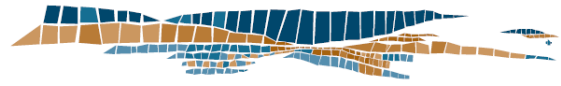




Government of **Western Australia**
Department of **Health**



Combined Universities Centre for Rural Health

INDIGENOUS HEALTHY LIFESTYLE PROGRAM EVALUATION

FINAL REPORT

JULY 2010

This report was commissioned by the Office of Aboriginal Health, Department of Health, Western Australia. The Indigenous Healthy Lifestyle Program was part of the Australian Better Health Initiative: a joint Australian, State and Territory Government initiative.

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TABLE OF CONTENTS

Executive Summary	1
Recommendations	2
Background	5
Evaluation	5
Section 1: Evaluation Framework	7
Section 2: Evaluation Methodology	11
Site visits	12
Evaluation team composition	13
Data collection and analysis	14
Section 3: Results from all five sites in 2009	17
Overall strengths and weaknesses of IHLP in 2009	17
Performance on each indicator	19
Goal 1: Clear and supportive governance	19
Goal 2: Service coordination and integration	23
Goal 3: Sustainable workforce	24
Goal 4: Community capacity and participation	26
Goal 5: Health promotion and prevention	28
Goal 6: Service quality	30
Goal 7: Increased access	31
Importance of good processes	33
Factors predicting good outcomes	34
Section 4: Understanding change	37
Changes between 2009 and 2010	37
Most significant change	42
Section 5: Conclusions and recommendations	45
Appendix 1: Indigenous Health Lifestyle Program Evaluation Framework	49
Appendix 2: Comparison of evaluation requirements and the evaluation framework	52
Appendix 3: List of project-related documentation requested by the evaluation team	54
Appendix 4: Most Significant Change Stories, compiled from all project sites	55
Appendix 5: Evaluation consent form for interviews	63
Appendix 6: Evaluation information sheet	64

EXECUTIVE SUMMARY

From 1 July 2006, the Australian Government and the state and territory governments started a four-year, \$500 million, national program called the **Australian Better Health Initiative (ABHI)** to refocus the health system to promote good health and reduce the burden of chronic disease.

The Office of Aboriginal Health received state funds as part of this Council of Australian Governments (COAG) agreement to coordinate the implementation of the WA Indigenous Healthy Lifestyle Program to reduce the burden of chronic disease. The program was designed to assist communities to build capacity within the local context to undertake a range of strategies to improve lifestyle and reduce risk factors for chronic disease.

The Combined Universities Centre for Rural Health (CUCRH) was contracted by the Office of Aboriginal Health to develop and implement an appropriate evaluation framework to measure the WA Indigenous Healthy Lifestyle Program. CUCRH based the evaluation on a framework which draws on three sources of expert advice: international consensus; Australian policies and guidelines; and systematic reviews of the evidence for effective practice.

The framework specified seven goals or dimensions related to governance, integration, workforce development, community engagement, health promotion, quality and participation. These goals included a total of 40 process, impact and outcome indicators for each goal with between three and seven indicators per goal.

An evaluation team visited each of the five project sites in 2009. Three were also visited in 2010. In each year the team reviewed documents and interviewed project workers and managers and stakeholders from the community and other local services. Information was recorded against each of the 40 indicators and then summarised. The team discussed the summaries and gave a score of 1 to 4 to rank performance. In total, 201 people were interviewed.

In 2009 the highest scoring indicators were for health promotion activities and workforce development. Common weaknesses in the IHLP projects were:

- lack of a common vision;
- few clear agreements between relevant organisations about roles and responsibilities;
- no protocols regarding engagement with the Aboriginal community; and,
- lack of attention to policy changes that can reinforce health promotion messages.

The sustainability of IHLP was investigated by examining the changes that took place over one year in three sites. The importance of committed and well connected community workers is clear, but there is also a danger of relying too much on workers. One project experienced significant declines in performance when their worker resigned. Strong management commitment to Aboriginal workforce development and Aboriginal community engagement are very important in creating the environment

for sustained improvements in health and well-being. Without good management and governance processes community workers can be isolated from their host organisation and other services.

The lasting influence of IHLP was also captured through the stories of significant change told by project workers and managers, members of the Aboriginal community and local service providers. The themes revealed that a high value was placed on improving the situation for individuals and family members so that they could take control of their health and their lives. More than half the stories were about positive changes for individual and families. These included stories of people who benefited from project activities and those for whom community workers intervened to avert a crisis by giving support and advocacy. Less common but still important were stories about Aboriginal people gaining opportunities to be leaders in health development either in the workplace or by services responding to community priorities. A few stories were about successful activities that improved a pressing community health issue such as food supply, environmental health or alcohol abuse.

More importantly, almost all of the stories told by Aboriginal people were about an individual, family or community gaining the confidence to make improvements in their lives or in the lives of others. It is this empowerment which is the legacy of IHLP and should be the goal for future projects to improve Aboriginal health.

The recommendations are based on the evaluation findings of the importance of clear project management based on a commitment to Aboriginal health development, which is the focus of Recommendation 1. The other recommendations focus on areas of weakness found across several of the projects and are informed by the successes of other projects. Recommendations address establishing partnerships with other service providers, Aboriginal community engagement, planning and monitoring, and developing the Aboriginal health workforce. These recommendations are relevant for any community-based Aboriginal health initiative. Successful implementation will enable future projects to enhance the abilities of Aboriginal people to achieve better health and well-being.

RECOMMENDATIONS

Recommendation 1. Organisations contracted to implement projects targeting Aboriginal health must first demonstrate that they have developed and implemented policies and procedures which acknowledge past injustices and their continuing impact and create a sustained strategy to address these through respectful partnerships and the development of opportunities throughout their structure.

Recommendation 2: Fund holders must demonstrate a clear organizational structure that connects the Aboriginal projects to the strategic Aboriginal development goals and core business of the organisation.

Recommendation 3: All Aboriginal projects which aim to improve service integration and access should be structured to ensure that there is a consultative group or committee, representative of key services and community organisations or groups, with defined yet flexible roles and responsibilities. The specific

form these groups take will vary between localities. These groups would benefit from input from an Aboriginal-led group which sets direction for all health programs.

Recommendation 4: Funders should promote a simplified planning framework that prompts project workers and management to consult with community and service representatives to define the goals, activities and targets for the project, and to include a process of regular monitoring, reflection and celebration with the community it services. A strategic plan is not necessary for a project. Where there is a strategic plan for Aboriginal health development, the project should clearly link to one or more of the objectives. The steering group described in Recommendation 3 is an appropriate group to undertake this planning but should include the community workers and other stakeholders as required.

Recommendation 5: Cultural security training, tailored to the local environment, should be offered to staff of the host organisation and partner organisations as part of an orientation to introduce the project and its workers. If local training is not available, a self-directed package could be used such as the one offered free by Combined Universities Centre for Rural Health.¹

Recommendation 6: Community workers should have regular access to a mentor or advisor who is responsible for increasing their knowledge and skills and encouraging continuous quality improvement. This person can be internal or external to the host organisation.

Recommendations 7: Greater commitment and creative solutions need to be found to improve the quality of monitoring. The purpose should be to provide the information needed for continuous planning as described in Recommendation 4.

¹ <http://lms.cucr.h.uwa.edu.au/moodle/index.php>

INDIGENOUS HEALTHY LIFESTYLE PROGRAM EVALUATION

BACKGROUND

From 1 July 2006, the Australian Government and the state and territory governments started a four-year, \$500 million, national program called the **Australian Better Health Initiative (ABHI)** to refocus the health system to promote good health and reduce the burden of chronic disease.

The Office of Aboriginal Health received state funds as part of this Council of Australian Governments (COAG) agreement to coordinate the implementation of an Indigenous Healthy Lifestyle Program (IHLP) to reduce the burden of chronic disease in Western Australian Aboriginal communities. The program was designed to assist communities to build capacity to improve lifestyle and reduce risk factors for chronic disease.

The design of IHLP was based on the Formative Evaluation of the Kuwinywardu Aboriginal Resource Unit Gascoyne Healthy Lifestyle Program.² Key factors that were identified to be integral to the success of that program included community support, addressing issues of community concern, flexible and well-resourced programs and the development of equitable partnerships between the community and service providers. These factors, plus the inclusion of a focus on better coordination of local services; a reduction in duplication; promoting better linkages between community and service providers; supportive workforce development; and models of service delivery that work with Aboriginal communities, were considered integral to the establishment of the IHLP.

IHLP was developed and implemented in two metropolitan (Kwinana and Peel) and three regional/remote communities (Halls Creek, Norseman and the Western Desert).

EVALUATION

The Combined Universities Centre for Rural Health (CUCRH) was contracted by the Office of Aboriginal Health to develop and implement an appropriate evaluation framework to measure IHLP against the following outputs:

- practical support available for people at risk of developing, or who have chronic disease to make informed lifestyle choices and healthy behaviour change;
- link individuals to health and lifestyle providers and activities to prevent chronic disease;

² Howie RJ. Formative Evaluation of the Kuwinywardu Aboriginal Resource Unit Gascoyne Healthy Lifestyle Program. WA: Telethon Institute for Child Health research; 2004.

- ensure availability of local level modification services, support and referral pathways within the communities;
- reduce risk factors within a community to improve quality of life;
- reduce or slow the progression rate of risk factors and their complications;
- increase ability of individuals and communities to manage risk factors and incorporate lifestyle modifications into their lives; and,
- increase training and mentoring to local community members to support program activities.

A further requirement was that the evaluation demonstrated a focus on the following key elements:

- increased health gains as a result of flexible funding and resourcing at the local level;
- acknowledging and articulating the purpose, values and desired outcomes for government, NGO service providers and community;
- health benefits of earlier access to primary health care services;
- increased individual and community commitment to social change;
- improved lifestyle behavioural and attitudinal changes per site; and,
- increased social capital per site.

Whilst the evaluation framework developed by CUCRH was designed to measure the above outputs, it is acknowledged that some of the key elements can only be measured effectively over a longer term. IHLP was a short-lived project; none of the five sites operated their project for three years and some operated for less than two years.

SECTION 1: EVALUATION FRAMEWORK

CUCRH based the evaluation on a framework which had been developed and used in the evaluation of other Aboriginal primary health care programs.³ This framework draws on three sources of expert advice: international consensus; Australian policies and guidelines; and systematic reviews of the evidence for effective practice.

1. The declaration of the World Health Organization's 1978 International Conference on Primary Health Care at Alma Ata and the subsequent global literature on primary health care.
2. National and state policy statements and tools related to primary health care service provision, including health promotion. Key documents were the Commonwealth's *Healthy Horizons*, Western Australian's Department of Health *New Vision* and the *Foundations* produced by WA Country Health Services (WACHS). The evaluation team made extensive use of the Australian Council on Healthcare Standards' continuous quality improvement, monitoring and evaluation process known as EQuIP (Evaluation and Quality Improvement Program), adopted by WACHS as its quality improvement tool in 2005.
3. Seminal research and systematic reviews of Australian and international research that underpins the broad policies and the practical implementation strategies used to achieve the goals of health and health equity enshrined in the policy documents and current best practice.

The evaluation framework used for IHLP has seven goals or dimensions related to governance, integration, workforce development, community engagement, health promotion, quality and participation.

These goals included a total of 40 process, impact and outcome indicators for each goal with between three and seven indicators per goal. The complete evaluation framework is in Appendix 1.

The seven goals and indicators are summarised below:

Goal 1: The project has clear and supportive governance

How is the project governed; are processes well documented and understood so that every partner knows what they are supposed to do and are accountable; and is the project flexible enough to respond to changes?

³ Hall J & Larson A. *Gascoyne Primary Health Service Evaluation* Report to Western Australia Country Health Services – Midwest. Office of Aboriginal and Torres Strait Islander Health. Geraldton, Western Australia: Combined Universities Centre for Rural Health, 2007.

Goal 2: The project results in improved service coordination and integration

Are there agreements between services; do services work well together and does that result in services being better able to offer culturally secure services to Aboriginal people?

Goal 3: Increase and build a sustainable workforce

What was the recruitment and professional development processes for project staff and how are workers supported to work in this challenging area? Has the project resulted in more Aboriginal people working in the health sector?

Goal 4: Increase/enhance community capacity and participation (2-way capacity building)

What is the process for community engagement and how does the project grow and develop in response to that active engagement?

Goal 5: Improve health and well-being through prevention and promotion

How does the project improve health by working holistically and on multiple levels? Does the project have the ability to monitor if those efforts are effective?

Goal 6: Improve the quality of services provided

What strategies are used to improve the quality of services provided to Aboriginal people in the community? Has the project resulted in better health care services and better health?

Goal 7: Increased access to prevention and treatment services and programs

What strategies are used to improve Aboriginal people's access to activities and services? Are more Aboriginal accessing services and participating in activities because of the project?

Together these goals and their indicators encompass the different dimensions that make up a responsive and effective primary health care system, as illustrated in Figure 1. These goals and their indicators align with the Office of Aboriginal Health's evaluation requirements described in the introduction. Appendix 2 shows the specific goals and indicators relevant for each item.

Figure 1: Seven goals for comprehensive primary health care.



SECTION 2: EVALUATION METHODOLOGY

In 2009 CUCRH sent evaluation teams to all five IHL project sites. A second visit to three of the sites occurred in 2010. During each visit interviews were held with project staff and managers, Aboriginal community representatives and other stakeholders from relevant services and organisations. While at the site all available project documentation was reviewed by the team. Appendix 3 has a list of possible documents. The documentation provided varied considerably between projects.

Additional data involved an interview method called ‘Most Significant Change’ (MSC), which has been used to monitor and evaluate social change programs and projects nationally and internationally. It is a participatory technique that can inform staff, managers, funders and policy makers about the impact and outcomes of programs on beneficiaries. As used in this evaluation, the method was essentially a story collection process from project workers and managers and from organisations and community groups who were directly or indirectly involved. Three to five MSC stories were collected from each project.

Table 1 describes the key milestones of the evaluation.

October 2008	Evaluation framework approved by Office of Aboriginal Health
	WAAHIEC approval granted
February 2009	UWA Human Research Committee approval granted
	Participation in the Indigenous Health Lifestyle Program Workshop
March 2009	Kwinana site visit
May 2009	Peel site visit
July 2009	Goldfields site visit
	Information for interim ABHI report provided
September 2009	Halls Creek site visit
November 2009	Western Desert site visit
March 2010	Western Desert site visit (Punmu)
May 2010	Halls Creek second site visit
	Kwinana second site visit
	Peel second site visit

The stories are about what people believe were the most significant changes that resulted from the program. The ‘changes’ could have been those that have occurred to other organisations as a result of

interactions with members of the service, or any other changes that may have been observed, or were perceived to be connected to the project. These stories are in Appendix 4 to this report. Section 4 has an analysis of the stories.

An opportunity to present the evaluation methodology at a workshop of project managers and workers in Perth in February 2009 provided a 'reality check' and led to some modifications of the original design.

The Office of Aboriginal Health introduced the CUCRH evaluation team by letter to key personnel in each project, including the fund holder, project manager and evaluators. In addition to that official notice CUCRH sent letters by email to project managers explaining how the site visits would operate.

The evaluation team leader negotiated with a project manager or someone in a similar role to set the date for the evaluation. At that time any concerns that the project team had about the visit and process were discussed. The evaluation team leader asked questions about the current issues facing the project and discussed which staff members, external service providers and community representatives the team should meet.

SITE VISITS

The initial visits took three days for each site. Because of the continuity of team members, the second site visits were completed in two days. Appointments were organised in advance. The assistance provided by the project staff in making these appointments and arranging for venues was greatly appreciated.

The timetable for most initial visits followed the schedule in Table 2, with time for travel between project locations. Members of the evaluation team often split up to maximise the number of people who could be seen. On average the evaluation team spoke with 25 people during each site visit. On the second visits a similar number of people were seen but interviews tended to be shorter because of less need to discuss project history and context.

Unfortunately, we could not visit every place where significant project activity occurs. In particular, the community of Coonana in the Goldfields had requested no visits from external agencies. Inclement weather prohibited visiting Punnu in the Western Desert in 2009 so a team went to that community in early 2010.

A member of the evaluation team explained the purpose of the evaluation to every person interviewed. Where possible each person was asked to sign a consent form. This form and an information sheet are in Appendix 5 and 6. The purpose of this exercise was to stress the importance that we placed in handling their information with sensitivity and confidentiality. We stressed that individuals would not be identified in the report and the main purpose of the evaluation was to determine the effectiveness of the program across all sites, and not to evaluate the work of an individual project or worker. Everyone approached during the visit agreed to participate. Other people had been approached by the project workers prior to visit and declined to arrange a time to see the team. During the visits there were also some people who could not make appointments that had been scheduled. In general there was excellent turnout in all of the sites and the teams were kept busy meeting many stakeholders and community representatives.

Day 1	Morning	Travel to site
	Mid-day	Meet with project manager and team members
	Afternoon	Meet with stakeholder or community representative
	Evening	Team review documentation, record notes from interviews
Day 2	Morning	Interviews with stakeholders and community representatives
	Mid-day	
	Afternoon	
	Evening	Team records notes from interviews
Day 3	Morning	Meet with stakeholders or project team
	Mid-day	Meet senior officers for interview and discussion of findings
	Afternoon	Team meet to discuss findings and allocate
	Evening	Travel home
Following the site visit		Conduct phone interviews with key informants not available during the site visit, finalise notes, teleconference to agree on rankings

A particular strength of this evaluation is that we were able to speak with many Aboriginal people. Out of 201 people interviewed in 2009 and 2010, 106 were Aboriginal workers and/or community members. This result is entirely due to the participation of the Aboriginal people on the evaluation team. These individuals were respected for their professional knowledge and their links to community and culture.

EVALUATION TEAM COMPOSITION

All five project teams had an Aboriginal member (visits to the Goldfields and Western Desert included two Aboriginal team members).⁴ Because three of the sites had a focus on men's health, men were part of the team visiting those sites in 2009. All three 2010 visits had male team members. All of the Aboriginal team members are from regional Western Australia and most are elders in their community. Their participation enabled the evaluation team to gain unprecedented insight into how the projects

⁴ Unfortunately a last minute family crisis meant that it was not possible to have an Aboriginal team member present during the 2010 Halls Creek visit. However, Aboriginal team members participated in the planning of the visit and discussing and feeding back findings.

were viewed by Aboriginal organisations and community members and the experiences of Aboriginal project workers.

In acknowledgement of the hard work by all of the team members, the people involved in each site visit are listed below. Unless otherwise indicated, they are employed by CUCRH.

Table 3: Evaluation team members for each site visit	
Project site	Team members
Kwinana 2009	Ann Larson, Trudy Hayes*, Katrina Skellern (private consultant)
Kwinana 2010	Ann Larson, Len Collard* (private consultant)
Peel 2009	Ann Larson, Trudy Hayes*, Katrina Skellern (private consultant)
Peel 2010	Ann Larson, Simon Forrest*
Goldfields 2009	Ann Larson, Trudy Hayes*, Des Thompson*
Halls Creek 2009	Ivan Lin, Glenda Taylor*, Katrina Skellern (private consultant)
Western Desert 2009	Isabelle Ellis, Neil Bodi* (health worker), Olive Joseph*, Katrina Skellern (private consultant)
Western Desert (Punmu) 2010	Isabelle Ellis, Joan Foley, Bruce Thomas* (Chairman, Wangka Maya Language Centre)
* Aboriginal team member	

DATA COLLECTION AND ANALYSIS

Not everyone to be interviewed could be expected to know about all facets of the program. Furthermore, the evaluation indicators were not in a language that was easy to understand. The evaluation team members used question lines that were developed as a guide to help them remember what information was needed and the interviews were conducted as a natural conversation. Extensive notes were taken by each team member present and these notes were later used to populate the evaluation framework.

The team arrived at a final ranking for each indicator by a process of incremental synthesis.

Information from interviews with project staff and managers were recorded and summarised separately from the interviews with community representatives and other stakeholders. The same was done for the documents that were reviewed. All notes of the interviews were summarised against the indicators.

This gave three summaries for each indicator, one summary each generated from the document review, the project staff and managers, and the stakeholders.

A synthesis of all three sources of information was drafted by one member of the team and then discussed with all team members. Next the team members discussed and agreed on a score of 1 to 4 for every indicator. A score of 1 meant that the project was not addressing this indicator at all. For

example, if project staff and stake holders had completely different ideas about what the project was about, the score for the indicator about a common vision would be 1. A score of 4 meant that the project was performing at a very high level for this indicator.

The strength of this methodology is that in the method of systematic synthesis of data. No conclusions were based on one piece of information alone. We had four stages of analysis: stages one to three were summaries of project documents, project staff and managers and stakeholders. The fourth summary combined all three summaries. When synthesising data we were looking for consistency. Where there was disagreement between people interviewed or from the project documents the synthesis reflected this.

Another strength of the methodology was the continuity in data collection tools and personnel across sites and over time. All sites were visited by at least one team member who had been to at least two other sites. Where a site was visited twice, at least one team member had been on both visits. This meant that there was uniformity in how information was collected and analysed.

SECTION 3: RESULTS FROM ALL FIVE SITES IN 2009

The scores for the 40 indicators from the five project sites give a comprehensive picture of the processes, impacts and outcomes of IHLP in 2009. All of the projects had been in operation for at least six months and, for some, up to 18 months. Data from Punmu, collected in early 2010, have been incorporated in this section.

General results are presented first to give a broad understanding of the strengths and weaknesses of the IHLP projects. Next, detailed information is given for each indicator. A final section generalises the findings, demonstrating how IHPL processes in community and service engagement influences the impact that the projects can have on improving health.

It is very important to keep in mind that these results are only a snapshot of what was happening in the projects. Over time changes may occur. For example, relationships may develop, increasing trust and participation. Initiatives might become more effective as skills improve and new opportunities emerge. Similarly, changes in staff, the host organisation and the Aboriginal community can have a profound effect on the project activities and effectiveness. The drivers and implications of change will be discussed in Section 5, using the experience of the three sites visited twice and analysis of the most significant change stories.

OVERALL STRENGTHS AND WEAKNESSES OF IHLP IN 2009

A simple way to view the general performance of IHLP is to look at the indicators which, across all five sites, scored the highest and lowest. This is done by taking the average score across all five sites for each indicator. High scoring indicators are those with an average score greater than 3 and low scoring indicators are those with an average score of 2 or less. The results are in Table 4.

It is obvious from Table 4 that IHLP has a very strong health promotion focus and that projects have been able to attract qualified, confident staff. These are all high scoring indicators.

Common weaknesses in the IHLP projects were:

- lack of a common vision;
- few clear agreements between relevant organisations about roles and responsibilities;
- no protocols regarding engagement with the Aboriginal community; and
- lack of attention to policy changes that can reinforce health promotion messages.

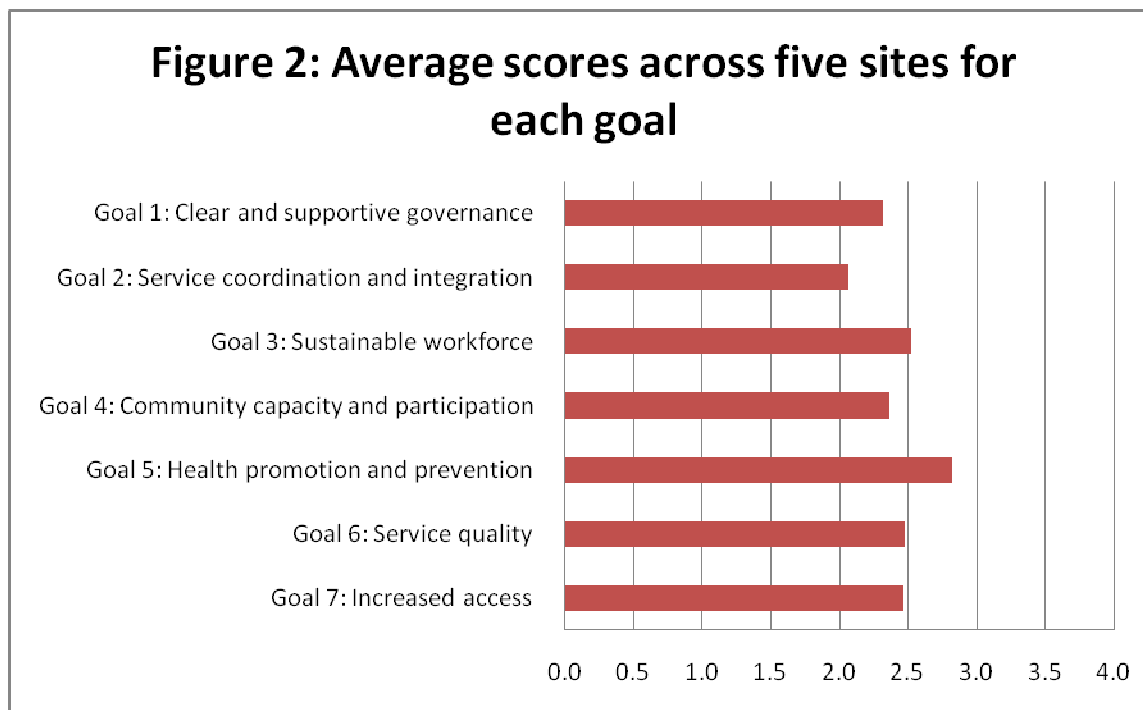
The high scoring and low scoring lists contain many 'process' indicators. These are indicators which describe how well a program is implemented. This suggests that there were many aspects of what IHLP

sites did in the initial stages of the project that established a strong foundation for making a difference in their communities. However, there were also some key ‘processes’ or ways of doing things that were lacking. The consequences of not having these processes in place will be explored in more detail later in the report.

Table 4: Strengths and weaknesses of the IHLP, based on high and low scoring indicators.		
Goal	High scoring indicators	Avg score
5	The project plan encompasses Aboriginal perspectives and a holistic view of health and well-being.	3.6
3	Project staff have the necessary skills to undertake the requirements of the job. Where there is a skills gap, training or other professional development is provided	3.2
5	The project plan has a strong promotion and prevention focus	3.2
5	Project activities and services assist people to gain knowledge and skills to help them change behaviours, including providing support through initiatives such as mentoring and coaching.	3.2
<i>Lowest scoring indicators</i>		
2	There are formal and informal agreements between project partners (providers, community stakeholders and other key organisations) which make each groups' roles and responsibilities clear. These agreements are reviewed regularly.	1.4
2	There is evidence of an appropriate level of interaction or articulation between project partners, depending on what was planned (e.g., information sharing, coordination or collaboration).	1.8
1	A community reference group has been formed with members who are relevant for the project. There are terms of reference for the group and an expected frequency of meetings. The actual frequency of meetings and the business conducted at the meetings are consistent with what was planned.	2.0
4	The community reference group, fund holders and other key organisations can describe a common vision and mission for the project	2.0
1	A robust strategic plan is used by all parties to decide on work priorities and monitor progress. The plan is regularly reviewed and modified when needed	2.0
3	There are more Aboriginal people working in the health sector in the project community.	2.0
1	Protocols are in place to guide how that engagement takes place	2.0
1	Project partners adopt policies and practices that foster behaviour change, such as adopting smoke free workplaces or incentives to walk to work	2.0

Looking at the average scores for each goal gives a very similar picture of performance. The highest average score in Figure 2 was for Goal 5, improving health and well-being through promotion and prevention. This confirms that all of the projects had a strong promotion and prevention focus. The

lowest scores were for improved service coordination and integration, followed by Goal 1, clear and supportive governance. These goals reflect internal management of the project and the relationship with other partners, particularly health and community services.



PERFORMANCE ON EACH INDICATOR

The indicators that make up each goal also describe what IHLP sites were able to achieve in their first 6 to 18 months. For each indicator we give the average score and the range across the five sites.

GOAL 1: CLEAR AND SUPPORTIVE GOVERNANCE

Governance was one of the poorest performing areas for the program as a whole. However, as Table 5 shows, this was not true for every site. For each indicator at least one site scored a 3 or a 4.

Community reference groups

None of the sites had conventional community reference groups operating when the site visit occurred. That is, there was not a single body composed of Aboriginal community representatives that meet regularly to discuss project goals and activities and make recommendations. When informants were asked if they thought there should be such a group, the response at several of the sites was that 'Aboriginal people did not like formal meetings and that there were more effective ways of consulting with communities'.

Local committees were functioning well in two sites. In one site the 'steering committee' was composed of local service providers, sometimes represented by Aboriginal staff. This was a powerful, if sometimes volatile, forum for information exchange, clarifying the objectives of the project and, to a lesser extent,

identifying areas for collaboration. It became the vehicle through which positive relations were built within and between mainstream organisations in relation to Aboriginal health.

Indicator Number	Indicators	Average Score	Lowest	Highest
1	A community reference group has been formed with members who are relevant for the project. There are terms of reference for the group and an expected frequency of meetings. The actual frequency of meetings and the business conducted at the meetings are consistent with what was planned.	2.0	1	4
2	There is an organisational structure in place which facilitates accountability and appropriate lines of responsibility	2.4	2	3
3	The community reference group, fund holders and other key organisations can describe a common vision and mission for the project	2.0	1	3
4	A robust strategic plan is used by all parties to decide on work priorities and monitor progress. The plan is regularly reviewed and modified when needed	2.0	1	4
5	There is evidence that the project plans and partnerships are flexible, adapting to new circumstances	2.8	1	4
6	Project staff, partner services and funding organisations fulfill their commitments to the project in a timely and coordinated fashion	2.4	1	3
7	According to the nature of the project, adequate funding is either available through project funds or is successfully leveraged from partner organisations	2.8	2	4

Another local committee that was functioning well was a finance committee. Composed of fund holders and community representatives, this body was responsible for the allocation of funds. As yet, it had not taken on a planning role. At this site the planning was done through regular discussions between project workers and managers and community members. People involved in this consultative planning, who also sat on the finance committee, were able to explain the rationale for funding requests. Informants told the evaluation team that the finance committee contributed to a good exchange of information and transparent decision making.

Some of the sites where projects were based had other forums in which community members and/or services met to discuss areas of common interest. With one exception, project workers or managers did not regularly attend these meetings, which meant that the opportunity to interact with stakeholders was not used. This will be discussed in more detail in Goal 2.

Organisational structure

Projects were invariably associated with the workers and, in two cases, the project manager or next most senior person in the organisation. The strong identification of the projects with the workers had strengths and weaknesses. The strengths were that dynamic community workers, who in most projects

were members of the Aboriginal community as well, had the autonomy to organise activities and to provide help that external people valued.

A weakness is that the workers usually did not have much authority within their own organisation. Their autonomy meant that people in their organisation often thought of it as 'her' project. These colleagues would profess that they did not understand what the project was about and would not seek ways to support it. Where the community workers had a line-manager who shared responsibility for the success of the project this was not as much of a problem.

Common vision

An evaluation of community development projects funded by Healthway concluded that one of the most important indicators of success was the extent to which local stakeholders could accurately describe its purpose.⁵

We found in all projects there was an inner core of people or organisations within and outside of the hosting organisation who could describe the purpose of the project. However, there was another group which interacted less frequently with the project workers or activities who professed that they did not know what the workers did or what they were supposed to do.

One informant said that the project had a large impact on the services and health professionals who worked very closely with the Aboriginal community. He added that the further you got away from regular contact with the community the less the project vision and mission was understood.

Strategic plans

All but one of the projects had a document that was called a strategic plan. For all of the projects, these documents were not used except for reporting purposes. All of the senior people in the organisations and some of the community workers were aware of what was in the strategic plans.

Nevertheless, the strategic plans were considered irrelevant and were only used when compiling annual activity reports. The documents were regarded as operational plans, describing the activities that were to be undertaken. No one had any problems with what was in the strategic plan because in most cases it was an accurate description of what the project did. However, the strategic plans did not help workers and managers to think about the bigger picture of what they were trying to achieve.

In none of the sites did any external groups know that there was a strategic plan much less what it contained.

⁵ Saunders J, Donovan RJ, Rosenberg M, Giles-Corti B, French S. The Healthy Community Pilot Projects: A Report on the Results of the Independent Evaluation. Perth: Health Promotion Evaluation Unit, School of Population Health, The University of Western Australia, 2003.

Flexibility

All of the projects received favourable comments about doing their very best to be responsive to needs and opportunities. In most cases projects were proactive. That is, committed community workers would seize on good ideas emerging from the Aboriginal community and put them into practice. There was only one project where workers tended to wait until the circumstances allowed them to run an activity the way they wanted to run it instead of proactively finding ways to overcome barriers.

As already mentioned, strategic plans were not the vehicle by which project plans were changed. The strategic plans tended to be left untouched. Flexibility and innovation tended to be demonstrated in how workers did things rather than what workers did.

As a result, new activities tended to be *ad hoc* rather than thought through in a systematic planning process. However, there were two exceptions to this. One site had a very strong commitment to consultation with the Aboriginal communities; all activities were discussed in detail with community members prior to and during implementation. These 'yarning sessions' were the vehicle by which new activities or processes emerged.

In another site a steering group of service providers and an evolving internal organisational structure made it possible to discuss changes in strategic direction. In this project informants were able to tell us how the project had changed over time and where it was going.

Fulfilling commitments

Informants varied as to whether they felt that projects were meeting their commitments. One project received praise from almost everyone for the reliability and conscientiousness of the community worker. Another project received fairly unanimous criticism for not doing enough.

The other projects fell within a middle ground. Lack of clarity about what was supposed to be done meant that some people, who might have had unrealistic expectations, felt that projects were not delivering what they promised.

Most Significant Change

Improved service coordination

Senior manager and clinician in a partner service told the evaluation team that through the project she has been able to develop partnerships with other services. Her team had long realised that many people in the community have financial problems and obtaining equipment to manage their chronic conditions was very difficult. There is a long process in gaining a letter from the general practitioner and then getting CentreLink to review the application and to obtain a voucher and then to return it to the health service. This enormous amount of red tape meant that people did not get the equipment they needed. The service would have loved to provide the equipment but did not have the funds to buy what was needed. A partnership with other local services solved this. They realised that alone they could not supply their clients' needs but if each agency purchased some equipment and made it available to clients from all services, there would be enough. And that is what has happened. If, for example, their client needs a glucose monitoring they can call the other service who will lend theirs. This partnership would not have happened without the relationship formed through the IHLP Reference Group.

Funding

In all of the projects workers and managers were of the opinion that the level of funding was adequate. In most cases the community workers did not know how much money was available and they sometimes expressed frustration that funds were not available for particular initiatives. Most of the projects had an underspend at the time of the site visit, largely because of delays in recruiting staff.

Funds were used flexibly. For example, project funds were often used to enhance activities that added value to the goals of the project, but were run by other organisations.

There was also evidence of initiatives being taken to raise additional funds. One project had devised a fund raising idea. Another project had managed to obtain a large grant from another source to continue its work. At least two sites worked hard to attract funding for external groups to enable them to offer services or programs which would achieve health lifestyle goals.

In a couple of cases the hosting organisation was subsidising the project to a very large degree. The senior officials considered that the project was enhancing their core business and it was therefore important that additional support was provided to sustain the program.

GOAL 2: SERVICE COORDINATION AND INTEGRATION

One of the expectations of the IHLP was that the project would be able to improve the coordination of health services for Aboriginal people. It was anticipated that the project would provide human and financial resources which would give service providers additional skills and strategies to work together to address Aboriginal health, and ultimately offer more culturally secure services.

The indicators in Goal 2 embody this ideal. Indicator 1 is about agreements between project partners. While formal agreements such as memorandums of understanding are not the only way to manage a partnership, all good partnerships are based on clear, shared ideas of how each party will work with the other. As the scoring in Table 6 shows, none of the sites performed well against

Most Significant Change

Community-driven planning

A project manager's story is about the community planning process and the impact it has had on people. Everyone came to the planning days. There were some people who were homeless, living in a deserted house that was falling apart around them. These men even came to the planning days. She remembers one of these men coming to the search. He was very resistant but by the second he was very involved. The search lifts our mob. They get such a creative spark. They focus on a better future.

But she warned 'It is so easy to collapse again. I live far away. I cannot give support to keep the momentum. It is necessary to have the local project officers. Who does the planning must live with the consequences of the planning.'

this indicator. There were very few examples of explicit partnerships between different stakeholder groups. Across the five sites there were only a couple of examples of formal agreements and those involved fund holding arrangements.

Despite the lack of agreements, there were many examples of good relationships. However, these were usually created and maintained through personal contact. They were also rarely strategic partnerships, rather community workers tended to find a core group of agencies or individuals with whom they could work. Partnerships were usually restricted to doing single activities together or working together to support a specific client. Only one site had a policy involving a partner organisation in every activity. This was done as a sustainability strategy; it was hoped that the partners would be able to continue the activity when the project ended.

Indicator Number	Indicators	Average Score	Lowest	Highest
1	There are formal and informal agreements between project partners (providers, community stakeholders and other key organisations) which make each group's roles and responsibilities clear. These agreements are reviewed regularly	1.4	1	2
2	There is evidence of an appropriate level of interaction or articulation between project partners, depending on what was planned (e.g., information sharing, coordination or collaboration).	1.8	1	3
3	The services and programs involved in the project offer culturally secure services to Aboriginal clients involved in the target group	3.0	2	4

Interestingly the outcome indicator (Indicator 3) for this goal scored the highest. This is probably because when project workers led certain activities themselves they were able to ensure that they were culturally secure because of the very good connections to the Aboriginal community. All of the projects made every effort to ensure that their own activities and services were culturally secure. A couple of projects had been able to influence other services' protocols and practices by way of their own examples and by facilitating access to Aboriginal people who could give advice.

GOAL 3: SUSTAINABLE WORKFORCE

Workforce was one of the highest performing areas for IHLP projects. In general each project was able to recruit workers with appropriate qualifications. Four of the five sites hired local Indigenous people who were known in their area. In several cases there was an effort to seek community advice in terms of who should be hired.

In all cases there was a transparent recruitment process. The most successful projects also had strategies to support applicants through what can be an alienating experience of applying for employment with government organisations.

Another strength in all of the projects was that workers took advantage of many opportunities for professional development. They attended training sessions and had opportunities to stretch themselves professionally through public speaking or representing their agency.

Appropriate mentoring and guidance from within the organisation was considered difficult to organise at several sites. These were often new positions, working in new ways or in new locations. It was found that in those projects supervision was a challenge and in some cases almost non-existent. Three of the sites arranged for external mentoring for community workers. In two cases the mentors were staff members of the host organisation and in one case the mentor was employed as an external consultant. The mentors had regular contact with the project workers and conducted formal and informal training. They helped the workers stay focused on the 'big picture' while giving them the knowledge and skills to do their jobs. Given the mentors' long term association with the project they were often able to help build relations with other stakeholders and help the workers to problem solve.

Indicator Number	Indicators	Average Score	Lowest	Highest
1	Recruitment, appointment and retention processes such as mentoring programs are in place to support Aboriginal and non-Aboriginal staff of the project	2.2	1	4
2	Career pathways for staff during and after the project are created	2.2	1	3
3	Project staff have the necessary skills to undertake the requirements of the job. Where there is a skills gap, training or other professional development is provided	3.2	3	4
4	Staff of the project are confident and capable of fulfilling their duties	3	2	4
5	There are more Aboriginal people working in the health sector in the project community	2	1	3

Another inevitable shortcoming was the lack of opportunities for career progression. Short term project work does not lend itself to long term positions or to promotion. However, most of the hosting organisations were committed to trying to maintain the positions beyond the funding period. Highly regarded community workers and project managers were sought after by other agencies.

In general the workers were confident and proud of their work. The only ones who expressed concern did not have good supervision arrangements and/or were feeling burned out.

On the other hand, it was not uncommon for stakeholders to question the competence of the workers. These comments were usually from agencies that did not work closely with the project or the workers. Some of this negativity originated from the spokespersons’ unfamiliarity with working with an Aboriginal community-driven project. These gaps in understanding will be discussed more in Goal 4.

Increasing the Aboriginal workforce in the health and community service sector had mixed results. In some cases the project workers themselves constituted an increase in the numbers of Aboriginal people employed. Several projects were trying to train up other Aboriginal people to undertake part time work. Only one site had evidence that other services were employing more Aboriginal staff, at least partly as a result of the example set by the project. Usually project workers and stakeholders reported there had been no change in the number of Aboriginal people employed in the sector.

GOAL 4: COMMUNITY CAPACITY AND PARTICIPATION

The engagement with the community is critical in Aboriginal health initiatives, yet despite the high quality community workers this goal scored the second lowest score. This shows that while community workers are essential they cannot increase community capacity and participation on their own.

The first three indicators shown in Table 8 were highly correlated. That is, projects tended to have the same score for consultation, protocols and responsiveness to community priorities. These are closely related processes and impacts. Without consultation with the entire community, including all age groups, men and women, and all family groups there is no way to know if a project is meeting communities’ needs. Without clear protocols on how to engage with Aboriginal people it is unlikely that any meaningful consultation can take place.

Indicator Number	Indicators	Average Score	Lowest	Highest
1	The project actively engages the community in identifying needs and priorities. There is a strategy to be inclusive of diversity within the community	2.8	2	4
2	Protocols are in place to guide how that engagement takes place	1.8	1	3
3	Project activities and services reflect community priorities for processes and outcomes	2.6	1	4
4	Project partners are learning from each other	2.4	1	4
5	Services involved in the project can demonstrate greater involvement with Aboriginal clients and communities (e.g., participation in advisory groups, more Aboriginal staff).	2.2	1	4

We found that many of the community workers had very good processes for engaging with all Aboriginal people in their community. If there were difficulties such as differences between families or gender, this was solved by recruiting new workers or partnering with another worker from another agency. In a couple of projects it was stated that the workers did not have the understanding or trust of the community, or the support of their managers to enable them to have good engagement.

The evaluation team found that effective consultations are not necessarily formal exercises. The projects that were more engaged with their communities were ones in which the consultation was informal and continuous. There is nothing wrong with a formal consultation process, but it cannot be used as a substitute for on-going dialogue.

In three sites strategic planning exercises had taken place in the local areas prior to the start of the project. To varying degrees the projects grew out of those activities. In one case the strategic planning exercise had been undertaken in a very creative way with the complete involvement and ownership of the Aboriginal community. The resulting goals identified by the community became the objectives for the project. During the site visit we were regularly told that this was the 'real strategic plan'.

In another case a strategic planning exercise had looked at all aspects of Aboriginal health. Led by an Aboriginal person with a health background and joined by representatives of other health organisations, this group produced a vision for what was required to improve access to services and better health for Aboriginal people. The project was in some ways a response to this plan, but changes in personnel meant that most people involved in the project did not know or did not remember the earlier strategic plan.

In a third case a broad scoping exercise was done with extensive consultation. However the scoping exercise has been used as a strategic plan even though the scoping exercise did not identify priorities amongst the many needs identified.

In summary, consultative strategic planning may give an excellent foundation for the project but it cannot substitute for on-going engagement processes. As familiarity and trust in the project grows, the needs expressed by the community will change.

Most Significant Change

Increasing family and community support

Children from one family in the community had been identified as not attending school. The project workers talked to the family and began to go around and pick up the kids to take them to school. Initially the kids had to be rounded up. After a while the workers would turn up and the kids would be ready for school. Eventually the workers turned up and the kids weren't there. They had already gone to school themselves.

Without a regular process of continuous and inclusive engagement the new needs or groups which were previously excluded will be missed.

Indicators 4 and 5 describe how the project has influenced how the host organisation and other services and organisations engage with Aboriginal people. Some of the barriers to partners learning from each other (Indicator 4) stem from the lack of engagement with other services as discussed above. Without that kind of engagement it is not possible for changes to have occurred. Nonetheless, one project has been very influential in changing how services work with Aboriginal people and another project has made good progress.

Many mainstream services either do not understand or value, or simply underestimate the importance of cultural protocols and ways of working with Aboriginal people. This can be challenging for Aboriginal people working in such organisations, often leading to frustration from both parties. The result is often that no relationship between the project and the service is established, the project workers are unsupported and the Aboriginal community is not fully engaged in the project.

Poor relationships had a particularly negative impact where community workers were expected to advocate on behalf of Aboriginal clients. The evaluation team heard many examples of mainstream services not working with the community workers to help clients. This often resulted in the client being denied the service, the service not learning how to provide culturally secure care and the community worker feeling betrayed.

GOAL 5: HEALTH PROMOTION AND PREVENTION

The IHLP projects were supposed to have a holistic approach to improving health and well-being. All of the projects interpreted this as promoting good health. They tackled this goal through fostering knowledge and behaviour which would lead to healthy lifestyles and by taking proactive measures to prevent sickness and worsening chronic diseases.

The success of the projects in health promotion and prevention can be seen in the high average scores for Indicators 1 through 5 in Goal 5 (Table 9).

Indicators 1 to 4 are process indicators. All projects encompassed Aboriginal perspectives of a holistic view of health and well-being. Four out of the five projects had a strong health promotion and prevention focus and had a plan which would enable them to promote and facilitate behaviour change.

Successful health promotion initiatives works on multiple levels. Going as far back as the World Health Organization's Alma Alta Declaration on Primary Health⁶ in 1978 and the Ottawa Charter for Health Promotion⁷ in 1986, the consensus has been that behaviour change requires more than increasing individuals' knowledge and skills to adopt healthy behaviour. Healthy behaviour needs to be reinforced by families and communities that value healthy lifestyles, services which encourage and enable healthy choices, and public policies that create healthy environments and discourage harmful or risky practices.

⁶ http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

⁷ http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

Indicator Number	Indicators	Average Score	Lowest	Highest
1	The project plan encompasses Aboriginal perspectives and a holistic view of health and well-being.	3.6	3	4
2	The project plan has a strong promotion and prevention focus	3.2	2	4
3	The project has used evidence to identify the relevant knowledge, attitudes and practices in the community that have positive and negative effects on physical and mental health	2.8	2	4
4	The project has a plan to promote and facilitate behaviour change which will result in better health	3.0	2	4
5	Project activities and services assist people to gain knowledge and skills to help them change behaviours, including providing support through initiatives such as mentoring and coaching.	3.2	2	4
6	Project partners take actions to reinforce healthier life styles through family or community support	2.6	2	4
7	Project partners adopt policies and practices that foster behaviour change, such as adopting smoke free workplaces or incentives to walk to work	2.0	1	4
8	The project and partner services support and reward clients who make positive lifestyle changes	2.6	2	4
9	There is evidence of increased proportion of people adopting healthy lifestyles.	2.6	2	3

The only poorly performing project in this area was very committed to health promotion, but the evaluation team felt that it was too narrow in its focus on increasing knowledge. It did not incorporate other strategies to promote healthy lifestyles.

The impact measures, Indicators 5 through 7, capture the different levels of health promotion. Indicator 5 is about programs that aim to improve individual's knowledge and skills. Indicator 6 is about fostering family and community support for healthy lifestyles. Aboriginal people value family and community relationships, therefore individuals will find making healthy choices much easier if this is valued and supported by their relatives and wider community.

Indicator 7 focuses in healthy policies. Examples of healthy policies are smoke free workplaces, decisions by stores not to stock unhealthy food and drink, or changing the purchasing habits of stores, improved access to condoms, and new recreational areas.

As Table 9 shows, most projects were successful in working with individuals, a few with increasing families and communities' capacity to promote healthy behaviours and only one made significant improvements in policies that impact on health. Influencing families and communities requires on-going

consultation with the Aboriginal community. The results from Goal 4 show that this does not occur in all projects. Changes in policies require excellent engagement from other services. Again, Goals 1 and 2 indicators demonstrated that there was not the common vision or good coordination across services which could foster agreement to implement policy changes.

The outcome indicators reflect changes in how services (including the project) conduct health promotion initiatives and the extent to which the project is making a difference for individuals. Indicator 8 is about the project and partner services and organisations consciously encouraging and rewarding healthy behaviours at the individual and community levels. At a minimum, celebrations of successes will encourage maintenance and enhancement of healthy behaviours. Indicator 9 is about whether more people are adopting healthy behaviours.

Despite the lack of a multi-level approach to health promotion in most projects, the outcomes are moderately promising. The projects and, less frequently, partners and other stakeholders, do celebrate and reward positive change. By putting on activities and making concerted efforts to improve access to those activities (see Goal 7 for more on access) most projects could say that they believed more people were adopting healthy lifestyles. The evidence for these changes is anecdotal and observational. However, they reflect consensus across workers and stakeholders, and reinforced through documentation, that the projects are making some difference on the ground.

GOAL 6: SERVICE QUALITY

Service quality is considered fundamental to all health interventions. There is a particularly strong tradition in clinical services about establishing quality improvement processes.

In Goal 6 the first process indicator measures the use of evidence or experts in the design and delivery of activities. This facilitates the development of activities that are relevant to the community, are underpinned by evidence and are considered to be effective. All five projects have scores of 3 or 4 on this indicating that IHLP projects made good use of existing evidence and/or expertise.

Indicator 2 measures the performance of projects to implement their activities in a culturally secure manner. Evidence based approaches developed for mainstream Australian populations or other Aboriginal communities might work in the local Aboriginal setting, but not without adapting it to ensure that it is culturally secure. The evaluation team concluded that three of the five projects were very good at delivering culturally secure activities and services. It is not surprising that these are the three projects with the closest engagement with their communities.

Monitoring and evaluation is key to delivering quality programs that make a difference. Indicator 3 measures if there are monitoring systems in place and Indicator 4 measures if the data collected is reviewed and used for project improvement.

Documentation is not a strong feature of IHLP projects. Only one project excelled at carefully recording of what was done and used that information to improve project delivery. Community workers in this

site could show the evaluation team those interventions taken up and who were still being targeted. Other sites were at varying stages of implementing monitoring systems. Participation figures were not always collected and this was more evident where there was a lack of regular supervision for community workers, and a more general lack of a shared understanding of what the project or activities were supposed to achieve.

Indicator Number	Indicators	Average Score	Lowest	Highest
1	The project has processes to ensure that activities are being conducted according to evidence base practice in terms of staff and client safety and methods to reduce health inequality	3.2	1	4
2	Standards and protocols are developed to ensure that project activities and services are culturally secure	2.8	1	4
3	Monitoring systems are in place to evaluate and continuously review the quality of services provided	2.2	1	4
4	There is evidence that the quality of services offered by the project or partner services are regularly reviewed and action taken to improve them	2.2	1	4
5	There is evidence that services have contributed to better health outcomes for clients	2.2	1	3

In some of the sites community workers were clearly unwilling to undertake reporting tasks. This was due to a range of perceived barriers that differed at each site, including a lack of computer skills or low literacy, misunderstanding of the purpose of data collection or confusing and time consuming data collection tools. Further support is needed to understand these barriers.

The ultimate aim of IHLP is encapsulated in Indicator 5 which measures if the project has contributed to better health. There are several reasons why the scores are low for all of the projects. One is the problem of documentation. Health outcomes are difficult to measure in the short term. While most projects could point to individuals or families in the community whose health had improved as a result of project activities, the achievements were modest and anecdotal.

The second reason is that improved health may take longer to achieve, especially without strong partnerships with other services. For example, it is unlikely that a set of health promotion activities alone can result in an improvement in population health indicators over 12 to 18 months. Nevertheless, as the most significant change stories show, all of the sites can point to individuals whose health has improved as a result of their projects.

GOAL 7: INCREASED ACCESS

In almost all Western Australian communities mainstream services exist to manage most health conditions and to facilitate healthy lifestyles. However, the experience has been that many Aboriginal

people do not use these services. Evidence suggests that this may be because the service is in a location which cannot be reached easily; the Aboriginal people have not heard of the service or do not understand what the service is offering; the service has been designed *for* Aboriginal people rather than with Aboriginal people, or there are strongly negative associations with the service. It may simply be that the most Aboriginal people have not heard of the service or do not think that it is something that they need. In some cases staff may have a reputation for being unwelcoming or disrespectful.

Increasing access to activities and services for Aboriginal people was a key objective of IHLP. The three process indicators in Goal 7 (Table 11) addressed promotion of services (Indicator 1), flexibility and innovation in offering services in order to improve access (Indicator 2), and routine monitoring of coverage in order to be sure that the service reaches all eligible members of the community.

Indicator Number	Indicators	Average Score	Lowest	Highest
1	The project successfully promotes programs and services to the community (for example, by using local media), and regularly evaluates the effectiveness of communication processes	2.4	1	4
2	There are strategies to improve access, such as different locations, hours of service, transport assistance	2.8	1	4
3	Processes are in place to measure project coverage and participation	2.2	1	4
4	There is evidence of a high level of awareness of project activities and services among the target group	2.4	1	4
5	There is evidence of a high level of participation in project activities and services among the target population	2.6	1	3
6	More clients (or clients previously not receiving a service) are accessing services and healthy lifestyle programs	2.6	1	3

The evaluation team found that almost all of the projects were very committed to increasing participation by trying different strategies. This is testimony to the tireless community workers who understand the importance of using different promotion strategies in small communities, even where everyone apparently knows everyone else. The evaluation team found that the most successful projects were ones which used many ways to make sure people knew about activities and services. Word-of-mouth is powerful but even in small communities notices at shops, appearing at other community events, texting reminders and other strategies help to make sure that the project and its activities are well-known.

How much promotion is necessary? It is impossible to say without devising participation targets and measuring if the project achieves them. To measure the quality of access, the best measure is the proportion of the eligible population that participates. As noted under Goal 6, documentation is not a strong feature of the IHLP.

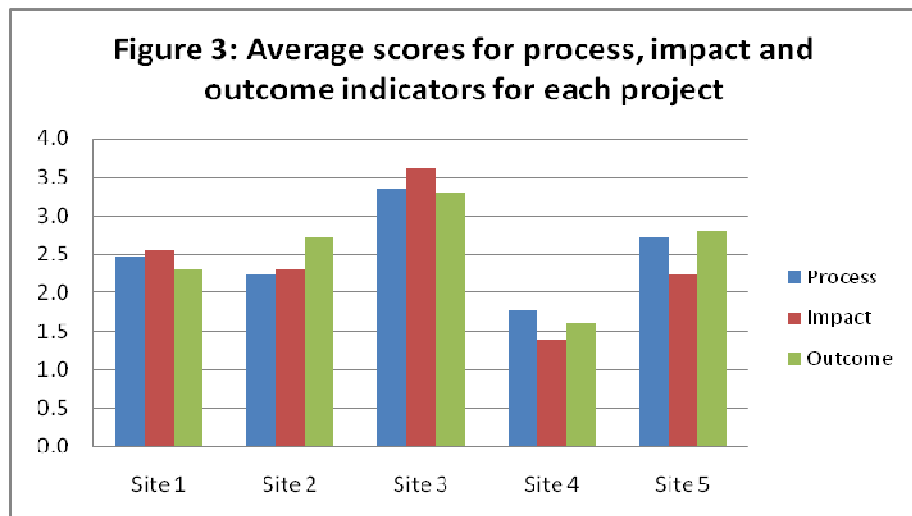
The result of good processes should be that the Aboriginal community is aware of the project and its activities or services and that there is a high level of participation. For these critical impact measures the results were mixed. In talking with community representatives and reviewing documentation the evaluation teams were convinced that awareness and participation was high in most projects.

The relationship between good processes to increase access and good awareness and participation were apparent. The scores of these two types of indicators were highly correlated. Projects with poor processes to increase access did not have as good awareness and participation in their activities. The only site that was better on process than their score on the impact and outcome indicators would suggest that they did not have particularly good relations with other services. Those services did not promote the project or refer people to the project workers.

IMPORTANCE OF GOOD PROCESSES

Another evaluation question we had was whether there was any relation between the quality of processes and the projects' impact and outcomes. The relationship between process and outcomes has already been mentioned for some of the goals such as Goal 4 about community engagement and Goal 7 about improving access.

Figure 3 shows that across the sites, the average score for process, impact and outcome indicators were about the same but there was some variation between sites. For example Site 2 scored higher on outcome indicators than on process indicators. This reflects the exceptionally hard work done by the project workers at this site.



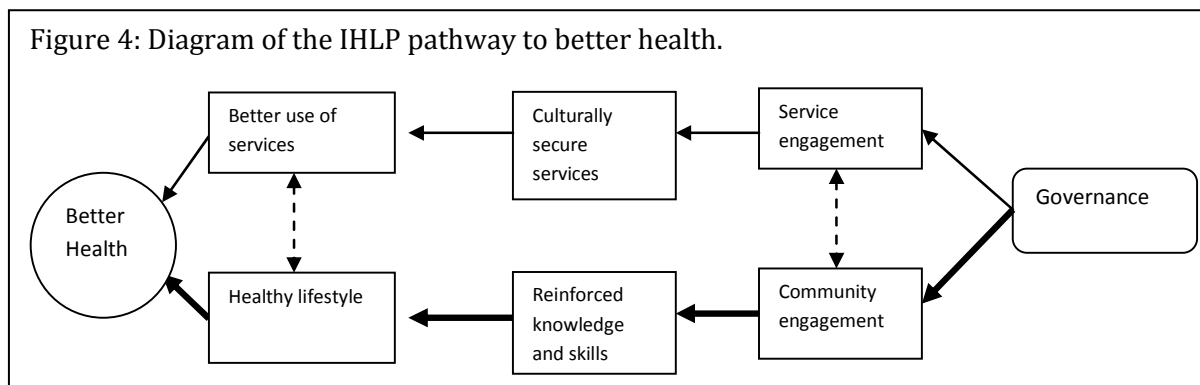
However, in general, the sites with high scores for process also had high outcome scores and the sites with low scores for process also had low outcome scores. Sites 1, 2 and 5 have similar scores for all three levels of indicators. Site 3 has high scores for all levels and site 4 has low scores.

The conclusion from Figure 3 is that good process in governance, workforce development, community and service engagement and the implementation of clinical care and health promotion matter. Poor processes are associated with lower impact and few positive outcomes.

FACTORS PREDICTING GOOD OUTCOMES

In order to understand the impact that IHLP was having on health, we built a simple diagram of the pathways by which health could be improved through the projects. In Figure 4 better health for Aboriginal people is described as being the result of better use of health services and healthy lifestyle.

Figure 4 only looks at the immediate causes of poor health and does not consider what are called the social determinants of health. The social determinants are financial security, employment, education, freedom from racism, self-esteem, safety from violence, good housing and water. For the most part IHLP did not address the social determinants of health, although a couple of the projects were attempting to address environmental health and employment.



The simple diagram in Figure 4 describes two inter-related pathways to achieve better health for Aboriginal people. The pathway at the top of the diagram shows that better health is the result of a timely and appropriate use of health services. The pathway at the bottom of the diagram shows how healthy lifestyles can be fostered.

Coordination and integration of services that are or should be used by Aboriginal people is critical to improving health. Much research has shown that Aboriginal people have much lower use of mainstream services than non-Aboriginal people, even though, on average, Aboriginal people's health needs are greater. The provision of services which are culturally secure are essential to increase service utilisation and one of the goals of the IHLP was to work with services to adopt culturally secure practices. The extent to which services are engaged depends on project governance, such as the use of steering groups, and formal and informal agreements.

Healthy lifestyles are most frequently fostered through multi-level interventions that reinforce healthy choices. These include educating individuals, providing opportunities to master new skills, encouraging family and community members to support health behaviour and improve policies and practices that facilitate healthy behaviour such as safe recreational areas and no-smoking policies. Governance is also important for promoting healthy lifestyles through practices such as employing Aboriginal workers and having protocols for discussing health issues with the Aboriginal community and patients.

The thicker lines at the bottom of Figure 4 indicate the path which several of the projects were able to take towards better health. Supported project workers were able to engage the communities, and design and deliver programs that had high participation. People who were participating in the programs gained knowledge, skills and confidence to make healthy choices and to support other members of their family and community to adopt a healthy lifestyle.

The path on the top of the diagram represented by the thinner lines depended on strong partnerships with services. This was much rarer for IHLP projects, although it did happen in at least one project.

Another way to look at the relative importance of health promotion and service engagement is shown in Table 12. This uses the average scores for a number of indicators representing the different approaches that projects could take. Every site had a score for health promotion that was at least as high as for service engagement and in three projects the scores were higher for health promotion. There were two sites (Sites 2 and 5) which had low average scores for service engagement but medium to high scores on health promotion.

Table 12: Ranked average scores for performance on service engagement, health promotion and health outcomes					
	Site 1	Site 2	Site 3	Site 4	Site 5
Service engagement	Med	Low	High	Low	Low
Health promotion	Med	Med	High	Med	Med
Health Outcomes	Med	High	Med	Low	Med
<p>Note: Service engagement is based on the average score of five indicators measuring partnership agreements, involvement in project activities, delivery of culturally secure services, learning from each other and greater involvement with Aboriginal people. Health promotion is the average scores of the eight health promotion indicators, minus the outcome indicator. The outcome indicator is the average of three indicators about better health, better access and adoption of healthier lifestyles. An average score of 2 or less was 'Low', greater than 2 and less than 3 'Medium' and 3 or greater 'High'.</p>					

The health outcomes are the indicators related to improved health, adoption of healthier behaviours and greater utilisation of services. As Table 12 also demonstrates, the scores for health outcomes are not related to either service engagement or health promotion. This is because it is difficult to see improvements in health outcomes in a short period and none of the projects had methods to measure changes at a population level.

It is also difficult to identify the most important factors in improving services, promoting healthy behaviours and enhancing health and well-being with just a single snapshot of project activity. The next section will take a close look at the experiences of three sites that were visited again in 2010. The purpose is to see what elements are critical for increasing and maintaining project effectiveness.

SECTION 4: UNDERSTANDING CHANGE

The original intent of the IHLP evaluation was to track the evolution of the five flexibly-funded, holistic, community based projects. The evaluation methodology put particular emphasis on measuring how projects implemented a comprehensive approach to addressing chronic health conditions in Aboriginal people. The evaluation framework used seven domains that captured aspects of governance, workforce development, service coordination and integration, community engagement and ownership, health promotion, service quality and access.

The five sites which had IHLP projects were diverse. They spanned the range between outer metropolitan areas to some of the most remote communities in Australia. None of the host organisations had run a project quite like the IHLP before. In one case the host organisation had very little experience in health. In other cases, very little work had been done with the Aboriginal community in that particular locality.

The initial expectation for IHLP was that each project would run for three to four years and that an evaluation site visit would be held each year. However, it was always recognised that there were not enough funds committed for IHLP. In the end, delays getting started and the inability to obtain additional resources meant that most projects only operated for about two years. This is a very short time to see changes in project management, project activities and health outcomes.

A snapshot of activities, like the one provided in Section 3, can only provide information on one point in time. It is very difficult to measure from one visit how indicators of performance have changed. Furthermore, considering that most of the projects had only recently started a full program of activities, it was also difficult to determine the potential for the projects to make a lasting difference.

Despite the short length of IHLP, the evaluation team was able to incorporate two methods to measure change. The first was a second site visit to some of the projects. The second was a method known as 'Most Significant Change' which captures what participants and project staff valued about the projects. The results of these two methods are reported in this section.

CHANGES BETWEEN 2009 AND 2010

The evaluation team conducted a second site visit to three of the projects in 2010 at the request of the Office of Aboriginal Health and with the permission of each project. As described in Section 2, the same methodology was used in 2010. Documents were reviewed and interviews conducted with project managers and staff, community representatives and service providers. Information was recorded for each indicator in the seven goals and then summarised. Evaluation team members discussed the summary for each indicator and agreed on a score from 1 to 4, with 4 indicating excellent performance.

Between 2009 and 2010 the three projects had three different experiences.

Project A had been performing moderately well in 2009. One of its greatest strengths was their staff comprised of committed community workers and led by a local Aboriginal woman. However, the

management structure for the project was weak and many of the service stakeholders reported that they did not understand the purpose of the project. Nonetheless, it was widely believed that the project was making a difference for some local families.

Project B was performing very well on most goals in 2009. A hard-working, proactive local community worker was able to establish strong engagement with the Aboriginal community and was having some success in encouraging other service providers to adopt culturally secure practices. The host organisation largely supported the worker's initiative but had not established policies and procedures for community or service engagement. The project was believed to be helping people to adopt healthier behaviours.

Project C was the poorest performing project in 2009. There was no common vision about what the project was supposed to do and the local community workers lacked confidence. Management structures were not in place which further isolated the workers who were working in an area which did not have a history of strong Aboriginal health programs. Community engagement was fairly low and project impact and outcomes were minimal.

In 2010 the evaluation team learned that change is a constant in Aboriginal health.

Project A enjoyed the most stability, even though there was a change in the host organisation, but not the fund holder. Key project workers had remained with the program. Their relationships with some other services in town had been strengthened although they remained weak with others. The project was making a significant difference for some families in town.

Project B lost their very effective community worker. Weak project governance and processes meant that almost all project activity stopped. The host organisation was finding it very difficult to recruit another worker and lacked the processes which would enable partnerships to be formed with the local Aboriginal community and other services.

Project C demonstrates that positive change is also possible. Significant improvements in management processes resulted in clarifying the organisational structure and providing much greater support to the community workers. The introduction at the most senior levels of the organisation of a Reconciliation Action Plan and the establishment of a leadership group comprised of Aboriginal community members to give direction on strategic and operational issues for all health services. The result was greatly improved scores on governance, workforce development, and community and service engagement. However, the improvements were too recent to show an impact on health outcomes.

Tables 13 and 14 and Figure 5 show in numbers the changes described above.

Table 13 shows the change in mean scores for each goal by project. The scores could range from 1 for not performing the indicator to 4 for excellence performance. The average scores for Project A declined very slightly, much less than a half a point, for each goal. The result was that the scores for each goal was almost exactly the same. Overall the average score was 2.6 in 2009 and 2.5 in 2010.

Project B, which had lost its community worker, experienced declines in mean scores of up to one point. The overall score declined from 2.5 to 1.9.

In contrast, Project C had an improved score across every goal. In the case of governance, service coordination, workforce development and community engagement, the mean scores increased by more than one point. The overall score increased from 1.6 to 2.5.

	Project A	Project B	Project C
Goal 1: The project has clear and supportive governance	-0.07	-0.86	1.29
Goal 2: The project results in improved service coordination and integration.	-0.33	-1.00	1.33
Goal 3: Increase and build a sustainable workforce.	-0.20	-0.60	1.20
Goal 4: Increase/enhance community capacity and participation (2-way capacity building).	-0.20	-0.80	1.80
Goal 5: Improve health and well-being through promotion and prevention	-0.06	0.00	0.11
Goal 6: Improve the quality of services provided.	0.20	-0.40	0.20
Goal 7: Increased access to prevention and treatment services and programs	-0.08	-1.00	0.67
Change in total score	-0.1	-0.6	0.9
Note: Mean change was calculated by subtracting the 2009 mean score from the 2010 mean score. A positive value means an improved between 2009 and 2010.			

Table 14 examines change in a difference way. The evaluation framework distinguished between three levels of indicators: process indicators, impact indicators and outcome indicators. Process indicators are about the systems that have been put into place to deliver comprehensive, culturally secure primary health programs for Aboriginal people. Impact indicators are the actions taken by the project and their partners. Impacts are different depending on the goal. In the case of the goal to promote health, an impact is putting on physical activity programs. For the community engagement goal, offering programs and activities that meet community priorities is an impact. Outcomes are indicators that show that the goal has been successfully achieved. For example, an outcome of good governance is that all of the project workers and partners, together with the community, contribute to the success of the program. Appendix 1 shows the level of each indicator.

As can be seen in Table 14, there was very little change in processes, impact or outcomes in Project A. The loss of a project worker, within the context of weak senior management, meant that in Project B there was a large decrease in the mean scores for process, impacts and project outcomes. This suggests that the good processes, impacts and outcomes were the result of the project worker. Without that position even the good processes were not sustained.

Levels of evaluation	Project A		Project B		Project C	
	2009	2010	2009	2010	2009	2010
Processes	2.71	2.56	2.53	1.88	1.76	2.47
Impacts	2.23	2.27	2.54	1.85	1.38	2.38
Project outcomes	2.80	2.65	2.30	1.90	1.60	2.50

The importance of strong management is also shown in Project C. Improvements in management resulted in large increases in the mean scores for processes, impacts and project outcomes.

Finally, Figure 5 displays the changes on a graph. Here the indicators are organised differently. The Governance score reflects basic management policies and procedures in relation to community and service engagement and workforce recruitment and development. It does not include measure of strategic and operational planning because those were not found to be important to the success of the IHLP projects. The workforce score is based on the presence of a competent and confident staff able to deliver programs which are accessed by the community. The community score measures engagement and dialogue with the community, including a community reference group, protocols, and high degree of awareness and participation in the project. The service score reflects the adoption of cultural secure policy and procedures.

Figure 5 demonstrates how closely related governance, workforce and service and community engagement are. The scores for Project A are constant. Project B had declines in management, workforce, community and service engagement, resulting in poorer performance on improving health outcomes. This shows how hard it can be sustain health outcomes in the face of a deterioration in project performance. Project C, on the other hand, shows that significant improvements can still take awhile to manifest themselves in better health.

Despite the mixed record of progress, the second site visits gave many reasons for hope for improvements in Aboriginal health. Project A, which has benefited from the continuity of their staff, have been able to acquire funding to continue the project. It is likely that this team will be able to continue to provide an essential service in their community and gradually be recognised for their role by other service providers.

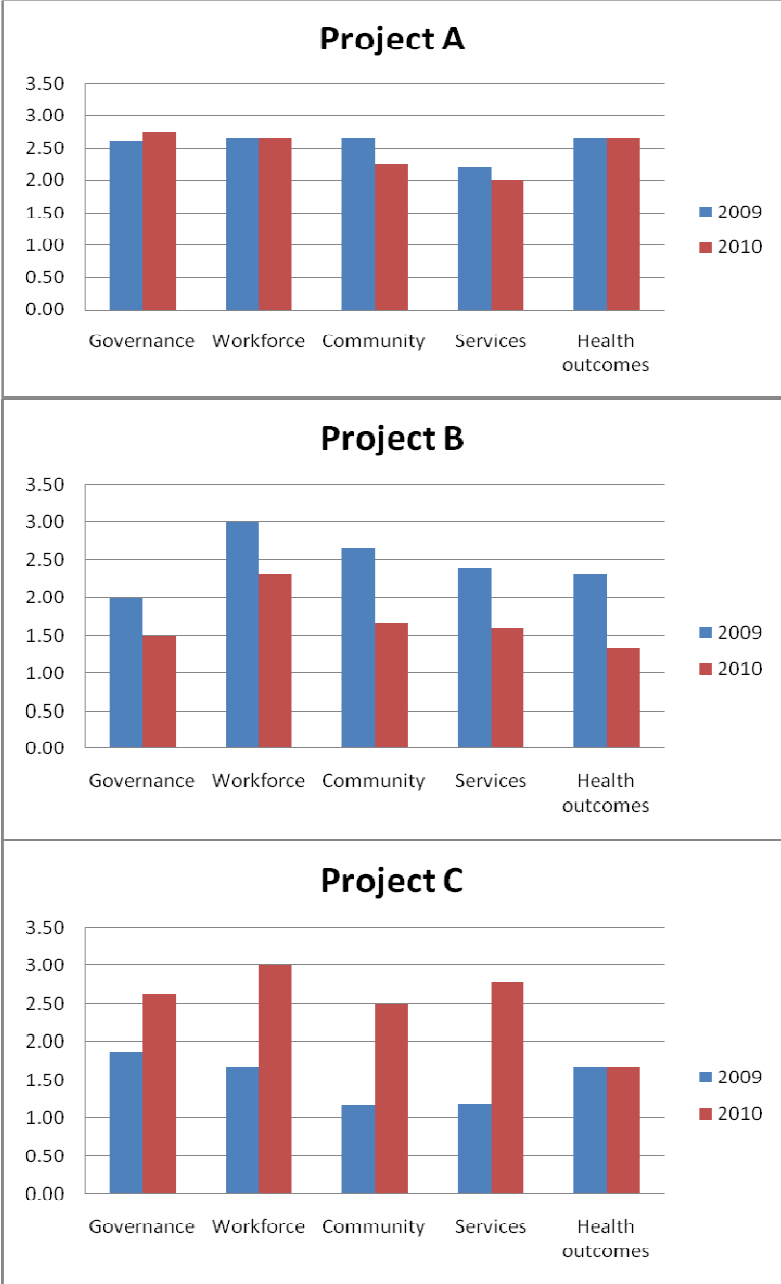
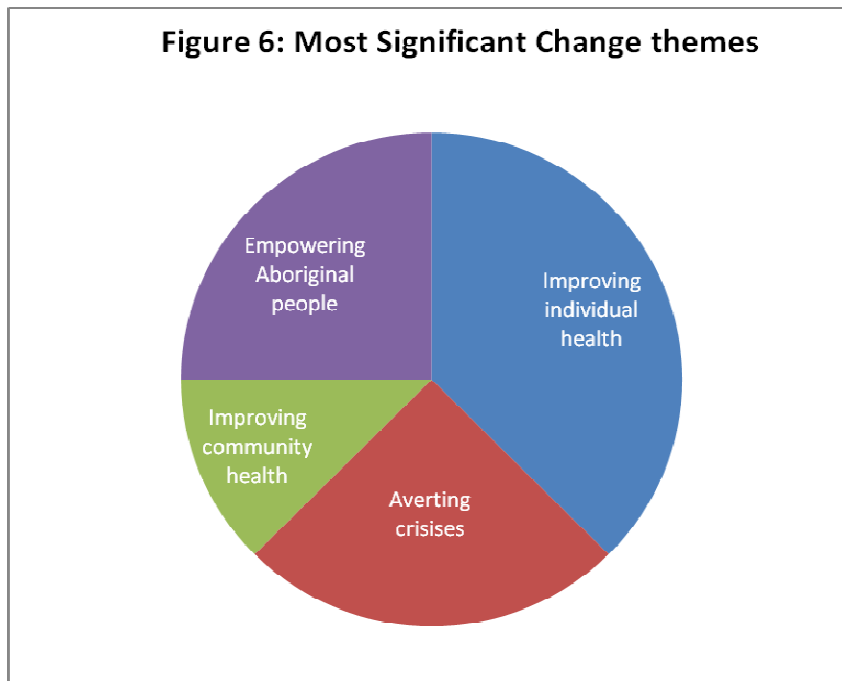


Figure 5:
Changes in the
operational
domains.

The far-reaching changes in governance described for Project C will also benefit the community served by Project B. A Reconciliation Action Plan and a structure for Aboriginal community leadership over health services recently established in the community served by Project B should result in significant improvements in health promotion and service utilisation. The Project B community’s positive experiences with IHLP project while it was functioning has increased their demand for better health care and made them more supportive of efforts to help them to adopt healthy lifestyles.

MOST SIGNIFICANT CHANGE

As described in Section 2, Most Significant Change is a process to clarify project benefits which are most valued by project workers and beneficiaries. The method can supplement but not replace other evaluation methods. The most common way that Most Significant Change is used involves the review of stories by different levels of management. For example, imagine that 30 stories were collected from people who had been involved in a project. Project workers would meet as a group to review all of the stories and decide which eight stories described changes which were most important to them as project workers. Those eight stories might be given to senior management for review and together they would



pick five stories which described changes that were the most important to them as managers. Those five stories might go to members of a board or a group of funding organisations for their review. Together these people would read the stories and pick two or three that were the most important for them. In this process everyone has an opportunity to reflect on how people are benefiting from the project, helping them to clarify what they want the project to achieve.

Most Significant Change can be a powerful way for organisations to learn about the effects they are having on their clients or beneficiaries. It can also help to resolve differences in philosophy or perspectives between workers, management and board members or funders.

Unfortunately, it was not possible to conduct a process of reviewing the Most Significant Change stories. A second meeting of project workers, where stories collected in 2009 could have been reviewed, never occurred.

In this section we take the second best approach and analyse the Most Significant Change stories from the perspective of an evaluator asking what changes were most valued to beneficiaries, project workers and management / stakeholders.

The analysis step was to describe for each story who was changed, what was the change that occurred, and how did the change take place. After several iterations of coding the main type of change described in each story, four main themes and 10 sub themes were selected. The four main themes are shown in

Figure 6. Although the actual number of stories falling into each type is not important, the relative magnitude does indicate what types of changes were mentioned most often.

Together ‘improving individual health’ and ‘averting crisis’ constituted more than half of the most significant change stories. Individual health stories were comprised of stories about a particular individual (or family) who benefited from a project. Averting crisis stories were also about improvements to specific individuals. However, while improving individual health stories are firmly within the biomedical health model of assisting individuals to change their risk factors, averting crises included actively intervening with services to prevent poor quality or unjust care. Averting crisis stories are much more about intensive problem solving. Some of the improving individual health stories were about enabling improved health through giving greater knowledge to family members or offering a service that *might* benefit individuals.

Given the IHLP objectives to reduce the impact of chronic conditions it is actually surprising that there are not more stories about individuals improving their health as a result of the program. This does not mean that such improvements did not occur, but that those changes were not the only aspects of the program that were valued.

The other type of story describes Aboriginal people gaining a greater say over services and health programs. This took the form of individual achievement in one case. Other stories were about Aboriginal workers gaining respect and authority in their workplace or an Aboriginal community having greater input into how services were prioritised and delivered. These stories reflected the importance of changing the power base so that Aboriginal people lead Aboriginal health development.

The final and least mentioned type of change were programs which benefited the entire community by effectively targeting a key health issue. These including improving food supply at the community store, providing essential environmental health services or tackling alcohol abuse and dependency.

Another way to analyse the stories is to look more abstractly at what was being achieved. Here we find that almost all of the stories told by Aboriginal people were about an individual,

Most Significant Change

Gaining confidence

A woman in her mid 40s was able to make fundamental changes in her life as a result of the project. This woman had uncontrolled diabetes. She was very shy and did not take responsibility for her health. However, she did the Journey Living with Diabetes course last year. From what she learned she decided to go to some of the activities. She started with boot scooting and water aerobics and continued as a regular participant. She ended up with the second place award for the Challenge. But the change was greater than that. With the worker’s help she went to her GP and followed up on all of the referrals and other instructions. This increased confidence in her own ability to make positive changes in her life (with the support and social interaction from others) led to her getting her learners permit so she could drive a car and to move out of her family home, which was very overcrowded and into a unit of her own. It was a tremendous change.

family or community gaining the confidence to make improvements in their lives, their workplaces or in the lives of others. This theme of gaining confidence and control is present in almost all of the stories about improving health, averting crisis and empowerment. It is this empowerment which is the legacy of IHLP and should be the goal for future projects to improve Aboriginal health.

SECTION 5: CONCLUSIONS AND RECOMMENDATIONS

The five IHLP projects were based in historically underserved areas and therefore presented a range of challenging implementation issues. In three of the projects the hosting organisation had not had experience in running these types of activities. In two of the projects the approach or the location was new for the hosting organisation.

It is impressive that all projects were able to recruit staff, engage the community, offer popular activities or programs, and demonstrate some signs of making a difference. The shortcomings that we have raised, mostly in governance and in partnership formation, can be rectified as the hosting organisation and other services become more confident of their role in the project. The experience of three projects highlight the importance of a strong management committed to Aboriginal development. Although dedicated community workers can achieve great results working in isolation, relying on workers alone is not sustainable.

These seven final recommendations build on the five offered in the interim report.⁸ They identify elements which should be incorporated in future funding programs that support flexible, community-based approaches to improving Aboriginal health. They stress that there should be: formal reconciliation or substantive equality policies which direct organisational involvement in Aboriginal issues; clear organisational structures in which the project sits; protocols for communication and collaboration with Aboriginal and mainstream services; simplified and iterative planning processes; cultural security training for all staff; mentoring for community workers; and improved methods for monitoring and evaluation.

The most essential requirement for a successful Aboriginal health program is that the host organisation has an understanding of and ability to provide a culturally service. Furthermore, this understanding must be embedded in policies and procedures such as Reconciliation Action Plans and protocols that ensure staff are culturally competent. Aboriginal health cannot be seen as a special interest which is the responsibility of only one small unit. Instead it must be business of everyone in the organization and everyone must understand what protocols to use. Frameworks to measure cultural competence are readily available through many organisations, for example, the Australian Government National Health and Research Council: *Cultural competency in health: A guide for policy, partnerships and participation*.⁹ The South Metropolitan Area Health Services' Reconciliation Plan¹⁰ and the Western Australian Equal

⁸ Combined Universities Centre for Rural Health, *Indigenous Healthy Lifestyle Program Evaluation: Interim Report*, Geraldton, February 2010.

⁹ <http://www.nhmrc.gov.au/files/nhmrc/file/publications/synopses/hp19.pdf>

¹⁰ South Metropolitan Area Health Service, *Reconciliation Action Plan 2009-2014*, Department of Health, Fremantle, 2009.

Opportunity Commissions Substantive Equality Framework ¹¹ are useful models of creating systemic organizational change.

Recommendation 1. Organisations contracted to implement projects targeting Aboriginal health must first demonstrate that they have developed and implemented policies and procedures which acknowledge past injustices and their continuing impact and create a sustained strategy to address these through respectful partnerships and the development of opportunities throughout their structure.

Several of the IHLP projects were taken on by the host organisation as an additional project. Project workers were sometimes managed by people who saw Aboriginal health as one extra activity rather than part of their core duties. Staff in other sections did not understand project workers' roles and responsibilities. This created numerous tensions in the workplace and reduced the effectiveness of the project.

Recommendation 2: Fund holders must demonstrate a clear organisational structure that connects the Aboriginal projects to the strategic Aboriginal development goals and core business of the organisation.

The evaluation team noted that relationships with other services (mainstream and Aboriginal) tended to be *ad hoc*. There was an assumption that other services would understand and support the strategies employed in the IHLP. However, without advisory or steering groups, clear partnership agreements or other vehicles, this kind of understanding never had an opportunity to develop.

This evaluation has demonstrated the importance of local committees or steering groups with representatives from services and Aboriginal community organisations as a key way to exchange information and increase the knowledge about the project. They should be a part of every project which aims to work holistically to improve access to services and opportunities for Aboriginal people. Such committees may be purely advisory or they may have authority to make decisions about funding. Such committees be responsive to and not replace Aboriginal- led groups which set local and district/regional strategic and operational priorities.

Recommendation 3: All Aboriginal projects which aim to improve service integration and access should be structured to ensure that there is a consultative group or committee, representative of key services and community organisations or groups, with defined yet flexible roles and responsibilities. The specific form these groups take will vary between localities. These groups would benefit from input from an Aboriginal-led group which sets direction for all health programs.

¹¹ <http://www.equalopportunity.wa.gov.au/pdf/framework.pdf>

Continuous reflection and improvement is a better model for Aboriginal health projects than strategic planning. Projects are necessarily time and resource limited. A collaborative approach to selecting a few key actions and a participative approach to discussing outcomes and setting new targets is more likely to result in activities which are needed and supported by the community and other services. Planning should not be an onerous task; rather it should be inclusive, responsive and intuitive with clear measurable targets and opportunities for celebrating success.

Recommendation 4: Funders should promote a simplified planning framework that prompts project workers and management to consult with community and service representatives to define the goals, activities and targets for the project, and to include a process of regular monitoring, reflection and celebration with the community it services. A strategic plan is not necessary for a project. Where there is a strategic plan for Aboriginal health development, the project should clearly link to one or more of the objectives. The steering group described in Recommendation 3 is an appropriate group to undertake this planning but should include the community workers and other stakeholders as required.

Some non-Aboriginal individuals highly valued the advice and mentoring provided by Aboriginal community workers while others were confused about their role, responsibilities and competencies. The latter confusion often arises from lack of cultural knowledge. Fundamental to building good rapport is 'cultural humility', which is the ability to honestly admit one's lack of knowledge and be willing to be taught by individuals about their personal realities. This is pivotal to understanding difference in the way people behave, work and communicate. The evaluation teams heard many examples of community workers' frustrations in working with non-Aboriginal colleagues who challenged their reasons for approaching their work in particular ways. Although cultural awareness education is made available to new staff within many organisations, cultural security training should be mandatory for all staff of the host organisation and offered to the staff of partner organisations.

Recommendation 5: Cultural security training, tailored to the local environment, should be offered to staff of the host organisation and partner organisations as part of an orientation to introduce the project and its workers. If local training is not available, a self-directed package could be used such as the one offered free by Combined Universities Centre for Rural Health.¹²

One of the weaknesses in several of the programs was that the host organisation was unable to provide appropriate expertise in health promotion and Aboriginal health development. In some cases this was because the organisation lacked this expertise and in other cases the project site was too distant for regular support. However, three of the projects were able to incorporate a facilitator to support the workers. This person was an expert in her own field (diabetes education, community consultation, early child development), was able to commit to regular visits to project workers and offer structured and

¹² <http://lms.cucrhu.uwa.edu.au/moodle/index.php>

informal training. These people were not line-managers. In one case the facilitator was employed as a consultant and in the other two cases they were internal to the organisation but based in another locality. In all three cases the continuity of support was highly appreciated by the workers and local stakeholders. The involvement of these facilitators increase the confidence and skills of the workers and provided a continuing focus on the ultimate goals of the projects. It is important to note that even projects with weak management processes had an effective community workforce when there was a person performing a dedicated facilitation role.

Recommendation 6: Community workers should have regular access to a mentor or advisor who is responsible for increasing their knowledge and skills and encouraging continuous quality improvement. This person can be internal or external to the host organisation.

Despite efforts to design friendly, simple monitoring tools, reporting is still a weak part of project performance. Poor monitoring results in limited knowledge for improving projects and reduces opportunities to find other funding for successful elements.

Most project workers resisted completing reporting forms, collecting participant evaluations or following up on outcomes. In the few cases where information was collected, it tended to not be shared with the community or service partners. The real cause for under-use of reporting is unclear and this should be investigated.

One solution may be that the supervisor take responsibility for data collection, including using techniques like documenting the debriefing of the project worker after activities. The information can then be fed back through a number of channels such as newsletters and newspaper stories and at team meetings. The information should be presented in a positive light and owned by everyone in the host organisation and the service partners. It should not be seen as being tool to criticise the workers.

Recommendations 7: Greater commitment and creative solutions need to be found to improve the quality of monitoring. The purpose should be to provide the information needed for continuous planning as described in Recommendation 4.

APPENDIX 1: INDIGENOUS HEALTH LIFESTYLE PROGRAM EVALUATION FRAMEWORK

Goals	Revised indicators
<p>Goal 1: The project has clear and supportive governance</p>	<p><i>Process</i> A community reference group has been formed with members who are relevant for the project. There are terms of reference for the group and an expected frequency of meetings. The actual frequency of meetings and the business conducted at the meetings are consistent with what was planned. There is an organisational structure in place which facilitates accountability and appropriate lines of responsibility.</p> <p><i>Impact</i> The community reference group, fund holders and other key organisations can describe a common vision and mission for the project. A robust strategic plan is used by all parties to decide on work priorities and monitor progress. The plan is regularly reviewed and modified when needed. There is evidence that the project plans and partnerships are flexible, adapting to new circumstances.</p> <p><i>Outcome</i> Project staff, partner services and funding organisations fulfill their commitments to the project in a timely and coordinated fashion. According to the nature of the project, adequate funding is either available through project funds or are successfully leveraged from partner organisations.</p>
<p>Goal 2: The project results in improved service coordination and integration.</p>	<p><i>Process</i> There are formal and informal agreements between project partners (providers, community stakeholders and other key organisations) which make each groups' roles and responsibilities clear. These agreements are reviewed regularly.</p> <p><i>Impact</i> There is evidence of an appropriate level of interaction or articulation between project partners, depending on what was planned (e.g., information sharing, coordination or collaboration).</p> <p><i>Outcome</i> The services and programs involved in the project offer culturally secure services to Aboriginal clients involved in the target group.</p>
<p>Goal 3: Increase and build a sustainable workforce.</p>	<p><i>Process</i> Recruitment, appointment and retention processes such as mentoring programs are in place to support Aboriginal and non-Aboriginal staff of the project. Career pathways for staff during and after the project are created.</p>

	<p><i>Impact</i> Project staff have the necessary skills to undertake the requirements of the job. Where there is a skills gap, training or other professional development is provided.</p> <p><i>Outcome</i> Staff of the project are confident and capable of fulfilling their duties. There are more Aboriginal people working in the health sector in the project community.</p>
<p>Goal 4: Increase/enhance community capacity and participation (2-way capacity building).</p>	<p><i>Process</i> The project actively engages the community in identifying needs and priorities. There is a strategy to be inclusive of diversity within the community. Protocols are in place to guide how that engagement takes place.</p> <p><i>Impact</i> Project activities and services reflect community priorities for processes and outcomes. Project partners are learning from each other.</p> <p><i>Outcome</i> Services involved in the project can demonstrate greater involvement with Aboriginal clients and communities (e.g., participation in advisory groups, more Aboriginal staff).</p>
<p>Goal 5: Improve health and well-being through promotion and prevention</p>	<p><i>Process</i> The project plan encompasses Aboriginal perspectives and a holistic view of health and well-being. The project plan has a strong promotion and prevention focus. The project has used evidence to identify the relevant knowledge, attitudes and practices in the community that have positive and negative effects on physical and mental health. The project has a plan to promote and facilitate behaviour change which will result in better health</p> <p><i>Impact</i> Project activities and services assist people to gain knowledge and skills to help them change behaviours, including providing support through initiatives such as mentoring and coaching.</p> <p>Project partners take actions to reinforce healthier life styles through family or community support. Project partners adopt policies and practices that foster behaviour change, such as adopting smoke free workplaces or incentives to walk to work.</p> <p><i>Outcomes</i> The project and partner services support and reward clients who make positive lifestyle changes. There is evidence of increased proportion of people adopting healthy lifestyles.</p>
<p>Goal 6: Improve the quality of services</p>	<p><i>Process</i> The project has processes to ensure that activities are being conducted according to evidence base practice in terms of staff and client safety and</p>

<p>provided.</p>	<p>methods to reduce health inequality. Standards and protocols are developed to ensure that project activities and services are culturally secure. Monitoring systems are in place to evaluate and continuously review the quality of services provided. <i>Impact</i> There is evidence that the quality of services offered by the project or partner services are regularly reviewed and action taken to improve them. <i>Outcome</i> There is evidence that services have contributed to better health outcomes for clients.</p>
<p>Goal 7: Increased access to prevention and treatment services and programs</p>	<p><i>Process</i> The project successfully promotes programs and services to the community (for example, by using local media), and regularly evaluates the effectiveness of communication processes. There are strategies to improve access, such as different locations, hours of service, transport assistance. Processes are in place to measure project coverage and participation. <i>Impact</i> There is evidence of a high level of awareness of project activities and services among the target group. There is evidence of a high level of participation in project activities and services among the target population. <i>Outcome</i> More clients (or clients previously not receiving a service) are accessing services and healthy lifestyle programs.</p>

APPENDIX 2: COMPARISON OF EVALUATION REQUIREMENTS AND THE EVALUATION FRAMEWORK

Table *: Mapping of requirements from the request with the IHLP Evaluation Framework		
Program outputs	Relevant Goals from the Evaluation framework	Relevant Indicators from the Evaluation framework
Practical support available for people at risk of developing, or who have chronic disease to make informed lifestyle choices and healthy behaviour change.	Goal 5 Improved health and well-being through promotion and prevention	Indicators 4, 5, 6, 7 and 8
Link individuals to health and lifestyle providers and activities to prevent chronic disease.	Goal 2 Improved service coordination and integration	Indicators 1,2 and 3
Ensure availability of local level modification services, support and referral pathways within the communities.	Goal 6 Improved quality of services provided	Indicators 4 and 5
Reduced risk factors within a community to improve quality of life.	Goal 5 Improved health and well-being through promotion and prevention	Indicators 4, 5, 6, 7 and 8
Reduce or slow the progression rate of risk factors and their complications.	Goal 5 Improved health and well-being through promotion and prevention	Indicator 9
Increased ability of individuals and communities to manage risk factors and incorporate lifestyle modifications into their lives.	Goal 5 Improved health and well-being through promotion and prevention	Indicators 4, 5, 6, 7 and 8
Increased training and mentoring to local community members to support program activities.	Goal 3 Increase and build a sustainable workforce	Indicators 1, 3, 4 and 5
Evaluation Focus		
Increased health gains as a result of	Goal 6 Improved quality of services	Indicator 5

flexible funding and resourcing at the local level.	provided	
Acknowledging and articulating the purpose, values and desired outcomes for government, NGO service providers and community.	Goal 1 The project has clear and supportive governance	Indicators 3, 4, and 6
Health benefits of earlier access to primary health care services.	Goal 6 Improved quality of services provided	Indicator 5
Increases individual and community commitment to social change.	Goal 5 Improved health and well-being through promotion and prevention	Indicator 6
Improved lifestyle behavioural and attitudinal changes per site.	Goal 5 Improved health and well-being through promotion and prevention	Indicator 9
Increased social capital per site.	Goal 7 Increased access to prevention and treatments services and programs	Indicators 4, 5 and 6

APPENDIX 3: LIST OF PROJECT-RELATED DOCUMENTATION REQUESTED BY THE EVALUATION TEAM

The following list was sent to project managers prior to the site visit to give them idea of the types of documentation the evaluation team wanted to see.

Documentation related to project management

- Project vision or mission statements
- Strategic/Project Plans
- Project evaluation framework
- Documentation of community consultation activities
- Terms of reference for advisory/management group
- Agendas / minutes of advisory / management group
- Membership list of advisory / management group
- Formal agreements with project partners
- Job descriptions for project staff
- Other HR related such as orientation manual, professional development reviews
- Budget and financial statements
- Policies and procedures
- Other management-related documentation

Documentation related to project activities

- Project Diary
- Media reports, articles, releases
- Activity / progress reports
- Project evaluation reports
- Other project material such as promotional material
- Other project related documentation

APPENDIX 4: MOST SIGNIFICANT CHANGE STORIES, COMPILED FROM ALL PROJECT SITES

MSC 1

Three examples of success

A grandfather approached the project worker to stop DCP taking children from the family after the parents of the kids had left. The worker supported him with that. He was successful and he now has control of the kids.

A young girl was in foster care. Her first child was taken by the foster carers that took care of her. The project worker helped her with the second child and told DCP that they needed to take a backward step and give the young girl a chance. She told the young girl to treasure the baby and to look after it. The project worker asked DCP how would the girl learn to grow up a baby if they took her baby away. This case is now closed with DCP.

A man will be coming out of prison, the project workers are supporting the family so they can support him when he comes out. The worker is also trying to get him back to the community lock up a few weeks prior to him being discharged from prison so he can have family contact whilst in a secure environment.

MSC 2

A senior person in another agency described a discussion with the project workers about the intervention the team had with a young child. The workers identified that the main issue involved in care of young children in the household was an elder sibling who had “began to bump into the law”, and was getting in trouble. This had made life in the household difficult, affected food security and impacted on the care of younger children. The project team provided a linkage between the family and DCP and juvenile justice in a way that was not threatening. The worker was concerned that this activity was outside of the scope of the program; was okay to be involved? The senior person encouraged her, remarking that the advantage of the project was the holistic view of the workers who could identify the main issues within the context of this case.

MSC 3

Two examples of success

Children from one family in the community had been identified as not attending school. The project workers talked to the family and began to go around and pick up the kids to take them to school. Initially the kids had to be rounded up. After a while the workers would turn up and the kids would be ready for school. Eventually the workers turned up and the kids weren't there, and had already gone to school themselves.

There was a difficult situation in which a local man with a history of violence had been taken away from the community to prison in a case that involved the death of a child. This case had an unusually high level of interagency cooperation with 12 agencies involved. The man was returning to the community with police as a public trustee, which I think meant he was returning without conditions. DCP were ready to remove the children from care of the mother who was adamant that the man would return home to her. Men from the project were preparing to work with the man and mentor him on his return in order to avoid repeated offending on his part as well as safety of the mother and children. Female workers would work with the mother and children to facilitate a stable and safe home environment.

MSC 4

Two examples of success

There had been a number of sad events recently with several people dying from diabetes related causes. This particularly affected two women in the community who had never attended any of the project events despite many invitations from the project worker. Recently they were in the car together and one of the women said 'When's that walking club? I'm going to go.' The project worker was thrilled that it happened 'out of the blue'. She followed up that good intention with texting and phoning as the time approached, teasing her to make sure that she came. And sure enough the woman attended – ten minutes late but she showed up.

For the worker this story meant that people can make changes. It can happen suddenly.

Another one of the stories that influenced the worker greatly was a colleague who is an AHW. He was on dialysis and very much wants a transplant. However, his health is not good and particularly he needs to lose weight. It seems to become a community project to help him lose the weight. He comes to as many of the activities as possible – sometimes as the only man. The project worker has found other men to support his daily exercise routine. She is proud of the effort that this man is making despite his many other family and work and personal health responsibilities.

MSC 5

A project manager was impressed with the project worker's initiative. There was a lady that had been told by her doctor to go immediately to the hospital. She did not understand that and went home instead. The next day she phoned the worker to say that she was sick. The worker picked her up and took her to the doctor but she no sooner got out of the office when the doctor's office called to say that it was necessary for the woman to go to the hospital. The woman eventually had a toe amputated. The worker knows of many times when this sort of misunderstanding occurred. She decided to do something about it and has designed a Take Home card for GPs to complete to explain exactly what is needed. It includes date of next appointment, immediate next actions and so forth.

The manager feels that this demonstrates the worker's initiative to come up with practical solutions.

MSC 5

Senior manager and clinician in a partner service told the evaluation team that through the project she has been able to develop partnerships with other services. Her team had long realised that many people in the community have financial problems and obtaining equipment to manage their chronic conditions was very difficult. There is a long process in gaining a letter from the general practitioner and then getting CentreLink to review the application and to obtain a voucher and then to return it to the health service. This enormous amount of red tape meant that people did not get the equipment they needed. The service would have loved to provide the equipment but did not have the funds to buy what was needed. A partnership with other local services solved this. They realised that alone they could not supply their clients' needs but if each agency purchased some equipment and made it available to clients from all services, there would be enough. And that is what has happened. If, for example, their client needs a glucose monitoring they can call the other service who will lend theirs. This partnership would not have happened without the relationship formed through the IHLP Reference Group.

MSC 6

This is a story about an event that is being planned. It is very exciting. The program is based on The Greatest Loser. It is about people coming together to lose weight and get healthy. The idea is that all of the services in town will work together to award points. A person might get 50 points for attend the gym, 20 points for going to an aqua-robics class and 100 points for attending a FoodSense workshop. Every six months there will be an award for those with the most points. It will be open to people of all ages and will be possible for people of all levels of physical fitness to participate. Winners will be written up in the newsletter.

The Aboriginal worker from a partner service picked this story because it shows how creative the project worker is, how the activity would involve the whole community and how all of the services could support each other.

MSC 7

The manager of a mainstream recreational facility feels that persistence is the key to engaging the Aboriginal community. The project worker organised aqua aerobics and the instructor didn't get anyone turning up and so the Manager asked her to keep running the session and eventually she has 3 turn up and then 6 and now it is growing. The Manager is aware that they have had a bad reputation with the attracting Aboriginal people to the centre in the past, he now is trying to organise an Aboriginal Family Day with the project worker to encourage families to the centre. They will have to wait until family feuding finishes before they can run this Day.

MSC 8

An Aboriginal woman was living in a small, nearby town and wanted to do things in the community because they had nothing. She told the evaluation team about working with the project worker to organise a women's group that had a lot of kid oriented activities and helped women get better knowledge about health. They also organised for organisations like the housing advocacy group to come to the meetings to find out how they could improve their housing. It was great for the community and it ran for about seven months. Unfortunately, it was meeting in a building owned by the school and the school wanted it back, so the group stopped.

MSC 9

An older Aboriginal woman told us that a training that she took that was offered by the project made her more aware of health issues. 'We have a white man, well, he is really the family pet. He has some serious health problems but is also raising teenagers and assisting his disabled mother. When he come over I saw a sore on his toe. That is what I learned about, foot sores. So I said to him, you got that sore, it ought to be looked at. You ought to go to a doctor and get your sugar tested. Well, he did but he didn't have sugar. Also, my granddaughter is a skinny thing. When she comes I give her a big feed but she doesn't gain any week. I told her to get tested for sugar. Just because you are skinny doesn't mean that you can't have diabetes. I learned that too. She didn't have it but it made me aware, see?'

MSC 10

An Aboriginal woman, very active in her community told the evaluation team that she and her mother both lost weight as a result of the course offered by the project. They cut out bread, coffee and are having skimmed milk. They have both lost quite a bit of weight and are both feeling good together. Sometimes if she feels like a biscuit, she will substitute it for something healthier as she knows how much sugar is in it and save herself to have a treat later.

She recalled that one of the instructors washed her mum's feet as part of the program. This made her laugh that a 'white woman' was washing a 'black woman's' feet but this showed support from a white person to assist in their health and wellbeing. Jennifer also feels that the course has created a 'competition' for young people involved in the course. They start competing to see how much weight they can lose – she wanted to share this story to show how the course can also be fun but also how to involve young people and keep them motivated.

MSC 11

There is one significant change that people told over and over again. That was the story of the two young men who had recently voluntarily checked themselves in to hospital for de-tox. These young men are alcoholic, and at least one of them has uncontrolled diabetes. But they also are valued community members. One is a 'bush man.' He loves going out bush and can teach the young kids so much. The community is afraid that they are going to lose these young men. Others have died before them.

Community members proudly pointed them out and explained that they were in de-tox. Others commented on how well they looked and how well they were doing. These young men are being encouraged and supported by the community. They have homes to go to – there is no homelessness in the town anymore; and they will get a meal. And they are giving back to the community as well. One Saturday morning they both got up early and went out for several hours to clean a community member's house and the young man with diabetes is visiting peoples' homes to show them how to monitor their glucose levels.

The hospital, the GP and the community development workers all spoke of them with pride, none of them boasting about how much they also had done to help. However the doctor did mention that there isn't this type of community based detox model anywhere and the health people expressed gratitude that their doctor had the skills to be able to manage the detox process. Many people also mentioned that there was now a need for an alcohol and drug worker and some sort of house or centre which could giving on-going support for those who

wanted to continue to not drink or drink less. Still even without that on-going support something marvelous has happened to the community. As one member says 'it is as though something has been lifted.'

MSC 12

A project manager's story is about the community planning process and the impact it has had on people. Everyone came to the planning days. There were some people who were homeless, living in a deserted house that was falling apart around them. These men even came to the planning days. She remembers one of these men coming to the search. He was very resistant but by the second he was very involved. The search lifts our mob. They get such a creative spark. They focus on a better future.

But she warned 'It is so easy to collapse again. I live far away. I cannot give support to keep the momentum. It is necessary to have the local project officers. Who does the planning must live with the consequences of the planning.'

MSC 13

An Aboriginal community member's most significant change was the improving relationships between youth and the police. The adults in the community recognised that their children had a very bad attitude about the police. This is the same in all Aboriginal communities and has its origins in many wrongs that have been done. The community wanted to stop this because they wanted their children to respect police and know that they were there to help them. The group did an action plan. Someone knew about orienteering and thought that it would be good if the police could organise a joint orienteering program. This would help to build better relationships. They took this plan to the police and it turned about that one member of the police was 'full bottle' on orienteering. They thought this was a great idea and she organised the whole course and trained the kids how to read a compass and calculate how far they were going while they were running. The day was held with full participation from everyone and it was a great day.

The results have been fantastic. The better relations have lead to a decline in juvenile crime and better, friendly relationships between police and the kids in town. But one of the unexpected results was that kids got interested in maths. There are families where they all sing the multiplication tables!

MSC 14

A Babies Death

Earlier this year the Community Families Program (CFP) coordinator was visited by the family of a young mother with a sick child, could she come down and see the child?. The CFP coordinator and some of her workers visited the house. Realising the baby was very sick they immediately took the child with the family to the hospital. The baby died shortly after arriving at hospital.

In the immediate emotional aftermath the CFP coordinator stayed with the mother to comfort her. The babies father, in shock and fearful of being blamed for the death ran away. Two male community workers took off to find him.

The CFP coordinator took the mother to her family to pass on the news as is the culturally correct thing to do. The coordinator stayed with the mother during the outpouring of grief by the family. During the emotional expression, and as is cultural way, the mother was flogged by the family.

The coordinator took the mother back to the hospital to be with the baby. Meanwhile during this time a group had gathered at the hospital. Rumours of substandard care by the hospital and other service providers in the days preceding the death fueled an emotional and angry crowd. Community workers from the CFP positioned themselves amongst the crowd to calm the situation and appeal for people not to transform emotion into destruction of the hospital. The mob was upset however did not become violent and the hospital was not damaged.

The CFP coordinator stayed with the mother and explained and interpreted for her what needed to happen to her dead baby as the mother did not understand what an autopsy was. Young parents showed their respect by coming to see the baby and were sensitively told about how picking up the child was not possible, again because of the autopsy. The CFP continued to support the family and went on to help organise a funeral and check on the well being of the parents. Male CFP workers have continued to check on the well being of the father as initially they were concerned he may pose a suicide risk.

As recounted by the CFP coordinator, "It should have gone bad but it didn't... it was a terrible day and a hard day's work".

Accounts from hospital staff who were involved in the event illustrated the impact that the CFP workers had on diffusing the situation. The matron of the hospital said "the group's involvement provided an outstanding result to something that we all thought was going to go very bad indeed". She explained how the trust the group had developed with the family over time gave them enormous security during the event. The longer standing impacts are significant. The family are now doing very well, and engaging with other services in town.

MSC 14

Story 1

This story follows on from a story recounted in the previous visit to HC for evaluation one (September 2009).

A man returning to HC from prison was under a Domestic Violence Investigation (DVI). Because of numerous offences and a high level of risk of re-offending the Director General (DG) wrote to local services instructing them to bring his children in, removing them from the home in preparation for this return. On behalf of the family, the project coordinator of the Community Families Program spoke to the service manager requesting that the children stay in the home. As a result of Valma's advocacy the service organisation team leader contacted the DG requesting that children remain in the home environment. A range of organisations worked separately with members of the family involved to support the man and family on his return.

This man is being seen by men from the CFP. Presently, in the words of a male community worker, "we go around to the men and check up. (We ask) how's the baby? Are you looking after your partner?".

The re-integration into the home environment has been successful. Since returning the man has not been drinking and there have been no reported instances of domestic violence. Recently the case of this family has been closed by the local service provider, meaning it is now judged to not present a risk for incidents occurring. As recounted by one service provider, "I don't know what they did but I believe Valma's program was doing the most effective work (with the family)... but you didn't see it".

MSC 15

The first story is about an Aboriginal woman who did the Journey Living with Diabetes course. She became so interested in health and in health education that she decided to become an Aboriginal health worker. She enrolled in the course and achieved an award for the best student. She is completing her Cert IV at present and has been doing a placement at South Coastal Women's Health. She will do her next placement at the new Aboriginal health centre in Mandurah. This is an example of the influence that the project has had to inspire real change for individuals.

MSC 16

The second story is more strategic. It is about the partnership that has developed to enable the centre to be established. The process to create the DACHAG was very inclusive and at times difficult. However the results have been profound. Non-Aboriginal people now have an opportunity to learn directly from community members what needs to be done. Community members have the opportunity to directly ask and challenge managers.

MSC 17

For her the most significant change has been the greater awareness in the health service that the leaders in Aboriginal health services must be the Aboriginal health professionals (members of the Aboriginal health team). Without that Aboriginal 'face', Aboriginal people will not access services. The Aboriginal health professionals have changed the way that non-Aboriginal people conduct themselves. The Aboriginal health professionals have the authority and non-Aboriginal health professional have learned that they proper place is to walk along side in a relationship built on equality and respect. To give an example, there was a recent case of a death at the Peel Health Campus. The Aboriginal family members were treated very disrespectfully by the staff at the hospital. Instead of being passive, the family complained. The hospital recognised that it was wrong and is now regularly attending DAHAG meetings and seeking advice from the Aboriginal health professionals in Mandurah.

MSC 18

My brother was diagnosed with diabetes. It was very hard to get him to change. He was very stubborn. I used to make little packages for him to take when he went away. She is very pleased that the hwhole community where he lives supports his behaviour changes. People like the shop keepers support him by telling him not to eat certain things. She feels that her experiences has given her more ability to support her brother.

MSC 19

The most significant change is the partnership that has been built with the local team. They had a hard time working with some of the team members. A particular person was very uptight and always frantic. This person often demanded that the Aboriginal team members do something right away and saying very inappropriate things in public and not to the Aboriginal team member's face. It got so bad that the Aboriginal team members spoke to the team leader about their problem. Although the team leader seemed to understand the problem, nothing

appeared to be done about and they were not given feedback. Unexpectedly the whole team was called into a meeting to discuss how they should work together. During this meeting the Aboriginal team members were able to speak up. Using a Substantive Equality framework there was a free discussion. In that free discussion, the difficult team member relieved things about herself which made her seem more human. Soon after the meeting they were involved in a joint activity. It was a success and the difference in this team member was amazing. She was glowing. Very happy and very relaxed. Although there was problems with the process, for example the team leader not giving feedback, the result was excellent and the working environment much, much better.

MSC 20

A woman in her mid 40s was able to make fundamental changes in her life as a result of the project. This woman had uncontrolled diabetes. She was very shy and did not take responsibility for her health. However, she did the Journey Living with Diabetes course last year. From what she learned she decided to go to some of the activities. She started with bootscooting and water aerobics and continued as a regular participant. She ended up with the second place award for the Challenge. But the change was greater than that. With the worker's help she went to her GP and followed up on all of the referrals and other instructions. This increased confidence in her own ability to make positive changes in her life (with the support and social interaction from others) led to her getting her learners permit so she could drive a car and to move out of her family home, which was very overcrowded and into a unit of her own. It was a tremendous change.

MSC 21

The change in the community was also very significant. She feels that the community is knowledgeable and united and is on track to take control of their health service. The Wellness Centre, which will be a place of information, referrals, services and programs, will be Aboriginal-controlled within four years. The community now knows what it wants and can speak up. They are also recognising that other issues like housing and employment is also important for their health. The people involved in the DAHAG which is leading this change are people who were regular participants in her project. This is where they gained their knowledge and confidence.

MSC 22

There is a high of participation in sports, ranging from cricket with up to 50 players, volley ball softball, basketball which is played most evenings with mixed teams, 5 a side is the preferred game. School holiday activities are well organised and fun for the kids as is the after school program.

Working together with the store and the CEO they have managed to get a 2 weekly fresh fruit and veges supply which they help with the transport for. People buy the new foods and have a more mixed diet. The cafe nights and cooking sessions are popular and young people talk about their skills in cooking.

They have facilitated and provided access to dog control and a dog health program locally.

APPENDIX 5: EVALUATION CONSENT FORM FOR INTERVIEWS



INDIGENOUS HEALTHY LIFESYLE PROGRAM EVALUATION CONSENT FORM

The Office of Aboriginal Health has contracted Combined Universities Centre for Rural Health to conduct an evaluation of the Indigenous Healthy Lifestyle Program in five sites in Western Australia.

I agree to be interviewed by the evaluation team about my knowledge and experience of the project in my community.

I understand that the information I give will be written down by the team and used for their evaluation. My words and stories may appear in their reports. However, the evaluation team will make sure that I cannot be personally identified.

If I wish, I can obtain a copy of the report on the project in my community for information and to correct any mistakes.

I am participating in the interview voluntarily and I understand that I can stop answering questions at any time without giving a reason.

Interviewer

Interviewee

Date

Date

If you have any questions about this evaluation please contact the Aboriginal Healthy Lifestyle Project worker in your community or Ann Larson from Combined Universities Centre for Rural Health (9956 0200) or Linda Waters from Office of Aboriginal Health (9222-2329).

APPENDIX 6: EVALUATION INFORMATION SHEET



Western Australian Indigenous Healthy Lifestyle Program Evaluation Information Sheet

Combined Universities Centre for Rural Health is undertaking the evaluation of the WA Indigenous Healthy Lifestyle Program funded through the Australian Better Health Initiative. The evaluation is being managed by the Office of Aboriginal Health.

The evaluation team is comprised of a multi-disciplinary team of both Aboriginal and non-Aboriginal researchers. The evaluation will measure the progress that all five project sites as a whole, make towards the delivery of integrated, patient and community focused services that increase the prevention, treatment or management of chronic disease.

The evaluation team will visit each project site once a year, at a time which is most convenient to project staff and members of the community reference board. During the visit, which will usually last three days, the team will review project documents and interview staff and representatives of partner services and community organisations. The team will also meet with the community reference group. During the interviews and meetings the team will ask a series of questions about how the project has functioned. Some individuals may also be asked to tell a story about the most significant change that has occurred to them, their organisation or their community as a result of the project.

Interviews and meetings will take between 20-40 minutes and the results (including your stories) will be shared with you at the end of the visit. You will be invited to make any changes at that time.

Results from the site visit will be shown to project staff and members of the community reference group before being finalised. The annual reports to the Office of Aboriginal Health (OAH) will describe the progress of all of projects. Identifying information on individuals (such as their name or position and community) will not be included in the report to the OAH.

If you have any questions about this evaluation you can contact the evaluation team leader Ann Larson at CUCRH on 9956 0200 or on alarson@cucrh.uwa.edu.au. You may also contact Linda Waters, the OAH program manager on 9222 2329.