within the literature state that protocol and policy must be centred on basic human rights and, given Australia’s difficult history, for Aboriginal people “these basic human rights are indissolubly linked to the right to self-determination and the right to development” (Jackson Pulver and Fitzpatrick 2004 p194). It is evident in the literature that there is tension between the notion of self-determination and collaboration, and the view of governments that self-determination implies a hands-off approach.

Self-determination for all people is supported by international law, “which as well as conferring the choice to determine their own political status is the basis upon which Indigenous peoples may share power within the existing state” (Jackson Pulver and Fitzpatrick 2004 p194).

Kaplan-Myrth (2005) states that there is a tension between outcomes and processes for governments in relation to Aboriginal health.

Kaplan-Myrth (2005 p75) goes on to highlight within both state and federal governments, that there is an “overwhelming desire for health outcomes that will stand up to public scrutiny” and that in order to achieve these goals governments recognise the need to collaborate with Indigenous communities. It is acknowledged that there are two specific policy responses occurring in respect of reconciliation, firstly whole of government approaches and secondly partnerships between governments and Indigenous communities (Jackson Pulver and Fitzpatrick 2004).

However, there is criticism that within their approach to collaboration, and in order to achieve health outcomes that will stand up to public scrutiny, governments will “look for ways to establish practical relationships with the community controlled sector, while avoiding the muddy impractical waters of Aboriginal empowerment and self-determination” (Kaplan-Myrth 2005 p75).

Inherent in this is the argument that whilst government rhetoric centres around self-determination and the expression of support for Aboriginal community empowerment, Kaplan-Myrth (2005 p75) states that there is ambivalent vacillation between this and “in the same breath, paternalistic expressions of concern about how much control can realistically be relinquished to Aboriginal people”.

It seems that given the historical context within which these issues are raised, there is tension between the notion of self-determination and the interpretation of this by governments as a hands-off approach. Fundamental within these arguments is the idea that governments appear to support and acknowledge the importance of self-determination, however as a bottom-up, community based focus that fundamentally renegotiates power between governments and Aboriginal communities, there remains an unwillingness to relinquish power to

The process of self-determination and thus reconciliation must see Indigenous groups have the power to effectively take responsibility for decision-making processes and in order for this to occur, there must be fundamental institutional and structural changes (Kaplan-Myrth 2005; Jackson Pulver and Fitzpatrick 2004).

**Collaboration as Reconciliation**

Whilst much of the literature speaks of both self-determination and the need to recognise the historical and social settings within which Aboriginal health occurs, much of the literature is focused around the practical implications of this for collaboration and partnerships with diverse Aboriginal communities in the policy cycle as well as the reconciliation process. The following section highlights the implications of historical context and the importance of both recognition and responsibility for collaboration as reconciliation.

Kaplan-Myrth (2005) highlights that the efforts of Aboriginal and non-Aboriginal people involved in Aboriginal health politics, and thus the pioneers of intersectoral and intergovernmental policy collaboration, have achieved tangible and quantifiable outcomes. Specifically these are recognised in lower rates of hospitalisations, decreases in rates of infectious diseases, better chronic disease management, successful immunization programs in Aboriginal communities, and the improvement of Aboriginal health curricula within medical schools (Kaplan-Myrth 2005).

Whilst this is acknowledged as a step towards practical reconciliation, there remains an expectation by governments, policy makers and health professionals, that Aboriginal people accept mainstream values (Kaplan-Myrth 2005). It is the role of governments to facilitate and assist Aboriginal communities to achieve their goals without taking over the process (Jackson Pulver and Fitzpatrick 2004).

Whilst the area of partnership building is critical to sustainable development, it is most effective when the Indigenous party is the dominant party responsible for determining “policy objectives and strategies and controls the way they are achieved by means of processes and institutions that the community respects and which reflect the group’s cultural values (Jackson Pulver and Fitzpatrick 2004 p195). This suggests that despite the premise of community-government partnerships, that “contemporary relationships are still, fundamentally, rooted in and informed by Australia’s colonialisist history with all of its attendant institutions, structures, and practices” (Kaplan-Myrth 2005 p69; Jackson Pulver and Fitzpatrick 2004).

“Despite bureaucratic initiatives and an emphasis on partnerships, Aboriginal critics of reconciliation point out that the Australian public—and by extension government— has not let go of the vestiges of colonialisist mentality” (Kaplan-Myrth 2005 p73). Whilst holistic notions of health are recognised, less understood is the importance and centrality of land to wellbeing: “Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist” (Lutschini 2005 p4).

Johnston et al (2007) highlights that the fundamental nexus of Aboriginal wellbeing and their land is inherently missing from policy, and suggests a number of reasons for this. Specifically, Johnston et al (2007) states that despite the recognition of Aboriginal legal rights to land and natural resources, the testimony of Aboriginal people is often given less weighting, particularly in medical settings, in terms of evidence used as a basis for policy development.

As well as the notion that Aboriginal voices are largely discounted within policy debate and that any presentation of these voices by non-Indigenous people is open to bias and selective reporting, Johnston et
Talking it up - Aboriginal voices in health policy that works

al (2007 p496) also states that culturally specific issues of health, place, wellbeing and identity are “complex and difficult subjects to discuss without the appropriate context and experience”.

The development and application of policy must be negotiated and implemented within the context of, and with acknowledgement of, the “diverse histories, cultures and social settings of the communities in which it is applied” (Gray et al 2006 p187).

In summation, the long term effects of colonisation has impacted on both self determination and reconciliation, thus collaboration and respectful engagement are important to address and support both self-determination and the reconciliation process. The following section, which focuses on the policy cycle, and includes discussion of collaboration, partnerships and engagement with Aboriginal communities at various stages within the policy cycle, is framed by the arguments of some Aboriginal critics of reconciliation who suggest that both the Australian public and the Australian government have “not let go of the vestiges of colonialist mentality” (Kaplan-Myrth 2005 p73).

8. The Policy Cycle: Process and Delivery

As highlighted in the previous section, the importance of collaboration with Aboriginal communities is significant within the literature. Whilst the previous section focused specifically on the need for collaboration as reconciliation, this section will focus on collaboration at all stages of the policy cycle.

This discussion is born from a body of literature that emphasises the importance of collaboration and partnerships, however highlights this at all stages of the policy cycle – from conducting research with Aboriginal communities, to policy design, implementation and evaluation. As the policy process is cyclical, there can be iterative tensions. A multitude of different actors with different agendas are expected to contribute to the policy cycle, however within the policy focussed Aboriginal health literature, these are exacerbated by the divergence between ‘white’ policy machinery and Aboriginal communities.

This literature also highlights the call for more practical guidelines for policy implementation, drawing attention to the limited number of practical recommendations for policy implementation in the available literature. Whilst there are useful and applicable recommendations for the implementation of policy, they are available in only a limited number of issue-focused areas, thus ensuring the fragmentation of Aboriginal health that contravenes more holistic notions of Aboriginal health and wellbeing.

With the emergence of good practice for policy implementation in some areas, these are fractured and not sustainable without recognition of both the historical context and the underlying determinants and inequities that contribute to these health issues, as highlighted in previous sections, thus the recommendations remain downstream and post-diagnosis.

It is evident that there are disconnects between research and policy recommendations, good practice and good policy, and downstream post-diagnosis service provision versus upstream determinants and notions of being holistic. These tensions are discussed in the following sections.

Collaboration and partnerships

The literature review identified broad policy recommendations emphasising the importance of partnerships and collaboration with Indigenous communities. Indigenous people must be involved at all stages, including policy and program
development, implementation and evaluation. It is acknowledged that Aboriginal communities and organisations are able to participate in health policy processes through both formal and informal mechanisms, however Kaplan-Myrth (2005 p80) states that policy processes and partnership relationships must be “no longer improvised or, left up to the whims of individuals”.

There is also a persistent argument from representatives of the Aboriginal community controlled health sector emphasising the importance of strengthening these mechanisms in order to ensure that Aboriginal communities and organisations are able to “harness more power within partnership relationships so that they will have greater influence on health policy and programs” (Kaplan-Myrth 2005 p80).

Whilst the importance of cooperation and collaboration with Aboriginal communities has been identified, it is also argued within the literature that government departments must also be responsible for improved communication and collaboration within and between departments.

Collaboration must include improved communication and the possibility for agreement to be reached between federal, state and local government levels, departments and roles in order to support the process of evidence-based health policy and the efficient coordination of resources in implementing a holistic model of health care (d’Abbs and Brady 2004; Gray et al 2006; Dugard 2006; Brown 2009).

Whilst collaboration within and between governments, departments and Aboriginal communities is discussed in the broader policy literature, there are also some specific recommendations linked to particular policies. Whilst they have different health priorities and operate in their own clinical settings, the details of these are outlined below.

An evaluation of the inclusion of injury and injury prevention within The National Strategic Framework for Aboriginal and Torres Strait Islander Health identified that it “was endorsed as a plan to guide all Australian governments in a coordinated, collaborative and multi-sectoral approach to achieving Aboriginal and Torres Strait Islander health gain over the next decade” (Anderson 2004, p3).

However, Anderson (2004 p3) highlights that its implementation does not have specific funding attached, whilst also noting “although arguably, the roll-out of the Primary Health Care Access Program will provide additional capacity to the implementation of the National Framework”.

In relation to injury prevention and safety promotion within this framework, Anderson (2008) observes some commitment to data respect, however questions the commitment to building safe environments, community capacity for safety promotion and the necessary inter-sectoral relationships. Anderson (2008 p60) recommends that these “vertical or issue-focused strategies as such in injury are coherently articulated with the broader strategic agenda and their impact maximised”.

In an examination of the policy response to petrol sniffing among Indigenous Australians, it was identified that it must be possible for agreement to be reached between relevant departments at one level of government, and between levels of government at multiple stages. d’Abbs and Brady (2004 p259) recommend that a “coordinated approach to the provision of resources, based on systematically reducing risk factors in inhalant-prone environments should be implemented”.

They argue that there is a perception that “government agencies can sit back and insist that communities take ‘ownership’ of the problem, and that all governments need to do is provide intermittent grants to community groups [and that this] needs to be exposed and rejected” (d’Abbs and Brady 2004 p159). They recommend that communities must be partners in any program to address petrol sniffing that there must be a genuine partnership approach involving government, non-government and community sectors, committed
to collating, utilizing and building on evidence of effectiveness, in order to address the personal and community damage caused by petrol sniffing (d’Abbs and Brady 2004).

It is both this literature and the broader policy commentary that highlight collaboration within and between government departments and communities as critical in the policy process for improving Aboriginal health.

Policy recommendations from research in urban Aboriginal communities

There is a paucity of policy focused research around health and health promotion for urban Aboriginal communities despite more than half of the Indigenous population living in urban and regional centres (Pyett et al 2009). The majority of public health research is devoted to descriptive studies that only occasionally offer direct solutions to policy problems (Nutbeam and Boxall 2008), and as such there are few specific policy recommendations observed from the existing policy focussed literature around health and health promotion for urban Aboriginal communities.

The existing literature around Aboriginal health and health promotion is largely focused on rural and remote communities, thus the complex and differing health needs of urban Aboriginal communities are overlooked in the research and thus existing Aboriginal health policy.

In comparison to remote and some rural communities, urban Aboriginal communities are “less homogenous, are not geographically discrete, and may not have a single central community organisation or council that can be referred to for guidance in research” (Pyett et al 2009 p52). Urban areas can provide a meeting place for people across many different cultural groups, therefore there is diversity in the cultures and beliefs across a geographic community, such as a service area (Kelly and Luxford 2007).

Research with urban Aboriginal communities

Broader political agendas are often reflected in policy debates about Aboriginal issues, and thus good evidence is required to advance these debates (Johnston et al 2007). There is a small body of literature identified that focuses on the role of research with Aboriginal communities, and the importance of collaboration and community consultation and involvement as advisory groups or partners in research (Pyett et al 2009; Leon de la Barra et al 2009; Jackson Pulver and Fitzpatrick 2004).

Positive partnerships are identified by Jackson Pulver and Fitzpatrick (2004 p197) as “those that brought Aboriginal community representatives around the table with government and high-quality research institutions to implement a community defined, health research agenda”. Whilst Leon de la Barra et al (2009) argue that current health policy ignores the evidence base that does exist, Nutbeam and Boxall (2008) argue that it is often the media and language with which public health research findings are presented that exclude policy makers from considering their importance.

With reference to the research process, Pyett et al (2009) recommend that there must be adequate consultation with Aboriginal communities before approval or support for a project is sought. “Too often researchers contact community organisations with a
research proposal requiring a letter of support so they can submit it for funding or ethics approval, but they have not begun to consult with any representatives of the relevant community” (Pyett et al 2009 p52). Pyett et al (2009) goes on to note that whilst community consultation has been a recommendation for policy documents and ethics guidelines, it is now explicitly required and supported by the National Health and Medical Research Council.

Leon de la Barra et al (2009) states that with the emergence of self-determination and community controlled services, Aboriginal people began to demand that research evidence be fed back to the community as it was felt that nothing was being done ‘on the ground’. This is supportive of the notion that previous research has been “too focused on the priorities and career objects of researchers rather than the priorities of communities and, as such, had been an impediment to sustaining partnerships and programs” (National Health and Medical Research Council 2003 as cited in Jackson Pulver and Fitzpatrick 2004 p197).

Leon de la Barra et al (2009) states there is a need for new initiatives to build capacity among researchers from Indigenous backgrounds, and recommends the community and researchers continue to advocate for the provision of funding for liaison positions, promotion of tools for collaboration or support for research training staff in Aboriginal Medical Services as valuable capacity building strategies.

International models such as those from Canada and New Zealand are recommended as best practice models to draw from in order to build capacity among Indigenous researchers (Leon de la Barra et al 2009). Leon de la Barra et al (2009) also identifies that even when federal policy documents do recommend building research capacity, there is a failure to include specific implementation plans and indicators for assessment, a theme consistent with other sections within the literature review.

Policy Design

Within the Indigenous policy design process, there must be collaboration and partnerships with Indigenous communities and the development of Aboriginal-led, evidence-based policy (lloyd et al 2008; Jackson Pulver and Fitzpatrick 2004). Aboriginal and non-Indigenous societies are heterogeneous and as such, contain a multiplicity of health concepts. Policy makers must have a greater understanding of holism in Aboriginal health in order to “engage meaningfully and confidently with Aboriginal concepts of health” (Lutschini 2005 p7).

Nutbeam and Boxall (2008 p753) recommend that public health practitioners and advocates seeking to influence policy outcomes need to “understand and participate in the policy-making process; present their research in ways that fit with the political context of the day; and where necessary, use research evidence in public health advocacy in order to influence political priorities more directly”. It is recognised that more attention must be given to the processes of health policy and strategy development in order to ensure the adequate inclusion and consideration of holism and Aboriginal concepts of health (lutschini 2005).

In reference to commentary surrounding the National Strategic Framework for Aboriginal and Torres Strait Islander Health in which the consistent application to the commitment to the principle of cultural respect is questioned, collaboration and involvement of communities is recommended in policy design (Jackson Pulver and Fitzpatrick 2004). This collaboration would thus result in “community focused solutions based on human rights principles” and will also ultimately contribute to community wellbeing (Jackson Pulver and Fitzpatrick 2004 p198).
Policy Implementation

There is a persistent voice within the literature that identifies shortfalls in the implementation of Aboriginal health policy (Leon de la Barra et al 2009; Westerman 2004; Brown 2009; Lloyd et al 2008; Anderson 2004). Brown (2009 p99) articulates that “despite awareness of what should be delivered, the mechanisms by which to achieve significant improvement remains elusive”. Policy implementation can happen at a number of levels, and the following section will highlight that “although there is a considerable body of evidence identifying the steps in developing effective public policy, there is less evidence to guide implementation” (Lloyd et al 174).

Jackson Pulver and Fitzpatrick (2004 p194) state that “making power sharing real for Indigenous peoples involves capacity development, for individuals and communities, and the control to freely and meaningfully participate in developing and implementing policies and regimes that affect their own lives”. Specifically, the literature identified centres around implementation of policy within service delivery and provision, and incorporates the role of the health workforce in this implementation.

Westerman (2004 p1) identified “at the system level, services struggle with embedding/incorporating culturally appropriate practice within policy and procedural frameworks”. Lloyd et al (2008 p179) also recommended that more Aboriginal people need to be employed as health professionals as “the cultural and local knowledge, skills, experience and community connectedness, combined with clinical and population health knowledge and skills” were viewed as essential to effective implementation of policy and to the achievement of positive health outcomes over time.

These arguments highlights that Aboriginal people continue to be under-represented in the health workforce particularly in higher level positions, and that effective, efficient implementation of health policy requires adequate Aboriginal representation at all levels of the health workforce (Lloyd et al 2008).

Other problems were identified in the transition from policy to practical implementation within service provision and service delivery, such as is highlighted by Lloyd et al (2008) in exploring the chronic disease policy implementation process. Lloyd (et al 2008) not only identified that consultation with communities and Aboriginal health workers was ad hoc and that they were typically excluded from the policy development process, but also revealed a number of structural and workforce issues associated with policy implementation. Implementation of chronic disease policy within the health workforce was dependent on support from health service management, and on structural support that saw the creation of dedicated chronic disease positions.

There is recognition that a skilled workforce must have roles that are congruent with achieving policy goals but also that Aboriginal health workers were under greater pressure from families and communities, but received little practical and professional support (Lloyd et al 2008).
Recommendations by Lloyd et al (2008 p181) in the role of the health workforce in chronic disease policy implementation are that implementation must happen in the community rather than the clinic and focus on the broader determinants; the workforce must be strengthened and that this includes support, training, greater representation of Aboriginal health professionals and decreasing staff turnovers that “erode trust and undermine the sustainability of interventions”; increased power and respect for Aboriginal health workers afforded by other health professionals and more champions in the bureaucracy for Aboriginal health workers.

These voices are heard throughout the literature, and Pholi et al (2009) argues that policy makers should be attempting to measure and monitor progress in the delivery of power and control over the Indigenous affairs agenda into the hands of Indigenous Australians. This highlights ongoing issues within the cyclical nature of policy and its ongoing motion. There are multiple points where there can be multiple problems, as highlighted in the preceding section, however with greater engagement and evaluation the cycle may be broken.

**Evaluation of services, programs and policy**

Johnston et al (2007 p496) states that there “remains a remarkable paucity of evaluation of the efficacy of various Aboriginal programs or policy initiatives”. Leon de la Barra et al (2009) agrees there is a need for continued improvement of current Indigenous policies through review and monitoring of their impact, but identifies that most research still focuses on describing the health problems or causes rather than testing interventions. Where intervention research does exist, it tends “to concentrate on risk factor modification rather than the wider social, economic and environmental determinants of health” (Nutbeam and Boxall 2008 p750).
9. Conclusions

The literature review has identified a number of points of convergence and divergence within the policy focused literature around Aboriginal health and wellbeing. There is agreement throughout the literature that there must be greater collaboration, evaluation, monitoring and accountability for Aboriginal health, and within this, equitable and holistic notions of health must be both recognised and celebrated. However, the literature raised, and left unanswered, a number of questions and unresolved tensions, particularly around practical issues of policy construction and delivery.

1. How do we assess and document Aboriginal health in a way that is simultaneously measurable, culturally appropriate and comparable over time and between areas?

It is acknowledged within the literature that there must be greater accountability for Aboriginal health. This includes both measurability and evaluation of Aboriginal health. However, there remains a tension between statistical equality and cultural diversity, where the goal of remedialism to ‘bring up’ Aboriginal people to the standards of non-Indigenous Australians people fails to recognise or celebrate cultural differences in health patterning. The focus on health outcomes (particularly life expectancy) as the major indicator of Aboriginal wellbeing fails to incorporate important cultural and historical perspectives, which would allow for greater recognition of, and emphasis on, historical and structural determinants of health.

2. How do we delivery genuinely intersectoral, holistic health policies, across health, housing, justice, education, community development, employment, transport and cultural sectors? How do we balance whole-of-community responsibility and collaboration with community-centred control and choice?

The notion of holism is widely discussed within the literature, including holism as an extension of the biomedical model of health to include wider determinants and meanings of wellbeing, as well as holism as incorporating community, cultural practices and structures within and across services sectors. However the literature does not provide clear guidance about how to achieve this.

Situated within this are unresolved tensions between the need for Aboriginal peoples and communities to be empowered and in control of their own health, and the need for governments and the whole-of-community, including non-Indigenous Australians, to take responsibility for their role as well. The literature does not address how self-determination, power and control for Indigenous people can be achieved at the same time as working together, and collaboration with policy makers and service providers.
3. How does the whole-of-community work towards redressing social, structural and historical inequities? How can sustainable reconciliation and social justice for Aboriginal communities be achieved?

The literature highlights the urgent need to address structural and underlying inequity, at both an upstream, policy level as well as a downstream, community level.

Aboriginal health policy tends to segregate Aboriginal from non-Aboriginal people, which broadly fails to recognise the role of non-indigenous Australians in the improvement and delivery of Aboriginal health, and the realities of integrated, urban communities.

The literature advocates for greater recognition and improved understanding of Aboriginal cultures, and a change in the attitudes towards Aboriginal peoples across the whole of the (non-Indigenous) community. However, it remains unclear how racism and discrimination can most effectively be challenged, how power can be shifted more equitably, and how reconciliation can be sustained.

These five questions, in the context of advocacy, collaboration, equity and accountability, may not have the same answers in all parts of Australia and for all Aboriginal communities. Good policy development needs to consider these questions and try to balance these tensions as part of the construction of community- and culturally-appropriate policies and guidance, and would require community consultation and participation of local communities within the policy process. The need for participatory research and engagement within the development of good and healthy policies for healthy Aboriginal communities is particularly recommended.
References


Anderson, I. 2004, ‘Recent developments in national Aboriginal and Torres Strait Islander health strategy’, Australia and New Zealand Health Policy, 1:3.


Dugard, C. 2006, ‘I needed to hear this’: Evaluation of the implementation and impact of 22 recommendations emanating from report ‘I want to be heard’: an analysis of needs of Aboriginal and Torres Strait Islander illegal drug users in the ACT and region for treatment and other services’, College of Medicine and Health Sciences, The Australian National University.


54 Talking it up - Aboriginal voices in health policy that works


Leon de la Barra, S., Redman, S., Eades, S., 2009, ‘Health research policy: a case study of policy change in Aboriginal and Torres Strait Islander health research’, Australia and New Zealand Health Policy, vol 6:2.


National Aboriginal Community Controlled Health Organisation 2003, National Aboriginal Community Controlled Health Organisation Business Plan 2003-2006, Canberra, NACCHO.


Chapter 3: HEALTH POLICY

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>57</td>
</tr>
<tr>
<td>Method</td>
<td>57</td>
</tr>
<tr>
<td>Limitations</td>
<td>59</td>
</tr>
<tr>
<td>Findings</td>
<td>60</td>
</tr>
<tr>
<td>Conclusions</td>
<td>62</td>
</tr>
<tr>
<td>Fig 3.1: Policies included in the analysis</td>
<td>63</td>
</tr>
<tr>
<td>Fig 3.2: Documented participation in the development of policies</td>
<td>64</td>
</tr>
<tr>
<td>Fig 3.3: Descriptions of participation</td>
<td>65</td>
</tr>
<tr>
<td>Fig 3.4: Influence of the National Strategic Framework</td>
<td>66</td>
</tr>
<tr>
<td>Fig 3.5: Influence of the 1989 National Strategy and the current Victorian Framework</td>
<td>67</td>
</tr>
<tr>
<td>Fig 3.6: Policies not clearly related to other policies in the analysis</td>
<td>68</td>
</tr>
<tr>
<td>Fig 3.7: Other policies related to the policies in the analysis</td>
<td>69</td>
</tr>
<tr>
<td>Policy Review</td>
<td>70</td>
</tr>
<tr>
<td>Fig 3.8: Criteria for policy review</td>
<td>70</td>
</tr>
<tr>
<td>References</td>
<td>71</td>
</tr>
</tbody>
</table>
Chapter 3: Health Policy

Introduction

Health policies are the decisions, announcements and documents that guide and govern health delivery. These include health-related frameworks and strategies, which give direction to health service providers and regulators. In Australia, “health policy is a big field... There is certainly no master plan... There has been a constant stream of reforms pursued at regional state and national levels, some of which have created change and some not” (Dugdale 2008, pages 1 and 13).

Policy is the way in which health sector practices change when laws and Acts of Parliament stay the same. Policy communicates priorities, ethos and principles; policies are the interpretation of evidence and best practice, and form the basis of the contemporary objectives for service management and delivery. Policies articulate how health should be delivered, regulated and accounted for.

For the purposes of this review, only published documents that come from health related departments at the Federal or Victorian state level are included. Policies that do not extend beyond announcements or decision-making, i.e. are not implemented or disseminated sufficiently for others in the health sector to follow, are not included. Therefore this review seeks to analyse the policy documents that form the shared policy environment for the health sector, its workers and its clients.

The widest conceptualisations of health would mean that all policies at all levels of governance would need to be considered, although this was clearly outside of the scope of the Talking It Up project. Therefore, this review seeks to analyse policies from within the health sector, and in particular those policies which are identified as guiding Aboriginal or Indigenous health.

It is important to consider the policy environment as this is one of the most important points of communication and negotiation between those in control of health delivery, those responsible for delivering health, and their clients. That communication and negotiation is often one-way, or heavily weighted in favour of those setting and producing policies; however, it is also empowering for communities to know what has been said about how they should be treated, and policies, when produced well, can be empowering for service users and clients.

Method

The full details of the review, against the criteria contained in Figure 3.8 (over page) can be found in the longer version of this report, accessible at www.deakin.edu.au/dro/ or www.wesley.org.au.

The policy review was a detailed process of collecting and documenting the policies that govern and guide Aboriginal health in Victoria. This includes national policies and frameworks, as well as those specifically from Victoria.

The first part of the process was to identify the policies that govern Aboriginal health. It was not possible to find a single-site summary of health policies relevant to Aboriginal health, so policies were collated from a range of sources. These included Australian Policy Online (www.apo.org.au); Victorian Government Online (www.vic.gov.au); Department of Health and Aging (www.health.gov.au); and Department of Families, Housing, Community Services and Indigenous Affairs (www.fahcsia.gov.au).
Policies were included if they were: current, specified a remit for Indigenous or Aboriginal health; existed in a policy document as a policy, framework, strategy or guidelines.

Policies were excluded if they were only applicable to states or territories outside of Victoria, or if they did not have a remit or a specific and substantial policy for Aboriginal or Indigenous health. In total, 15 Federal/National policies and nine Victorian/State policies were identified. An additional policy, the National Framework for Aboriginal Health 1989, was initially excluded because it was not current implemented, although it became useful in later stages of analysis as it remains influential in the policy environment.

A Fairer Victoria 2008 and A Fairer Victoria 2009 are included in the review, as both were considered current across the course project; however only the 2009 policy is included in the third stage of analysis as the most up-to-date policy.

The next stage of the review process was to conduct an initial analysis, summarising the policies, frameworks and strategies against a criteria that aimed to identify key aspects. The criteria covered the extent to which the policy governed Aboriginal health (which level of government, its jurisdiction and who it applies to, its longevity and for how long it applies, its level of impact as guiding or obligatory); its aims and rationale (what it sets out as its objectives and why); what outcomes it seeks and whether these will be monitored; how it proposes to implement its aims; how much money has been allocated to achieving its aims; and additional key points about what actions will be done and by whom.

The full criteria are presented in Figure 3.8 (page 70). This criteria-based analysis is presented in the second part of the review, with each policy presented in its own sub-section. The exact wording from the policy documents has been used wherever possible. Occasionally, we have summarised available information to answer the review criteria.

Not all of the criteria were clearly addressed in the policy documents, and in particular, there is a lack of clearly stated plans for implementation or plans to achieve the aims that are set out, and a lack of plans to monitor or to review the impact and outcomes of a policy. Where information is not readily or clearly available in the policy documents this is denoted as ‘Not clearly specified’.

The second stage of the analysis was to identify the relationships between the policies. Sometimes this was very clear, where policy documents state that they are guided by or build upon the principles of existing frameworks; or where later strategies are the implementation plans of earlier frameworks. Sometimes the relationship was less clear.

These relationships were mapped and a full, but somewhat complicated, database was produced which located each of the policies presented here and their stated inter-relationships. This is presented in the full report. To simplify the presentation of this analysis, each policy has its own relationships presented in a diagram at the start of its policy sub-section.

The third stage of the policy analysis was to compare the policies against each other, along dimensions of interest indentified by the literature review and community forums. These dimensions included: the extent to which Aboriginal people and communities had been involved or consulted in the policy process; the extent to which policies indicated an integrated policy environment; and the extent to which policies were informed or guided by principles of good practice for Aboriginal health (specifically the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013).

This analysis used a variation of the ‘heat mapping’ technique. All of the policies were arranged in a grid across the two layers of national or state level. A simple coding process attempted to answer the questions of ‘to what extent’ participation, integration and guidance by principles of existing frameworks
were identified in the policy documents. This coding was represented visually by using a gradient of shading; deeper shading represents a greater extent. Heat mapping has the advantage of using categorical data in a way that is indicative of a gradient without needing to use numerical data, and therefore supports indicative comparisons across a variety of data sources.

Finally, the findings from the policy review were circulated to the participants and co-researchers. The summary diagrams of the policies and the extent of Aboriginal participation, and diagrams of inter-relationships between four of the policies were circulated to all participants that had provided postal addresses in the summary report (available in the full report). The interim report contained an earlier draft of all three stages of the analysis and this was discussed at the second round of community consultation, attended by interested participants.

On the basis of feedback from the co-investigators and community members several revisions were made to improve the clarity of the presentation of the analyses. This included moving the complex spreadsheet of relationships to the appendices for reference, and developing the individual diagrams of each policy to be larger and presented across two facing pages, so that the relationship ‘blobs’ and the lists of non-relationship were more easy to view.

The interpretation of the policy environment as a whole was refined, to reflect community input and an additional heat map was produced to capture ‘what else’ the policies were related to, outside of the immediate Aboriginal health field. This was identified as important, so that policies that were identified as not clearly related to others in the review were not inadvertently portrayed as completely disconnected from other policies. This additional analysis was illuminating, as it emphasised how Aboriginal health policy can be influenced by other policies that were not produced with Indigenous communities in mind.

**Limitations**

Without an up-to-date and comprehensive national or state repository of Aboriginal health policies, it is possible that there are omissions from this review, for example, policies that we need not identify and did not realise were missing. In some sections of the criteria-based analysis, we entered ‘not clearly specified’.

It may be that the information is available elsewhere but not explicitly linked to the policy document, and simply not identified within the search and collation process. Similarly, some of the inter-relationships between policies are coded as ‘not clearly stated’.

This may also be explicitly stated outside of the policy documents under review here and not adequately captured by the summarising process. Finally, our use of the original text in the criteria-based analysis was chosen so that the meaning of the policy was kept throughout the reductive process of summarising the key points of the documents; however, this faithfulness to the phrasing of documents may have limited the comparability of the policies for the reader following through the sub-sections.
Findings

Findings about the policy environment emerged through the analysis process. Firstly, it was found that the full range of policies and strategies that govern and guide health for Aboriginal people is not easily available, and that there is no accessible index to help people (as community, clients or professionals) find out what principles and policies are in place.

The first of the ‘maps’, Figure 3.1 (page 63), summarises the policies that were included in the analysis here. Secondly, the mapping exercise revealed that few individual policies are well integrated, and that the policy environment for Aboriginal health is quite fragmented (see full report for policy mapping). This was demonstrated visually by the mapping and the subsequent production of individual diagrams of the relationships between policies, presented throughout the policy summaries in the second part of this review.

Four questions were specifically addressed by heat map analysis, presented in the following Figures 3.2-3.7 (page 64 - 69).

1. To what extent is there clearly documented Aboriginal participation and/or consultation in the development of the policy or strategy; and how is this described in the policy documents?

Participation, and ownership, of health policy is important for generating policies that are empowering, culturally appropriate and avoid paternalistic approaches to improving health. It is important for policy makers to consult with the communities they seek to influence; and important for policy writers to recognise and document this in the policy documents.

Descriptions of community participation or consultation were extracted from the policy documents, and coded in four levels, ranging from formalised participation in the development of the policy; through community consultation; to proposed consultation; to none specified (this last code may represent both non-participation and also non-reporting of participation).

This is displayed in Figures 3.2 and 3.3. Similar extents of Aboriginal participation were documented at the national level compared to the state level, as well as similar rates of no clearly documented participation.

2. To what extent is the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013 integrated within the policy environment?

The current National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 is broadly the ‘gold standard’ of Aboriginal health policy, with extensive Aboriginal participation in its construction, and sets the direction for health and health reform across all levels of governance.

A strong policy environment would integrate the National Strategic Framework across subsequent policies, as being guided by, building on or seeking to implement the principles of the framework. Stated relationships were extracted from the policy documents, and coded across three levels: clear relationship; relationship stated by unclear; no clearly stated relationship.

This is displayed in Figure 3.4. The National Strategic Framework is more clearly articulated as integrated within national policies, compared to the state level policies.
3. To what extent are national policies informed by the National Aboriginal Health Strategy 1989; and to what extent are state policies informed by the Victorian Indigenous Affairs Framework?

Given the varying extent to which the current National Strategic Framework guides the policy environment, as identified in the second question above, it was important to consider what other frameworks were influential. During the mapping of relationships between the policies it became clear that the National Aboriginal Health Strategy 1989 remains influential and guides current policy, even though later policies have effectively superseded it.

Additionally, the Victorian Indigenous Affairs Framework is important for Victorian state policies. Therefore, the extent to which both of these policies are currently integrated in Aboriginal health policy was explored, and the findings are presented in Figure 3.5. The 1989 strategy is nearly as integrated as well the current national strategy, and is clearly still guiding policies at the national level. At the state level, the Victorian Indigenous Affairs Framework is slightly more clearly articulated as integrated in policies than the National Strategic Framework.

4. Which policies are not connected to other Aboriginal health policies discussed here; and which other policies are related to current Aboriginal health policy?

The health of Aboriginal peoples and communities is influenced by a wide range of policy decisions and implementation. A strong policy environment is not only clearly guided and well integrated; it is also related to and embedded within wider policy structures.

With this in mind, the policies included in the analysis were coded as either clearly connected to at least one other policy reviewed here, or not clearly related to other policies in the analysis, based on the policy mapping.

This is presented in Figure 3.6 (see full report for further details of the policy mapping). There were more policies at the state level that were coded as not clearly related to other policies in the analysis, compared to the national level. Overall, more policies were integrated in the body of policies reviewed here than were not.

Following this, all of the policies were assessed to consider what additional policies and guidelines were articulated as related or guiding. This is presented in Figure 3.7.

This was important to understand the ways in which current Aboriginal health policy is connected to other policies, and to avoid creating a false impression that some of the policies under review are disconnected or isolated from all other policies. All of the policies included in the analysis articulated relationships with at least one other policy.

At the national level, some of the policies were integrated within the policies reviewed here, and no additional policies were explicitly related. This was not found at the state level. The analysis also revealed that ‘mainstream’ or non-Indigenous-specific policies are influential and connected to the current Aboriginal health policy environment. Of the five policies that were not explicitly related to other policies in the review, three articulated being guided by United Nations policies (convention, covenants and declarations).
Conclusions

There are some examples of good practice across the policy environment, but this is inconsistent. Participation and consultation with communities has been highlighted as particularly important in both the literature review and the participant forums, and formalised participation structures have been established in some, but not all, of the policy development documented here.

Some policies are guided by the current National Strategic Framework, some by the National Strategy 1989, some by the Victorian framework, and some by United Nations human rights frameworks; but again this is inconsistent. Aboriginal health policies are not disconnected from ‘mainstream’ or non-Indigenous counterparts, and may be as influenced by them as by Indigenous-specific frameworks.

It is important therefore that policy makers at all levels of governance consider the effects of their decisions on Aboriginal communities, who may be secondary consumers of their policies through the shared policy environment, and consider carefully how to engage with Aboriginal communities in the construction of good, health policies.
**Policy analysis: national and state policies, frameworks and strategies that inform or govern Aboriginal health in Victoria**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework</td>
<td>Framework for Reporting on Indigenous Disadvantage</td>
<td>Cultural Respect Framework for Aboriginal and Torres Strait Islander Health</td>
<td>Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities</td>
</tr>
<tr>
<td>A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males</td>
<td>Be active Australia: a framework for health sector action for physical activity 2005-2010</td>
<td>National Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Well Being Framework</td>
<td>Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 – 2008</td>
</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies  
Rows 5-6 are Victorian policy and frameworks
Is there clearly documented Aboriginal participation and/or consultation in the development of the policy or strategy?

Rows 1-4 are National policies, frameworks and strategies
Rows 5-6 are Victorian policy and frameworks
Darker shading = more, formalised participation
### Figure 3.3 Descriptions of participation

How is Aboriginal participation and/or consultation specified in the policy document?

<table>
<thead>
<tr>
<th>Prepared by the National Aboriginal and Torres Strait Islander Health Council for the Australian Health Ministers’ Conference</th>
<th>Developed by the Standing Committee on Aboriginal and Torres Strait Islander Health</th>
<th>Not specified.</th>
<th>Prepared by Social Health Reference Group for National Aboriginal and Torres Strait Islander Health Council and National Melbourne Health Working Group 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Aboriginal and Torres Strait Islander Health Workforce Working Group is charged with planning, implementation, coordination and monitoring</td>
<td>Consulted widely with Indigenous organisations, governments and researchers. The insights gained from Aboriginal and Torres Strait Islander people will be reflected in the next report.</td>
<td>Widespread consultation.</td>
<td>Not specified.</td>
</tr>
<tr>
<td>National Aboriginal and Torres Strait Islander Males Health and Wellbeing Reference Committee… meetings and conferences around the country</td>
<td>Based on consultations with Aboriginal and Torres Strait Islander stakeholders</td>
<td>Not specified.</td>
<td>The Aboriginal and Torres Strait Islander Peopels’ Reference Group was established to negotiate the development of this action plan.</td>
</tr>
<tr>
<td>Government needs to involve Indigenous people in the design and delivery of programs locally and regionally, and share responsibility for outcomes.</td>
<td>Many organisations and individuals have made valuable contributions to the development of the Strategy and Action Plan, including Aboriginal and Torres Strait Islander nutrition workforce; NACCHO; and ATSIC.</td>
<td>Monitoring and evaluation will also require adequate consultation and involvement of Aboriginal Torres Strait Islander people.</td>
<td>Not specified.</td>
</tr>
<tr>
<td>Forums will in future involve … ongoing representation of Aboriginal communities.</td>
<td>Would not have been possible without contributions from Aboriginal signatory organisations, a range of staff in Aboriginal Community Controlled Organisations, through regional Aboriginal advisory groups and through individual consultations.</td>
<td>Victorian Aboriginal Child Care Agency (VACCA) was commissioned.</td>
<td>Not specified.</td>
</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies
Rows 5-6 are Victorian policy and frameworks

**Darkest shading** = formalised participation in developing or writing the policy

**Mid-shading** = community consultation or advisory groups

**Lightest shading** = proposes participation
Integration of the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013 within the policy field

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework</td>
<td>Framework for Reporting on Indigenous Disadvantage</td>
<td>Cultural Respect Framework for Aboriginal and Torres Strait Islander Health</td>
<td>Good practice framework, Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities</td>
</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies
Rows 5-6 are Victorian policy and frameworks

Dark shading = guides, informs or builds on; integrates principles or implementation
Light shading = relationship stated but not specified
No shading = no clearly stated relationship between the policies
Figure 3.5 Influence of the 1989 National Strategy and the current Victorian Framework

Integration of the National Aboriginal Health Strategy 1989 (national) and the Victorian Indigenous Affairs Framework (Victoria)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework</td>
<td>Framework for Reporting on Indigenous Disadvantage</td>
<td>Cultural Respect Framework for Aboriginal and Torres Strait Islander Health</td>
<td>Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities</td>
</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies
Shading = builds on or is informed by the 1989 National Aboriginal Health Strategy

Rows 5-6 are Victorian policy and frameworks
Shading = relationship with the Victorian Indigenous Affairs Framework
### Policies not clearly related to the other Aboriginal health policies reviewed in this analysis

| --- | --- | --- | ---
| Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework | Framework for Reporting on Indigenous Disadvantage | Cultural Respect Framework for Aboriginal and Torres Strait Islander Health | Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities

Rows 1-4 are National policies, frameworks and strategies
Rows 5-6 are Victorian policy and frameworks

Shading = not clearly related to other policies included in this review
### Additional policies and guidelines related to the Aboriginal health policies reviewed in this analysis

| Framework agreements; COAG reconciliation framework | National Health Performance Framework | See policy links diagram | National Mental Health Plan 2003-08 |
| State and Territory agreements on ATSI health | See policy links diagram | See policy links diagram | National Drug Strategy |
| Aboriginal Services Plan 2004 | NHMRC Road Map; National Public Health Partnership; Primary Health Care Access Program; National Rural Health Alliance | National Drug Strategy; Framework agreements | National Drug Strategy; ATSI Family Violence Strategy |
| Mental Health Promotion Plan 1999-2002 | COAG Action Plan on Mental Health; Care in your community; Victorian Charter of Human Rights; Vulnerable Youth Framework; Aging in Victoria | Growing Victoria Together; Aboriginal Human Services Plan | Protocol between VACCA and DHP CS; UN Convention on the Rights of the Child |

Rows 1-4 are National policies, frameworks and strategies  
Rows 5-6 are Victorian policy and frameworks  
Shading = not clearly related to other policies included in this review
Policy review

The remainder of this chapter is presented in the full long version of this report accessible at www.deakin.edu.au/dro/. The full version considers the first and second stages of analysis, reviewing policy documents against criteria, detailed in Figure 3.8, and presenting diagrams to represent the relationships and integration between the policies, strategies and frameworks.

Figure 3.8 Criteria for Policy Review

<table>
<thead>
<tr>
<th><strong>Criterion</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Which level of government? Which Department?</td>
</tr>
<tr>
<td>ATSI involvement</td>
<td>Have Aboriginal Australians been involved in the development or implementation of this document? Who? How? i.e. was it individuals (who), communities and/or Aboriginal Organisations?</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Who does it apply to? Who is bound by it? E.g. other parts of government, organisations receiving certain funding, etc.</td>
</tr>
<tr>
<td>Longevity</td>
<td>When was it introduced/ published? When does it run from/to?</td>
</tr>
<tr>
<td>Level of impact</td>
<td>Obligatory or guiding?</td>
</tr>
<tr>
<td>Relationship to other instruments</td>
<td>Does it refer to any other policies or strategies? Which ones?</td>
</tr>
<tr>
<td>Aim</td>
<td>What does it set out to do? Include mission and/or purpose statements where available.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Why are they doing this? What problems or issues is it seeking to address? Is there anything specific about the methodology they are using that is relevant to ATSI people?</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Does the document seek specific outcomes or targets? What are they and how will they be measured? How were they identified? Is there a timeframe for when they need to be achieved by?</td>
</tr>
<tr>
<td>Key points/aspects</td>
<td>What will be done and by whom? Focus on specific actions and requirements.</td>
</tr>
<tr>
<td>Implementation</td>
<td>How does the document propose achieving its aims and outcomes? Who else is involved in the implementation (i.e. other organisations, departments, etc)?</td>
</tr>
<tr>
<td>Review processes</td>
<td>Are there specific review processes? Have any reviews been conducted and if so, what were the main findings?</td>
</tr>
<tr>
<td>Outcomes to date</td>
<td>What has happened so far? Is there any outcomes data available and what does this say about the effectiveness of the instrument (May not be available if recently introduced)?</td>
</tr>
<tr>
<td>Amount of money allocated</td>
<td>Is it a commitment? Who is the money going to? Is it for a specific program?</td>
</tr>
</tbody>
</table>
References


Australian Health Ministers’ Advisory Council’s Standing Committee on Aboriginal and Torres Strait Islander Health Working Party (Comprising the Northern Territory, Queensland and South Australia), 2004, AHMAC Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2004 – 2009. Department of Health, South Australia.


Department of Planning and Community Development, Victorian Government Indigenous Affairs Report 2006/07, Aboriginal Affairs Victoria, Department of Planning and Community Development, Victoria.


National Public Health Partnership, 2005, Be Active Australia: A Framework for Health Sector Action for Physical Activity, NPHP, Melbourne.

NSFATSih (National Strategic Framework for Aboriginal and Torres Strait Islander Health): Framework for action by Governments, NATSIHC, Canberra.


Standing Committee on Aboriginal and Torres Strait Islander Health, Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework , AHMAC, Canberra, 2002.


National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males:


Appendices

**TABLE OF APPENDICES**

| Appendix 1 | Poster used to advertise the first round of community consultation | 75 |
| Appendix 2 | Invitation to second round consultation | 76 |
| Appendix 3 | 9 Principles from National Strategic Framework ATSI Health, 2003-2013 | 77 |
Appendix 1 Poster used to advertise the first round of community consultation

**TALKING IT UP!**

What makes a difference to your health?
What are the issues that people need to hear about?
— use your voice and talk it up!

---

When? Tuesday June 9, starting at 10am
10.30 – Cultural blessing
11am – Talking about health
12pm – Lunch
1-3pm – Group discussions

Where? Maya Healing Centre, Rossyoyne Street, Thornbury

What? Take part in group discussions, be a part of the research project.

Who? The Healing Stories team will be here to listen to anyone who wants to TALK IT UP!

Why? The findings from these group discussions and others across the local Aboriginal community will be taken to VicHealth and used in reports to argue for better Aboriginal health.

Please talk to Aunty Shirley if you have any questions about Talking it Up or the group discussions.
Thank you for taking part in Talking it Up!

Thank you for participating in the first consultation round of the Talking it up Project. You are most welcome to attend the second consultation round to see and hear what has been done about the findings of the project so far and share your ideas about what needs to be reported and recommended in the report to VicHealth. We are inviting everyone who took part in the group discussions to come back together for a second round of community consultation.

Please join us for a second round of community consultation.

**Program**

- **Date:** Monday 28th September, starting at 10am
- **Place:** Northlands Secondary College, East Preston
- **Purpose:** This is an opportunity for you to hear about what’s been going on with Talking it Up and have your say about what gets said to VicHealth in the Talking it Up report.

10.00am: Welcome.
We will start with morning tea and we will then have a couple of hours building on the findings of the project so far, sharing information from the research and listening to your ideas about what the project should say. We will finish at lunchtime.
12pm: Lunch will be provided.

**RSVP** to Uncle Reg Blow. If you need some help getting to Northland, please let Uncle Reg know and he will help arrange a lift for you.
Appendix 3 9 Principles from National Strategic Framework ATSI Health 2003-2013

This National Strategic Framework is based on a commitment to nine principles:

Cultural respect

Ensuring that the cultural diversity, rights, views, values and expectations of Aboriginal and Torres Strait Islander peoples are respected in the delivery of culturally appropriate health services.

A holistic approach

Recognising that the improvement of Aboriginal and Torres Strait Islander health status must include attention to physical, spiritual, cultural, emotional and social well-being, community capacity and governance.

Health sector responsibility

Improving the health of Aboriginal and Torres Strait Islander individuals and communities is a core responsibility and a high priority for the whole of the health sector. Making all services responsive to the needs of Aboriginal and Torres Strait Islander peoples will provide greater choice in the services they are able to use.

Community control of primary health care services

Supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing National Strategic Framework for Aboriginal and Torres Strait Islander Health appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context. Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way.
Working together

Combining the efforts of government, non-government and private organisations within and outside the health sector, and in partnership with the Aboriginal and Torres Strait Islander health sector, provides the best opportunity to improve the broader determinants of health.

Localised decision making

Health authorities devolving decision making capacity to local Aboriginal and Torres Strait Islander communities to define their health needs and priorities and arrange for them to be met in a culturally appropriate way in collaboration with Aboriginal and Torres Strait Islander health and health related services and mainstream health services.

Promoting good health

Recognising that health promotion and illness prevention is a fundamental component of comprehensive primary health care and must be a core activity for specific and mainstream health services.

Building the capacity of health services and communities

Strengthening health services and building community expertise to respond to health needs and take shared responsibility for health outcomes. This includes effectively equipping staff with appropriate cultural knowledge and clinical expertise, building physical, human and intellectual infrastructure, fostering leadership, governance and financial management.

Accountability

Including accountability for services provided and for effective use of funds by both community-controlled and mainstream health services. Governments are accountable for effective resource application through long-term funding and meaningful planning and service development in genuine partnership with communities. Ultimately, government is responsible for ensuring that all Australians have access to appropriate and effective health care.
Wesley Mission Melbourne is a part of the Uniting Church of Australia.