Decolonising public health policies: Rightfully giving effect to Aboriginal and Torres Strait Islander peoples' knowledges and cultures of ways of being, knowing and doing in public health policies

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A THESIS SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

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DECLARATION

Statement of authentication

This thesis is submitted to the University of Sydney in fulfilment of the requirement for the Degree of Doctor of Philosophy. The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or part, for a degree at this or any other institution.

Signature:

Date: 11/11/2020

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FINANCIAL AND IN-KIND SUPPORT

In February 2016, I was awarded a Wingara Mura Leadership Program Academic Fellow position with the Poche Centre for Indigenous Health at the University of Sydney. The Wingara Mura Leadership Program is an early career academic initiative designed to attract, develop and retain talent by offering career support pathways and meaningful employment for Aboriginal and Torres Strait Islander people. This provided me with the means to undertake and successfully complete a Doctor of Philosophy (PhD) degree. Initially though, I successfully secured and was awarded a 2015 Lowitja Institute three-year PhD scholarship. However, I became ineligible for this scholarship when the Poche Centre agreed to sponsor me under the Wingara Mura Leadership Program.

In May 2016, I attended the University of Melbourne's Summer Intensive Professional Certificate in Indigenous Research (PCiIR) that was fully paid by an anonymous philanthropist. I remain grateful for the opportunity to participate in this winter intensive course because, being a higher degree familiarisation program, it put me in good stead by enabling me to gain an appreciation of the requirements, expectations and challenges of undertaking a PhD. The PCiIR provided credits towards undertaking a Graduate Certificate in Indigenous Research and Leadership that was again funded by an anonymous philanthropist. I undertook the graduate certificate course in the first half of 2019 and graduated in 2020.

Also, in 2016, I was awarded a Lowitja Institute conference bursary to support travel and accommodation to attend their Inaugural International Health and Wellbeing November Conference to present a poster. Additionally, in 2019 I was awarded another Lowitja Institute conference bursary to give a 20-minute presentation at their

June Second International Health and Wellbeing Conference held in Darwin, Northern Territory.

The work of this thesis was also supported by a 2016 Scheme for Remote Research Students grant from the School of Public Health, University of Sydney. This helped pay my travel expenses to attend face-to-face meetings with my PhD supervisor as well as a range of training sessions such as Endnote software training from the University of Sydney Library.

The National Indigenous Research and Knowledge Network (NIRAKN) also provided fully paid places in several workshops that were primarily held at the Queensland University of Technology's Kelvin Grove campus in Brisbane, Queensland and led by Distinguished Professor Aileen Moreton-Robinson. These workshops included:

(i) A capacity building workshop on 15–16 February 2016 aimed at developing research and academic skills and learning about Indigenous research methodologies.

(ii) The NIRAKN members' meeting and workshops from 11–15 July 2016 that was a follow-up to the above capacity building workshop. This meeting provided me with an invaluable opportunity to expand my knowledge base, reconnect with fellow students and meet new ones. Topics included understanding the research ethics process, project methodology, quantitative research, yarning as a methodology, tips for applying for and administering research grants, leadership in academia, academic progressions and promotion planning, copyright and intellectual property, and media PR tips. I also had an opportunity to do a three-minute thesis presentation in front of

peers and highly renowned Australian Indigenous scholars that came with feedback.

(iii) The NIRAKN Critical Reading Group, Critical Indigenous Studies: Engagements in First World Locations held on 11 October 2016.

The University of Sydney provided funding that enabled me to successfully complete an Advanced Qualitative Health Research course in the first half of 2017. The University also provided funding that allowed me to successfully complete an Analysing Health Policy course in 2018.

At the end of 2017, the Wingara Mura Leadership program also provided funding to support my participation in the International Public Policy Association 2018 public policy winter school intensive held in Grenoble, France.

The Deeble Institute at the Australian Healthcare and Hospitals Association Offices in Canberra awarded me a 2018 Summer Research Scholarship. Whilst this scholarship was not fully completed, the six weeks in Canberra provided me with an opportunity to finalise discussions seeking community support and identifying potential policy actors. The Katherine Hospital case study idea began to evolve during this time. This idea was later informed by the stories of policy actors.

I am grateful for Anthea Mahoney, who lives and works at the University of Canberra, for willingly opening her house up to me and allowing me to stay over the six-week period mentioned above. There were many other occasions that I stayed at her house as well, particularly when collecting my data.

In 2018, I received a Cross-Cultural Public Health Research Award totalling $1,600. I used grant to engage a transcription service to transcribe the policy actors' stories told

during yarning sessions. This is an annual award that was established by Professor Janice Reid, formerly of the University of Sydney's School of Public Health and Community Medicine, to support higher degree public health research affecting Indigenous Australians, refugees or recently arrived migrants to Australia. Also, I was awarded a Postgraduate Student Research Scheme grant and a Research Student Grant in 2018 which assisted with my PhD research, primarily during the data collection stage. Further, the Wingarra Mura Academic program provided funding for my attendance at the Eighth Healing Our Spirit Worldwide Gathering in Sydney in November 2018 where I presented a poster.

In 2019, the University of Melbourne's Poche Centre provided financial support allowing me to attend a Maori Doctoral Conference and writing retreat auspice by the University of Otago and held in Aotearoa New Zealand. It was also an opportunity to build networks and explore potential international collaborations. Importantly, it also provided me with a space to write for four days in the fishing village of Karitane, north of Dunedin on the east coast of the South Island of Aotearoa NZ.

The National Health Leadership Forum members provided in-kind support such as guidance for my research and, a venue and lunch for the December 2019 yarning workshop. Also, the Poche Centre for Indigenous Health provided access to equipment, research expertise and other related research resources including funding.

While undertaking my PhD research study, I had several opportunities to continue my involvement in the national Aboriginal and Torres Strait Islander public affairs policy arena. As approved by my work supervisor, I was able to undertake several outside earning activities involving the provision of facilitation and advisory services to: the National Aboriginal and Torres Strait Islander Health Standing Committee of the

Australian Health Ministers Advisory Council of the Council of Australian Governments Health Council, the Australian Commission of Quality and Safety National Health Services Standards and Accreditation Steering Committee; the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM); and the Southern Cross University Gnibi College of Australians First Peoples. More recently, I provided facilitation and advisory services for the Wide Bay Hospital and Health Services and the Cancer Institute of NSW.

Finally, I am an ambassador for the Mayi Kuwayi longitudinal study that is aiming to quantify the benefits of cultural factors in improving the health and wellbeing of Indigenous Australians. I am provided a stipend to support me in carrying out this role. I am grateful for the Mayi Kuwayi team, particularly Associate Professor Ray Lovett, for support and advice given while undertaking my PhD.

DEDICATION

I dedicate this thesis and its content to Indigenous people, my family and future generations.

ACKNOWLEDGEMENT

First and foremost, I thank my family and dearest friends for their support, tolerance and patience. Specifically, I thank Madelyn O'Malley-Jones, who has remained my strongest emotional supporter and intellectual sounding board.

I also thank Associate Professor Kylie Gwynne (formerly Director of the Poche Centre for Indigenous Health, University of Sydney), and Shane Houston (formerly Professor and Deputy Vice Chancellor Indigenous Services and Strategies, University of Sydney) who made it possible for me to commence my PhD. Also, I thank the Sydney Poche Centre for Indigenous Health, particularly Vita Christie and Boe Rambaldini, who supported my endeavours to complete a PhD under the Wingara Mura Academic Leadership program.

Dr Shawn Wilson initially worked at the University of Sydney Centre for Rural Health in Lismore NSW. I am grateful to him for introducing me to Indigenous Philosophies and inviting me to participate in the Gnibi Doctorate of Indigenous Philosophy tutorials.

My relationship with Gnibi at Southern Cross University Lismore campus continued as my PhD journey progressed. Importantly, I have attended the weekly Gnibi student support group and I have appreciated the contributions of the many participants who shared their experiences of the challenges of navigating a higher degree research program in the academy whilst using an Indigenous Research Methodology. Specifically, I am grateful for their advice and feedback on the work I was doing during my PhD. A writing group arose from my encounters with Gnibi. Thanks goes to Darlene Rotumah who organised weekly zoom writing sessions.

I would also like to thank the many mentors who willingly provided their advice and guidance such as Donna Murray (CEO, Indigenous Allied Health Australia and formerly Deputy-chair of the NHLF), Janine Mohamed (formerly CEO CATSINaM and now CEO of the Lowitja Institute and formerly Chair of NHLF) and Karl Briscoe (CEO National Aboriginal and Torres Strait Islander Health Worker Association). Actually, I am grateful to the entire membership of the National Health Leadership Forum who willingly agreed to become my PhD reference group. Importantly, Romalie Mokak (formerly CEO of Lowitja and now the Indigenous Policy Evaluation Commissioner at the Productivity Commission) was always on hand to take my calls and made himself available to respond to any questions I had. I remain indebted to Romalie.

I want to also recognise the earlier contributions of Dr Mark Lock, the policy expert on my PhD panel from 2016 to 2018. His initial input into the direction of my PhD was instrumental and highly beneficial. Also, I would like to acknowledge the contributions that Dr Donna Hartz made when she was my primary PhD supervisor from 2017–2018. She was instrumental in helping with my human research ethic applications and the first published article. Dr Shawn Wilson has remained on my PhD supervisory panel since its inception. I remain grateful for his knowledge and wisdom concerning Indigenist paradigms, philosophies and methodologies. Dr Josephine Gwynn joined my PhD panel in 2018. I was extremely reliant on her comments in relation to the many papers we did including my final thesis. Finally, I thank Dr John Skinner who became my primary supervisor in early 2019 for his pragmatism. His willingness to learn about Indigenous research methodology was so welcomed.

Most importantly, I thank the very busy policy actors (formerly known as policy elites) who willingly gave me an hour of their time to share their stories and knowledges from June to December 2018.

I acknowledge the editorial support provided by John Revington, owner of Correctional Services Editing and Proofreading. John suggested changes to spelling, punctuation and written expression, and he reviewed the referencing of my final draft thesis. Also, I thank Michelle Holland who provided the necessary assistance for formatting my final thesis. In addition, Dr Jenine Beekhuyzen, OAM, Founder and CEO of Adroit Research, provided much-needed training for the use of NVivo.

Finally, I thank Mother Earth for giving me the strength and perseverance to complete a milestone like a PhD. Also, I thank my ancestors who were with me as I travelled this journey of discovery and taught me through dreams.

My goal to do a PhD has been accomplished.

THESIS OUTLINE

I present this PhD thesis for examination as a thesis containing published work. It includes two publications, one paper in press and three others under review. These works are complemented with additional unpublished text. The thesis is structured as follows:

Chapter 1: Introduction – my story begins

- Unpublished text about my rationale for working as a policy maker in government, including the challenges of implementing Indigenous culture and Indigenous knowledge that became the genesis of my Doctor of Philosophy (PhD) topic. This is followed by a discussion on preparing for and seeking support for a PhD, including preliminary preparation for an ethics approval.
- Publication 1: Parter, C., Wilson, S., & Hartz, D.L. (2019). The Closing the Gap (CTG) Refresh: Should Aboriginal and Torres Strait Islander culture be incorporated in the CTG framework? How? *Australian and New Zealand Journal of Public Health,* 43(1), 5-7. Doi:10.1111/1753-6405.12850

Chapter 2: The research study – storying

- Unpublished text that sets the scene for this research study's context, including an overview of the policy environment, key policy commitments and actors. In addition, I discuss the rise of culture as a determinant of health, including where the current research study fits within the present Indigenous public health policy environment. The study's governance and ethics are briefly discussed.
- Publication 2: Parter, C., Wilson, S., Gwynn, J., Skinner, J. C., & Hartz, D.L.

(2020). A research protocol – Indigenous culture saves lives – Australian Indigenous cultural views and knowledges in health policy: a case study – The National Aboriginal and Torres Strait Islander Health Plan 2013–2023. *Journal of Indigenous Wellbeing*, 5(1). 28-37.

Chapter 3: The theoretical basis and methodological underpinnings and methods of the research – storytelling

- Unpublished text about theory, theory's use and how theory is applied in this research study, including clarifying an Indigenist paradigm and standpoint. The chapter then describes the methods of the research study, including further details of the yarning sessions and how they were conducted. Also, descriptions of policy actors are provided, and I discuss how the coding and analysis process was undertaken, including how the data was managed and organised. I also discuss the implications of using a Storywork methodology for the coding, analysis and reporting process.
- Publication 3: Parter, C., & Wilson, S. (n.d), My research is my story – A framework of inquiry told through storytelling by a Doctor of Philosophy (PhD) student, *Qualitative Inquiry* – under second review for publication.

Chapter 4: Storytellers' stories from policy actors – The study's results

- Unpublished text containing the policy actors' stories and a set of three themes. The chapter establishes that culture is about knowledges, and that Indigenous knowledges count. Importantly, it makes the case that policy makers must be willing to listen and learn. Finally, the chapter argues that despite there being a willing readiness of accepting the relevance of culture to improving health and

wellbeing, a deep-seated resistance impacts on policy makers' abilities to effectively implement Indigenous people's knowledges and cultures.

- Publication 4: Parter, C., Murray, D., Mohamed, J., Rambaldini, B., Calma, T., Wilson, S., Hartz, D.L., Gwynn, J.C., & Skinner, J. (n.d). Talking about the r word: A right to a health system that is free of racism. *Public Health Research and Practice Journal* – under review for publication.

Chapter 5: A systemwide translational model of practice to address racism

- Unpublished text that introduces and explains in detail a systemwide translational model of practice (the model of practice). The development of the model of practice has been informed by the stories of policy actors. A systems perspective has been adopted that considers leverage points in systems to address the challenges associated with implementing Indigenous knowledges and Indigenous cultures once incorporated in a public health policy.
- Publication 5: Parter, C., & Skinner, J. C. (in press), Implementing Indigenous cultures and Indigenous knowledges: A public policy dilemma, *European Journal of Public Health* – in press.

Chapter 6: Putting Indigenous knowledges and Indigenous cultures front and centre to practice – re-storying

- Unpublished text that introduces the following article:
- Publication 6: Parter, C., Gwynn, J., Wilson, S., Hartz, D. L. & Skinner, J. C. (n.d).

Putting Indigenous cultural beliefs and knowledges front and centre to clinical practice: a rural and remote case example – the Katherine Hospital. *Rural and Remote Health Journal* – under review for publication.

Chapter 7: Final discussion, recommendations and concluding remarks

- Unpublished text that concludes the thesis. It contains a final discussion, recommendations and concluding remarks

Appendices

- Appendices containing unexaminable supplementary documentation.

COLLECTION OF OUTPUT FOR EXAMINATION

In terms of this research study's outputs for examination, I formulated the research question answered by this thesis. I also designed the research approach, gained ethics approvals, acquired funding from various sources to support the research study, recruited participants known as policy actors, travelled nationally throughout the country and performed all yarning sessions, analysed stories told at yarning sessions, and interpreted the results. Additionally, I sought approval for and led a modification to the initial ethics approval that allowed the 12 December 2019 Yarning Workshop with selected policy actors to occur. A number of conceptual frameworks and models of practice in response to the research question have been developed and they are outlined in Chapter 7.

I am the first author for each of the six papers included in Chapters 1 to 6, and the sole author of the rest of the thesis. As such, I was responsible for deciding the topics and aims, undertaking the analyses, undertaking most of the writing, and finalising and submitting the papers to peer-reviewed journals. All the papers have co-authors who were members of my PhD supervisory team with exception of the article contained in Chapter 4 – Talking about the r word: A health system free of racism. Additionally, opportunities to disseminate research study learnings was provided at several forums such as the Poche's Research Advisory Board and the PhD Reference Group – the National Health Leadership Forum. Most importantly, the research study findings were presented at the Lowitja Institute Cultural Determinants of Health Policy Roundtable held on 14 September 2020, with the attendees including senior departmental officials, non-government experts, and members of the Department of Health's Indigenous

Policy Advisory Group. The work of this research study will contribute towards recommendations about implementing the cultural determinants of health.

All co-authors have approved the final versions of the papers included in the thesis. The descriptions of their contributions and their permission to include the papers in my thesis are provided in the relevant chapters. My PhD academic panel also approve this thesis.

ABSTRACT

This study is a qualitative public health policy intervention research project.

Study aim

To develop a conceptual framework or frameworks that will assist in introducing the meaning and understanding of Indigenous cultures, and indeed Indigenous knowledges, into public health policies. It is envisaged that a model of practice will be developed as part of this framework that implements – that is, enables, embeds and enacts – Indigenous Australian cultures and knowledges.

Research question

When the culture of Indigenous Australians has been incorporated into a public health policy instrument like the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013–2023 (the Health Plan), how do policymakers implement cultures, and indeed their knowledges?

Methodology

The methodology in this research study involves the underlying assumptions, concepts and parameters that guide the practices of discovery. An Indigenous research methodology – Storywork – directs this research study. Storywork is underpinned by an Indigenist paradigm, standpoint of Indigenist ways of learning and teaching (pedagogy), being (ontology), knowing (epistemology) and doing (axiology).

Method

This study uses the Health Plan as a case study because Indigenous culture is central to its policy framework. Also, yarning sessions were held with policy actors who were

selected using purposive sampling. They were drawn from the Indigenous public health policy sub-domain of Australia's large and highly complex public health policy domain. These policy actors are best placed to answer the research question.

Background

As an Indigenous Australian who has worked extensively in government, the inclusion of Indigenous culture in the design and delivery of policies and programs has been a critical and essential element in efforts to support the improvement of the health and wellbeing of Indigenous Australians. However, my experience has demonstrated that Indigenous culture is not valued, recognised, or understood, and is usually dismissed from the public policy discourse and public health policy processes and responses. This research study builds on previous research that encourages policy makers in governments to provide the means for Indigenous communities to apply their cultural understandings within policy development.

PAPERS AND PRESENTATIONS

Peer reviewed publications

Parter, C., Wilson, S., & Hartz, D.L. (2019). The Closing the Gap (CTG) refresh: Should Aboriginal and Torres Strait Islander culture be incorporated in the CTG framework? How? *Australian and New Zealand Journal of Public Health*, *43*(1), 5-7. Doi:10.1111/1753-6405.12850

Parter, C., & Skinner, J. C. (2020). Implementing Indigenous cultures and Indigenous knowledges: A public policy dilemma, *European Journal of Public Health* – in press.

Parter, C., Wilson, S., Gwynn, J., Skinner, J. C. & Hartz, D.L. (2020). A research protocol – Indigenous culture saves lives – Australian Indigenous cultural views and knowledges in health policy: A case study – The National Aboriginal and Torres Strait Islander Health Plan 2013–2023. *Journal of Indigenous Wellbeing*, *5*(1)

Papers submitted for peer review

Parter, C., & Wilson, S. (n.d). My research is my story – a framework of inquiry told through Storytelling by a Doctor of Philosophy (PhD) Student. *Qualitative Inquiry* – under second review for publication.

Parter, C., Murray, D., Mohamed, J., Rambaldini, B., Calma, T., Wilson, S., … Skinner, J.C. (2020). Talking about the r word? – a right to a health system that is free of racism. *Public Health Research and Practice Journal* – under review for publication.

Parter, C., Gwynn, J., Wilson, S., Hartz, D. L., & Skinner, J. C. (n.d). Putting Indigenous cultural beliefs and knowledges front and centre to clinical practice: A rural and remote case example – The Katherine Hospital. *Rural and Remote Health Journal* – under review for publication.

Conference presentations

Parter, C. (2016). Indigenous culture saves lives – Australian Indigenous cultural views and knowledges in health policy. *Inaugural Lowitja Institute International Health and Wellbeing Conference.* Melbourne, Victoria, Australia, 8-10 November 2016.

Parter, C., Wilson, S., & Hartz, D.L. (2017). Indigenous culture saves lives – an overview of an impending qualitative study that intends to bring meaning and understanding to Indigenous culture and Indigenous knowledges in health policies. *Eighth Healing Our Spirit Worldwide International Conference – Our knowledge, our wisdom, our promise – for our grandchildren's grandchildren*. Sydney, New South Wales, Australia, 26–29 November 2017.

Parter, C. (2018). Keynote address: Culture is life for Indigenous Australians: approaches that enable Aboriginal and Torres Strait Islander culture for better health outcomes –a public policy perspective. *2018 Australian Public Health Conference – Leadership in public health: Challenges for local and plenary communities*. Cairns, Queensland, Australia, 26-28 September 2018.

Parter, C., & Wilson S. (2019). My research is my story. *Lowitja Institute International Health and Wellbeing Conference – Thinking, Speaking, Being*, Darwin, Northern Territory, Australia, 18-20 June 2019.

Parter, C. (2019). Authenticating the centrality and validity of my Indigeneity and Indigenist standpoint – a Doctor of Philosophy student's story. *2019 Doctoral Conference –Voyage to a new horizon*, Dunedin, Aotearoa New Zealand, 14-17 November 2019.

Parter, C., Wilson, S. & Skinner, J.C. (2020). Storywork – an Indigenous research methodology – storytelling, stories and storying: a PhD student's experience. *Sixteenth International Congress of Qualitative Inquiry – Qualitative Inquiry in Repressive Times*. Illinois, Urbana-Champaign, USA, 20–23 May 2020.

Note: Due to the coronavirus, I was unable to present at the above conference.

Parter, C. & Skinner. J.C. (2020). Implementing Indigenous cultures and knowledges: a public policy dilemma. *Sixteenth World Congress of Public Health Virtual Conference*, Rome, Italy, 12–17 October 2020.

PROLOGUE – STORYING

Inspired by Kovach (2009), this thesis commences with a prologue that introduces the reader to preliminary details which allude to critical factors and begin to set the scene for the stories that follow.

As an Aboriginal person, cultural protocol would have me introduce myself. A comprehensive introduction to my ancestry, genealogy and relational family and community positioning has been provided in the article, 'My research is my story', in Chapter 3. I reaffirm that I am a proud Australian Aboriginal of the Birra Gubba Nation, Darumbal and Juru Clans from the Australian state of Queensland. I also have ancestry as an Australian South Sea Islander with family connections to Tanna Island of the Republic of Vanuatu. Being a mature aged, visibly black, higher degree research scholar who comes from a westernised first world developed and colonised country, I bring many stories to this research study and thesis.

These stories are complemented by others drawn from oral history, lived experiences, peer reviewed and grey literature, and knowledges held by my family and communities. I weave the policy actor's stories – the research participants - throughout this thesis as well. They are represented by *italicised text* usually with a P and a number. Although, there might be occasions that I de-identify the policy actor by referencing them as a *policy actor representative*. I explain this in Chapter 3 below.

These stories paint a picture of a reality that is real. My writing tells these stories through storytelling that conveys this reality. Importantly, my voice is privileged, and the reader has an opportunity to see and hear these stories, told through my eyes. My

experiences are woven throughout this thesis. I deliberately write in the first person with a purpose, as demonstrated in the following reflection:

> I write as an Indigenous Australian, a black person, a woman, a person of many bloods, a person of South Sea Islander, Scottish and Aboriginal heritage. I write about my story, a story of being black in a colonised country (extract from personal reflections, 5 December 2016).

As described by Moreton-Robinson (2000) such writing is a form of life writing where I weave my own reflections, including poems, throughout the storytelling process to further enhance these stories (as evident in the above reflection).

The use of such reflections conveys the insights gained. They also demonstrate the struggles I encountered and the strength of the emotions behind them that are sometimes represented through poems. Without these critical reflections, I would not have been able to acquire the understanding required to undertake a PhD or write the articles that I have written.

When relevant to the topic in question, the voices of others are also woven throughout this thesis such as scholars and policy actors. This is a way of further establishing that the knowledge gained from one's lived experiences, and oral knowledge, are just as valid as western literary knowledge (Moreton-Robinson, 2000; Rigney, 1999). This stance is the very antithesis of the western positivist and scientific of ways of being, knowing and doing that are at variance with Indigenous ways of being, knowing and doing (Smith, 1999).

Inspired by Martin (2008), I use visual stories in the form of diagrams and pictures help express very complicated ideas, assumptions and theories that are then transposed

into writing. On many occasions, I scribbled numerous diagrams and pictures during the course of my research study to help with bringing meaning and understanding to what I was learning. I have used some of these diagrams and pictures in this thesis and in the articles it contains. These visual stories contain many layers not visible to the literary eye, such as the conference poster shown in Appendix 1 that provides an overview of my research study. In Chapters 2, 3, 4 and 5, visual stories are also used to explain sometimes complex concepts, particularly about the findings of this research study.

As Indigenous knowledges and cultures of ways of being, knowing and doing are central to this research study, I weave the stories with relevant concepts and/or theories drawn from the literature. A review of the literature is not presented in a standalone chapter (Archibald, 2008; Rix, Wilson, Sheehan, & Tujague, 2018; Wilson, 2008). Instead, scholarly knowledge is woven throughout the stories in this thesis because our stories are theories (Brayboy, 2005).

As Moreton-Robertson (2015) attests, Australian Indigenous peoples are still being colonised because systems of whiteness continue to negate our sovereignty and the knowledges that Indigenous people possess. I agree with Moreton-Robertson and go on to reflect:

> A country that has excluded our ‘blackness’, a country that expects me to be white, a country that tried to make me white! A whiteness that does not gel with my black origins. An origin that brings with it a worldview of knowing, being and doing. A worldview that recognises a reality and an understanding that dismantles and deconstructs the ‘whiteness’ that dominates our thinking and ways of working (extract from personal reflections, 5 December 2016).

So, as a researcher who is Indigenous, it is my responsibility to deconstruct and decolonise the dominant western science paradigms that continue to dismantle our knowledges and ways of being, knowing and doing (Rigney, 1999; Sherwood, 2010; Smith, 1999).

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Glossary

Aboriginal – in line with NSW policy, ‘Aboriginal’ is the preferred term to that of Aboriginal and Torres Strait Islander people in recognition that they are the original inhabitants of NSW. In using Aboriginal in this context is about acknowledging that Torres Strait Islanders are autonomous to Aboriginal people of NSW with their own cultural beliefs, knowledges and practice.

Aboriginal and Torres Strait Islander - will be used inter-changeably with Indigenous to represent the original inhabitants of Australia.

Axiology – refers to value judgements about ways of doing and why it is that the things that are done are done in the way that they are done.

Close the Gap – is the people’s movement campaign comprising of a coalition of national Indigenous and non-Indigenous professional organisations.

Closing the Gap – is the Council of Australian Government’s National Indigenous Reform Agenda about closing the health, education and employment gaps between Indigenous and non-Indigenous people.

Epistemology – refers to ways of knowing and how knowledge is acquired and understood.

Indigenist – is the knowledges and cultures of ways of being, knowing and doing that are held by Indigenous people.

Indigenous – will be used inter-changeably with Aboriginal and Torres Strait Islander to represent the original inhabitants of Australia.

Indigenous Methodology – is a set of culturally informed Indigenous guiding principles that underpin how new knowledge is gained and why specific methods are used.

Indigenous Paradigm – is a set of Indigenous cultural beliefs and principles that guide the way that things are to be done, how they should be done and why they are done in the way that they are done.

Methodology – refers to a set of guiding principles that help inform how things are done and why they are done.

Methods – is the process or actions done to achieve something.

Ontology – refers to ways of being and relates to what is real and a reality of why we believe in what we understand.

Paradigm – is a set of beliefs that guide the way that things happen or how we behave.

Policy actors – are the many players and individuals who interact in a policy environment.

Policy elites – Policy elites are the advocates and entrepreneurial policy actors of a policy environment. In this thesis, policy elites will be replaced with the term policy actors.

Policy makers – are those who work in government making policies.

Policy sub-domain – is a domain of a larger domain and sometime referred to as sub-system.

Public health policy – is policy relating to the public health policy environment made by government who decide what they will do or not do.

Public policy – refers to the decisions and actions that governments decide to do or not do.

Abbreviations

AH&MRC – Aboriginal Health and Medical Research Council of NSW

AHMAC – Australian Health Ministers Advisory Council

AIATSIS – Australian Institute of Aboriginal and Torres Strait Islander Studies

CHC – Council of Australian Government's Health Council

COAG – Council of Australia Government's

CTG – Closing the Gap Council of Australian Governments

CTG Coalition – Close the Gap campaign coalition

HREC – Human Research Ethic Committee

NAHS – National Aboriginal Health Strategy

NATSIHSC – National Aboriginal and Torres Strait Islander Health Standing Committee

NHLF – National Health Leadership Forum

NIEC – National Indigenous Equality Council

NIRA – National Indigenous Reform Agenda

NSW – New South Wales is a state of Australia

Qld – Queensland is a state of Australia

SAG – Senior Advisor Group of the Commonwealth Department of Health

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CHAPTER 1. INTRODUCTION – MY STORY BEGINS

1.1. Introduction

Chapter 1 begins by providing the background to the motivation for my interest in the research topic of this thesis.

I won't write about my personal story here because it's contained in the article, 'My research is my story' in Chapter 3. What I write here in Chapter 1 is essentially an extension of my public policy making experience while working in the public sector. I talk about why I entered the public policy environment after a career as a nurse. I also provide an overview of my public policy journey.

I then introduce an earlier study conducted in 2005 concerning the role of governments in supporting Indigenous people in their expression of culture in the development of policy, which really represents the genesis of my Doctor of Philosophy (PhD) research study. My policy making experiences and the challenges of implementing Indigenous culture are briefly discussed. The published article that is part of this chapter is about whether culture should be included in a refreshed Closing the Gap policy commitment, and it further expands on my policy making experience.

Chapter 1 concludes with a short discussion that directs the reader to Chapter 2.

1.1.1. From nursing to policy making

I entered the policy making environment in 1990 following a career as a registered nurse and a registered midwife. It was a deliberate career move because I had observed that the existing policies relating to Indigenous peoples, particularly in regard to health, were not appropriate. The Aboriginal Health Working Party had just released

the landmark 1989 National Aboriginal Health Strategy (the NAHS) when I entered the NSW Aboriginal health public policy environment. It was a time of significant change for Aboriginal health and Indigenous affairs in Australia.

My public policy career had commenced. I was determined to use my abilities and skills to contribute towards the development of culturally responsive and appropriate policies for Aboriginal communities of NSW. So began my public policy stories and public sector journey.

1.1.2. Working in government as a policy maker

Working in government involved leading, influencing and making policies related to Aboriginal people of NSW.

Initially, in Aboriginal health from 1990–2002, I was a junior policy officer who eventually made my way into middle management roles. Then, from 2002 to 2005 I worked with the Aboriginal Justice Advisory Council (AJAC), a ministerially appointed peak state-wide community representative body, to help develop the NSW Aboriginal Justice Plan (AJP). Once the AJP was developed I led its implementation, working within the Attorney-General's Department.

In 2006, I left the AJAC to work as the Director, Aboriginal Services Branch of the then Department of Community Services within the child protection system. In 2008, I returned to health as the state-wide Director for Aboriginal health at the NSW Ministry of Health. I was responsible for state-wide planning, policy and programming.

Due to my role as chair of the National Aboriginal and Torres Strait Islander Health Standing Committee (NATSIHSC) of the Australian Health Ministers Advisory Council

(AHMAC), Council of Australian Government's Health Council (CHC) from 2011 to 2015, I also had opportunities to work on national Indigenous health policies.

The NATSIHSC of AHMAC is primarily responsible for the provision of nationally focused strategic advice relating to Aboriginal and Torres Strait Islander health. It consists of senior policy makers, usually heads of Aboriginal and Torres Islander Health, from the Commonwealth, state and territory governments' health departments (NATSIHSC representative, personal communication, 30 March 2019).

When chairing the NATSIHSC, I represented AHMAC on several committees, particularly when the National Aboriginal and Torres Strait Islander Health Plan was being developed. For example, I was the AHMAC representative on the National Indigenous Health Equality Council (NIHEC) whose responsibility was to provide policy advice to the then Minister for Indigenous Health, the Hon Warren Snowdon. The NIHEC also supported the development of the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013–2023 (the Health Plan). The NIHEC consisted of a diverse range of experts drawn from the community, the higher education sector and government officials. NIHEC was initially chaired by Professor Ian Anderson and then by Professor Kerry Arabena, both from the University of Melbourne at that time.

I also represented AHMAC on the Senior Advisory Group (SAG) established by the Commonwealth Department of Health in relation to the Health Plan. This was a group that was co-chaired by a senior government official (David Lemmond) and the National Health Leadership Forum (Jody Broun of the Congress of First Nations People). The SAG was a governmentally led group responsible for bringing a range of government heads of departments together to examine responses to the social determinants of

health that were arising from the national consultations during the development of the Health Plan.

In these roles, I received first-hand experience of the political and often uncertain nature of a policy environment which contained many actors from governments, interest groups, experts and communities who had diverse views and conflicting goals. These experiences confirmed the reality that policy is politics where power dynamics are at play (Buse, Mays, & Walt, 2012). I write further about the national public health policy environment in Chapter 2.

1.2. Cultural dimensions in policy development

1.2.1. Introducing the 2005 research

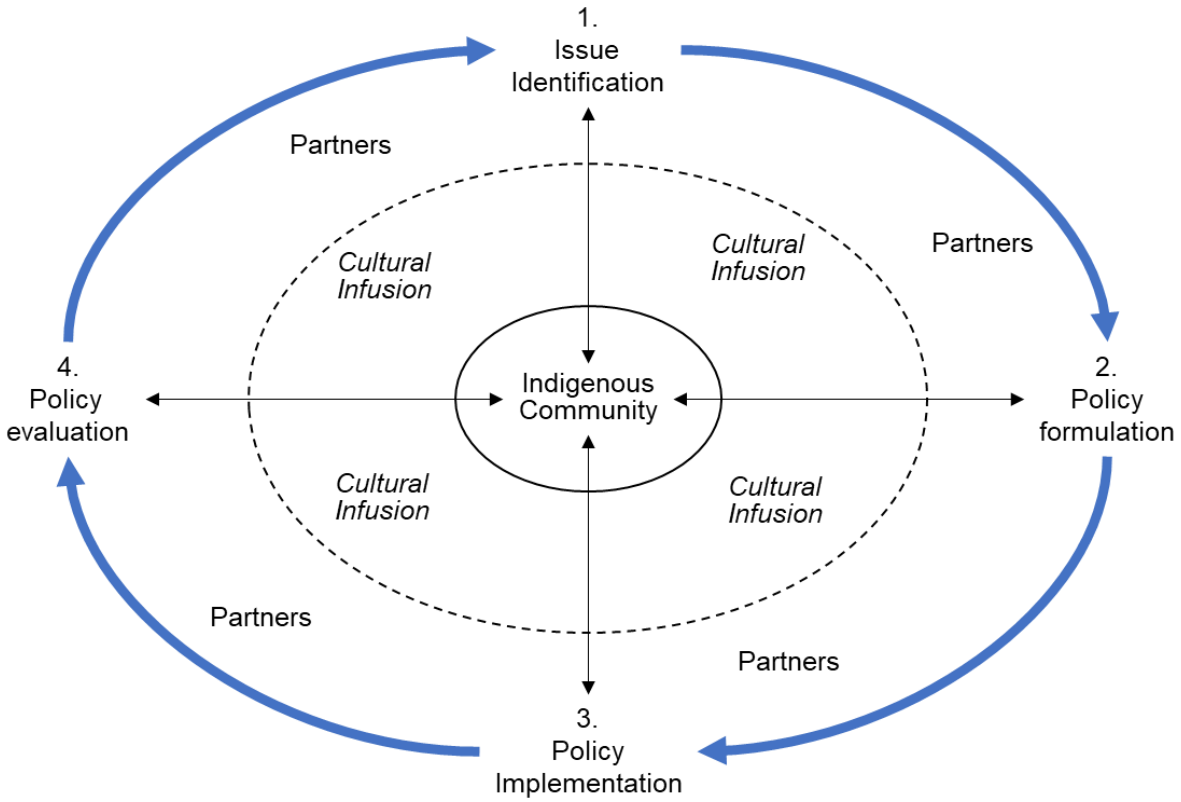
Using the NSW Aboriginal Justice Plan as a case study, I began to explore how governments could provide the means for Aboriginal people to practice their culture when developing policy (Parter, 2005).

Applying the policy cycle and building on the anthropological concept of a social space, and Indigenous governance principles of cultural match and community engagement, an “Our Way Model” was developed that contextualised for governments what was required to enable the cultures of Aboriginal people when developing policy(ies) (Parter, 2005).

The ‘Our Way Model’, conceptualises the central positioning of Aboriginal people in the policy cycle to facilitate the incorporation of Indigenous people’s culture in policy development processes. This involves Indigenous people playing a central role in identifying the policy issue(s), formulating policy responses, implementing policy

responses, and evaluating the success or failure of policy responses (Buse et al., 2012).

Figure 1: ‘Our Way Model’ and cultural infusion.



(Adapted from Parter, 2005 and Buse et al., 2012)

The positioning of Aboriginal people at the centre of the policy cycle, demonstrated by adapting the policy cycle (and replicated above), in partnership with governments and non-government policy actors, is a prerequisite for success (Parter, 2005). Policy actors are those individuals who work in government or in non-government organisations, including private or civil society agencies (Buse et al., 2012; Weible, 2014).

The meeting of the Indigenous and non-Indigenous cultural worldviews meant that they did not dominate each other’s frames of reference (Parter, 2005). Rather, each

worldview would respect the other as a separate and valid entity, allowing for creative and innovative solutions to occur (Parter, 2005). I call such interactions at that social space a cultural infusion (Parter, 2005).

My earlier 2005 research had its limitations though. This is because Indigenous culture in a public policy instrument was not fully understood especially by governments and policy makers. Also, governments had no understanding about how to give effect to the implementation of our cultures – hence the genesis of my PhD topic.

1.2.2. The social space: What the literature says?

Nakata (2007) conceived the social space where worldviews interact, as the cultural interface. A social space where the complexities of the interplay of knowledge systems unfold. He writes that the cultural interface is:

> a multi-layered and multi-dimensional space of dynamic relations constituted by the intersections of time, place, distance, different systems of thought, competing and contesting discourses within and between different knowledge traditions, and different systems of social, economic and political organisation. It is a space of many shifting and complex intersections between difference people with different histories, experiences, languages, agendas, aspirations and responses … it is also a space that abounds with contradictions, ambiguities, conflict and contestation of meanings that emerge from these various shifting intersections (Nakata, 2007, p. 199).

In other words, the interaction of knowledge systems at the cultural interface is arguably a highly challenging and disputed social space where engagement occurs.

Ermine (2007), from a legal stance, describes the place where knowledges meet as an ethical space. He writes that such a space:

> Offers a venue to step out of our allegiances, to detach from the cages of our mental worlds and assume a position where human-to-human dialogue can occur … offers itself as the theatre for cross-cultural conversation in pursuit of ethically engaging diversity and disperses claims to the human order (Ermine, 2007, p. 202).

Ermine goes on to write that:

> The dimension of the dialogue might seem overwhelming because it will involve and encompass issues like language, distinct histories, knowledge traditions, values, interests, and social, economic and political realities and how these impact and influence an agreement to interact (Ermine, 2007, p. 202).

Ermine argues that the western philosophy of universality must give way to notions of equality in which the rights of Canadian First Nations peoples are upheld through engagement with Elders and knowledge keepers, and through collaboration with the legal fraternity (Ermine, 2007, p. 202).

Mason Durie (2004) acknowledges the two distinct worldviews of western science and of Maori researchers and highlights the tensions between these two knowledge systems. He concludes that

> Maori researchers … have been encouraged by the possibilities that two world views, two bodies of knowledge, can be bought closer together (Durie, 2004, p. 1143).

Durie goes on to state that Indigenous people in developed countries “live at the interface i.e. they are informed by science and by Indigenous knowledge” (2004, p. 1143). He concludes that:

> The challenge is to afford each belief system its own integrity, while developing approaches that can incorporate aspects of both and lead to innovation, greater relevance, and additional opportunities for the creation of new knowledge (Durie, 2004, p. 1143).

Finally, Kincheloe and Steinberg, in an educational context, propose an intercultural synergistic dialogue “that pedagogically works to create conditions where both intra- and intercultural knowledge traditions can inform one another” (2008, p. 154). They add that:

> This synergistic dialogue is encouraged by the assumption of the intrinsic worth of various frames of reference. Different ways of seeing can illuminate problems in unique ways and should be understood in this manner – a central tenet of multi-logicality (Kincheloe & Steinberg, 2008, p. 154).

The space where knowledge systems meet, particularly where Indigenous and non-Indigenous frames of reference interact, clearly involves a contentious interplay between different worldviews and ways of learning and teaching, and ways of being, knowing and doing. Essentially, Nakata, Ermine, Durie, and Kincheloe and Steinberg acknowledge the contestability of the space where diverse knowledges meet. They go on to call for each knowledge system that is bought to such a space of interaction to be complementary. An understanding of this knowledge space of interaction was lacking in the earlier 2005 research, and it will be explored further in the following chapters.

1.3. The genesis of a Doctor of Philosophy (PhD) research study

1.3.1. My experience with policy and Indigenous cultures and Indigenous knowledges

Despite commencing a PhD formally in 2016, the work for this research study really began 20 years earlier, and it has been a longstanding pursuit of mine.

After spending a decade in the Aboriginal health policy arena of the NSW Government, I began to wonder why the efforts to address the poor health status of NSW Aboriginal people were not having any impact on the 17- to 20-year life expectancy gap (at the time). Specifically, I wondered why the policy commitments made by governments such as the COAG's Closing the Gap education, employment and health targets were not being met. The challenges of addressing Indigenous health are discussed in the published research protocol article that follows in Chapter 2.

Importantly, Indigenous Australians remain clear that culture is critical to any response that aims to address the social, political and economic issues facing their communities. A case in point is the NSW Aboriginal Family Health Strategy (AFHS) which aims to address violence in Aboriginal communities in NSW (NSW Department of Health, 2011). In 1999 I was the AFHS Coordinator responsible for the strategy's implementation. I recall being very excited because communities were clear that any response which addressed violence needed to adopt a whole-of-family and community approach. Hence, in their design and implementation local programs needed to be underpinned by fundamental cultural and historical factors. I recall that the paradigm for addressing violence in Aboriginal communities in NSW conflicted with the paradigms which underpinned mainstream and non-Indigenous responses.

Similarly, the NSW Aboriginal Justice Plan (NSW AJP), which aimed to reduce the number of Aboriginal adults and young people encountering the criminal justice system, was another strategy that took cultural and historical factors into consideration (NSW Aboriginal Justice Advisory Council, 2003). However, I was most excited when I learned that the NSW Aboriginal and Torres Strait Islander Child Placement Principles contained in the 1998 Child Protection Act (NSW Government, 2019) was based on a set of principles designed to keep children and young people in contact with their cultures when they entered the child protection system.

Despite these initiatives, I concluded that governments, the public sector and policy makers did not have the capacity to integrate the cultures of Aboriginal people into policies, and nor did they have the capability to implement expressions of Aboriginal culture into programs and services. This view is expressed in the article that forms part of this chapter and was originally published in the *Australian and New Zealand Journal of Public Health*. This article also raises concerns about the lack of evidence in relation to how Indigenous Australians' cultures can be enabled, embedded and enacted once included in a public policy.

1.3.2. Including Aboriginal and Torres Strait Islander culture in the Closing the Gap Refresh

Reference

Parter, C., Wilson, S. & Hartz, L. D. (2019). The Closing the Gap (CTG) Refresh: Should Aboriginal and Torres Strait Islander culture be incorporated in the CTG framework? How? *Australian and New Zealand Journal of Public Health*, 43(1), 5-7

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We confirm that Carmen Dorothy Ruby Parter made the following contributions:

The candidate planned and prepared the manuscript that involved several drafts in readiness for publication. Dr Shawn Wilson and Dr Donna L. Hartz contributed to subsequent drafts by reviewing and editing the content, and providing advice. The final draft was reviewed and approved by all co-authors.

Signed [REDACTION] Date 3 June 2020
Dr Shawn Wilson

Signed [REDACTION] Date 2 June 2020
Dr Donna L Hartz

This statement aligns with the requirements of the University of Sydney regarding policy as described in the policy documents:

*Thesis and Examination of Higher Degrees by Research Policy 2015
*Thesis and Examination of Higher Degree by Research Procedures 2015

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doi: 10.1111/1753-6405.12850

The Closing the Gap (CTG) Refresh: Should Aboriginal and Torres Strait Islander culture be incorporated in the CTG framework? How?

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In recent years, Australia has seen the emergence and incorporation of Aboriginal and Torres Strait Islander* culture into national public health policies and frameworks as an essential requirement for the health and wellbeing of Indigenous Australians.[1,2] Nationally, this represents a significant shift in public policy because Indigenous culture was often dismissed as irrelevant from the development of policy.[3] Despite these advances, a significant evidence gap remains concerning the significance of Indigenous culture to these frameworks, and how public policy makers can best enable, embed and enact Indigenous culture within public policies and frameworks. These concerns have been raised elsewhere in a discussion paper that asks whether the culture of Aboriginal and Torres Strait Islander people should be incorporated into a refreshed Closing the Gap initiative and, if so, how.[4] This commentary article further explores these concerns by highlighting how Indigenous knowledge is intrinsic to Indigenous culture and vice versa. Understanding the relationship between Indigenous knowledge and Indigenous culture could bring greater meaning to culture when incorporated into public policies or frameworks. However, further investigation is a necessity to resolve a significant evidence gap when Indigenous culture is incorporated into a policy framework.

A cultural dimension for public policy

The Australian Government, its organisations and government officials (known as policy makers) develop public policies in order to address issues of significance.[5] They are the things that governments decide to do.[6] The National Aboriginal and Torres Strait Islander Health Plan is an example of a public policy that aims to address racism, health disparities and inequities, and the social inequalities experienced by Indigenous Australians.[1] The culture of Aboriginal and Torres Strait Islander people is central to this policy framework.[1]

Policy makers have previously been encouraged to create a cultural infusion by providing the means for Indigenous Australians to bring their cultural worldview to policy development.[3] Cultural infusion occurs when the Indigenous and non-Indigenous cultural worldviews meet in an intercultural social space and innovative solutions are developed.[3] Critical to this infusion is the central positioning of Indigenous people.[3]

The Closing the Gap Initiative

> *What is repeatedly missing in officialese accounts of what lies behind 'disadvantage' is the very thing that everyone in such circles is usually quick to say needs proper recognition – Indigenous tradition, social values and culture.*[7]

The 2007 Close the Gap peoples' movement campaign called upon governments to embrace a new national agenda of achieving equality for Indigenous Australians.[4] In 2008, governments agreed to an aspirational plan for generational change.[8] This involved the signing of the Statement of Intent between the Australian Government and communities. The National Indigenous Reform Agenda (NIRA) – known as the Closing the Gap initiative (set out in Box 1) – was also agreed to by governments through the Council of Australian Governments (COAG).[8]

Box 1: Extract from Council of Australian Government's Fact Sheet about the NIRA.[10]

The National Indigenous Reform Agreement (NIRA) signifies the importance all governments place on Closing the Gap in Indigenous disadvantage.

The six COAG Closing the Gap targets are:

- to close the gap in life expectancy within a generation;
- to halve the gap in mortality rates for Indigenous children under five within a decade;
- to ensure all Indigenous four-year-olds in remote communities have access to early childhood education within five years;
- to halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade;
- to halve the gap for Indigenous students in year 12 equivalent attainment by 2020; and
- to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

It also provides an overarching summary of action being taken against the Closing the Gap targets as well as the impact on Indigenous disadvantage of the mainstream N[ational] A[greement]s in health, schools, skills and workforce development, disability services and housing and several N[ational] P[artnership]s.

A decade on, these commitments to addressing the health, education and employment inequities have not successfully achieved all their targets.[9] Only one of the seven targets agreed by COAG is on track: halving the year 12 attainment gap by 2020.[9] Life expectancy and child mortality targets are not being met; school attendance rates with reading, writing and numeracy skills of children are behind; and employment targets have also not been achieved.[9]

If improvements are to be made to the COAG Closing the Gap, Indigenous culture must be integral to addressing these health, education and employment targets. However, if culture is to be incorporated into public policies and frameworks, it would be prudent to further explore and understand this intercultural social space and the concept of cultural infusion.

Indigenous culture

> *Culture has been defined as "that complex whole which includes knowledge, belief, art, moral, law, custom, and any other capacities and habits acquired by man as a member of society".*[11]

The importance of culture was outlined in the seminal work of the 1989 National Aboriginal Health Strategy (the Strategy) that argued for the necessity of culture to inform culturally

** In recognition of the diversity that exists among Aboriginal and Torres Strait Islander Australians, from this moment forward Indigenous will be used except during citations or when expected practice would suggest otherwise.*

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appropriate and responsive initiatives.[12] The Strategy urges that approaches to health should focus on:

> *Not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community.*[12]

Health for Indigenous people includes the right to practice their cultural values, beliefs and norms[13] including such practices that reaffirm connection to Country, languages and the spiritual world.[1] This Indigenous whole-of-life and whole-of-community approach to health and wellbeing often conflicts with Western concepts of health.[12,14] This tension is a longstanding reality experienced by Indigenous Australians who regularly challenge Australia's understanding and approaches to health.[12]

Importance of Indigenous culture

The importance of culture is one of several domains in a model for wellbeing that affirms culture's significance as being critical to the mental health and social and emotional wellbeing of Indigenous Australians.[2] Similarly, they must be led and owned by Indigenous people and "informed by an Indigenous – not a Western – worldview" that ensures a holistic and culturally responsive program is designed and delivered.[15] The consideration and incorporation of Indigenous culture has shown to impact on program and health outcomes.[14-16] Further, a health promotion project to address chronic disease demonstrated good health gains when culture and an Indigenous worldview had been incorporated into the 'Healthy Country Healthy People' initiative. This initiative saw a reduction in a range of chronic disease indicators, and also called for government policies to recognise the significance of cultural approaches and its relevance in achieving such health outcomes.[17]

Culture and the National Aboriginal and Torres Strait Islander Health Plan (the Health Plan)

The Health Plan represents Indigenous culture as:

- Aboriginal and Torres Strait Islander peoples hav[ing] the right to live a healthy, safe and empowered life with a healthy strong connection to culture and country;[1] and
- that culture adapts and changes according to current or past influences.[1] Further, it recognises the legacy of colonisation dismantling the practice of culture and the strength that Indigenous Australians have despite past policies.[1]

The importance of Indigenous culture is further reinforced in the 2017 My Life, My Lead national consultation report about the social determinants and cultural determinants of Indigenous health, which argues that culture must be incorporated into services to contribute towards robust health gains and resilient individuals.[16] The use of Ngangkari traditional healers in South Australia is an example of how the practices of culture have been successfully incorporated into mainstream services.[2] Aboriginal patients now have a choice of accessing Ngangkari healers as an integral part of their healthcare.[18]

Despite the incorporation of culture in the Health Plan, it is argued that culture's representation is insufficient in a public policy context and without a deeper understanding of Indigenous culture in these contexts little real improvement will be made. The missing link is Indigenous knowledge and its relationship to Indigenous culture.

Indigenous knowledge

While lessons can be learnt from the above example and some improvements have been made, further investigation is required to address an evidence gap. Indigenous-led initiatives, supported by governments, are vital to bridging this evidence gap because it is only Indigenous peoples and communities who hold this knowledge and are rightfully able to practice it.

Although Australia's Indigenous health leaders were clear that references to Indigenous culture in the Health Plan were inextricably tied to Indigenous knowledge,[19] this tacit and intrinsic relationship with Indigenous knowledge is not considered in the national public policy dialogue.

Indigenous knowledge in academia has been prominent since the 1980s.[20] It has also been prominent in the arts in relation to intellectual property rights,[21] education about the relevance of Indigenous knowledge to the sciences,[22,23] health concerning translational research,[24,25] global development programs about designing projects[26] and research regarding Indigenous paradigms.[27] Although Indigenous knowledge is clearly recognised as an invaluable asset for programs and services,[20] it is rarely acknowledged in a public policy context – let alone valued. This is the experience of Aboriginal and Torres Strait Islander people who work in government, which is clearly articulated by this insider (first) author:

> *I have come to observe and experience tensions between Western and Indigenous ways of knowing, thinking and working. In Australia, governments espouse the importance of working in partnership with Aboriginal and Torres Strait Islander peoples concerning their health. I have observed the benefits of such arrangements and the challenges of two distinct yet valid worldviews coming together and clashing in conflict with the other. More significantly, I have watched the dominance of the Western system overriding Indigenous frames of reference and knowledge during the policy development process as well as the design and implementation of services… It appears that little is known about the relationship between the Indigenous and non-indigenous frames of reference including the practical integration of Indigenous knowledge into complex health policies and services.*[28]

Indigenous knowledge could aid the enactment of culture; however, further work is warranted to understand the innate relationship between Indigenous knowledge and culture. Despite three decades or more of scholarly knowledge concerning Indigenous philosophy and methodologies, the theoretical and conceptual framework(s) that could support enabling, embedding and enacting Indigenous culture (and Indigenous knowledge) in public policies are absent.

Discussion

Given the shortcomings of previous government policies and frameworks, it is timely for Indigenous philosophies and methodologies to become praxis, and for governments and policy makers to provide the means for Indigenous Australians to apply their culture in policy development.[3] An evidence gap undoubtedly exists about enabling, embedding and enacting Indigenous culture once it is incorporated into public policies. Although a range of initiatives offer answers to this gap in evidence, the absence of theoretical and/or conceptual frameworks is problematic. Similarly, Indigenous culture's intrinsic relationality with Indigenous knowledge must be understood. Time, investment and research with an Indigenous worldview-led project is fundamental to overcome this evidence gap and the failings of the Closing

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the Gap and health initiatives. Governments and policy makers must be open and respectful to Indigenous ways of knowing, being and doing, and to the meanings of Indigenous culture and Indigenous knowledge.

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1.4. Planning and preparing for the Research Study

1.4.1. Seeking support for the research idea and its intent

Before commencing my research, I wanted to be certain that what I was doing had the support of community, including other critical partners. Initially, in 2015, I presented my research idea to Southern Cross University's (SCU) Gnibi Elders Council at a week-long intensive for their Doctorate of Indigenous Philosophy course. All members of the Gnibi Elders Council were present, as were course lecturers and at least 20 other higher degree students.

In my presentation I informed the Gnibi Elders of my heritage, my family and community relationships and positioning, my lived experiences, and my professional journey through to a PhD. I presented the idea of a PhD which involved a public policy intervention study that would examine the nexus between the western non-Indigenous and Indigenous worldviews, and that would investigate the space where worldviews and knowledges meet. I remain grateful that the Elders were supportive of the study's initial idea.

Armed with the support of the Ginibi Elders Council, I was confident about proceeding further with the idea. As will be shown in this thesis, this early idea matured as the research study progressed. The presentation subsequently informed the contents of my PhD enrolment applications that were made to three Australian-based universities.

Following formal approval to commence a PhD on 1 January 2016 by the University of Sydney, I began investigating further community support. In the meantime, I secured a Wingarra Mura academic fellow position with the Poche Centre for

Indigenous Health at the University of Sydney. I commenced working in this role on 10 February 2016 and was able to continue with my PhD research idea.

I made an early decision that because the research study was being undertaken in the Australian state of NSW, I felt that I had an obligation to seek appropriate support from the state-wide peak Aboriginal community-controlled body, the Aboriginal Health and Medical Research Council of NSW (AH&MRC). The AH&MRC represents the 160 Aboriginal community-controlled health organisations based throughout NSW.

In August 2016, I approached the AH&MRC requesting their support for the research study. I was successful in obtaining their written support in October 2016. However, an urgent review of my research protocol occurred. This was because the initial approach of the study was unmanageable for a PhD. Consequently, a revised research protocol was completed and re-submitted to the AH&MRC by 29 November 2017. They reaffirmed their support in January 2018 with a request to have a copy of the final outcomes of the research study. Their letters are contained in Appendix 2. I had successfully secured support for my research idea from a community organisation.

While I had community support from the Gnibi Elders Council and now the AH&MRC, the nature of my research study meant that I needed to seek additional support from policy actors.

Due to my previous national experience, I knew that the critical policy actors were the National Health Leadership Forum (NHLF) and the National Aboriginal and Torres Strait Islander Health Standing Committee (NATSIHSC) of the Australian Health Ministers Advisory Council (AHMAC) of the Council of Australian Government's Health Council (CHC). I write about these policy actors in Chapter 2.

In April 2017, I commenced conversations with the National Health Leadership Forum (NHLF) chair with intention of gauging their potential interest in the research topic.

The NHLF is Australia's nationally recognised national peak Aboriginal and Torres Strait Islander health representative alliance and it plays a key role in influencing national Indigenous health policy in Australia (NHLF representative, personal communication, 17 April 2017). The NHLF consists of representatives from the National Community Control Health sector, the Healing Foundation and the Lowitja Institute. In addition, the membership of the NHLF includes professional associations of doctors, nurses and midwives, psychologists, dentists, physiotherapists, health workers, and mental health workers, as well as allied health associations and a representative from the Torres Strait Islander Authority (NHLF representative, 17 April 2017). I write further about the NHLF in Chapter 2.

The NHLF provided its support for the research. The relevant letter from the NHLF is in Appendix 3. Additionally, some member organisations of the NHLF also provided letters of support that are similarly included at Appendix 3. The National Community Controlled Health Organisation (NACCHO) provided their verbal support during a meeting held in early 2018 (NACCHO representative, 3 March 2018).

In August 2017, I had an opportunity to speak with the Chair of the NATSIHSC about the research study's intent. This was also an opportunity to gauge the NATSIHSC's interest in the research.

On 25 September 2017, during a telephone conversation with the NATSIHSC chair, she confirmed that members were comfortable with my research idea. Subsequently, in November 2017, the research study had progressed significantly and a further meeting with the NATSIHSC chair occurred. I reaffirmed the intent of the research

study and sought their advice as to whether they would like to be involved, and if so, what process should be set up to engage with them.

I sent an email to the NATSIHSC secretariat on 18 December 2017 confirming my conversation with the chair, which was an action that arose from the November 2017 meeting. A flyer attached to this email contained additional information about the research study and its intent. The NATSIHSC secretariat sent the flyer out to members on 12 January 2018. By May 2018, I provided NATSIHSC with an out-of-session paper. Subsequently, I obtained a formal response indicating support for the research study from NATSIHSC members. Official government support for the research idea had been successfully obtained. The study now had support from another forum of policy actors.

Additionally, some parts of my research are related to family and their stories. So, it was just as important to ensure that my family were comfortable with what I was doing and my topic. It was important to discuss my idea with my mother and gain her support and permission as well. She remained happy with what I was doing, and I have had many conversations with her over the course of my PhD. This was a necessity when I was writing the ‘My research is my story’ manuscript because the paper contained stories of her and her parents (my grandparents), my great grandparents and my great, great grandparents.

1.4.2. Lessons learnt from seeking support for the idea and intent of the research study

As described above, intuitively, I just knew that I had to gain the necessary community and policy actor support, and it was inherently natural to seek that support. To guide

me through these early processes, several mentors from the NHLF provided advice to help me fulfil my cultural responsibilities respectfully.

I discovered that the seeking of support for the research study idea and its intent is a necessary part of the relational accountabilities that are written about by a number of Indigenous scholars (Martin, 2008; Moreton-Robinson, 2000; Rigney, 1999, 2001, 2006; Wilson, 2008). Such relational accountability is underpinned by an Indigenist paradigm, including an Indigenous research methodology that is discussed further in Chapter 3. Also, I concur with the view held by Rigney (2001) that Indigenist research practice is a "body of knowledge [held] by Indigenous scholars in relation to research methodological approaches" (p. 1).

These initial contacts with policy actors proved to be highly beneficial, particularly in light of the study's findings. As Wilson (2008) writes, Indigenous epistemology is all about ideas developing through the formation of relationships (p. 8). These initial relational engagements were a critical step in my research process because they were preparing me to be what Archibald (2008) describes as story ready (Archibald, Lee-Morgan, & De Santolo, 2019). Similarly, it was also about preparing the key policy actors to be story ready.

As will be demonstrated in Chapters 4, 5 and 6, if I had not become story ready I would not have been given the rich data and knowledges that policy actors willingly entrusted me to hold. I became a keeper of knowledge, which is an obligatory responsibility of Storywork (Archibald, 2008).

Also, the support from the Ginibi Elders Council of the SCU Lismore campus was a critical step because I am not from the Bundjalung country, but that is where I live, work and study. I have a relational accountability obligation to seek the required

permission from the Elders of that country out of respect for being on their country. This is something that researchers often do not consider, and it is seldom incorporated into the design of research and research studies. However, such a step had been front and centre to my cultural obligations as a researcher of Aboriginal and South Sea descent. It involves an Indigenism that relates to:

> a body of knowledge [held] by Indigenous scholars in the interest of Indigenous peoples for the purpose of self-determination. Indigenism is multi-disciplinary with the essential criteria being the identity and experience of the writer (Rigney, 2001, p. 1).

Also, because I live and work in the Australian state of NSW, I was acutely aware of the ethical obligations of securing support from community, in addition to the Ginibi Elders Council. I was confronted with having to determine which was the most appropriate community. Despite the availability of guidelines like the Lowitja Institute's practical guide for researchers undertaking research in Indigenous health (Laycock, with Walker, Harrison, & Brands, 2011), identifying an appropriate local community was not an easy task. I understood that I required community support in readiness for applying for an ethics approval, and this is one of several principles of the AH&MRC Human Research Ethics Committee (Aboriginal Health & Medical Research Council Ethic Committee, 2019). More importantly, gaining community approval was about fulfilling my cultural obligations and relational accountabilities by ensuring I had the support of community in doing the research that I was about to embark on. This is a factor that is not often considered when undertaking research, but such practice is inherent in an Indigenous research methodology of ways of being, knowing and doing, including ways of learning and teaching.

1.4.3. Preparing for ethics approval – the challenges

As part of preparing for ethics approval, several guidelines required evidence of support from the local community and Indigenous organisations (Aboriginal Health & Medical Research Council Ethic Committee, 2019; Aboriginal Health and Medical Research Council Ethic Committee, n.d). While the whole Indigenous community would benefit from my research findings, the national nature of the research study meant that there was not an appropriate local community relevant to the scope of the research focus.

Several mentors provided advice and direction. One mentor argued that because my research had a national focus, it was imperative that I sought ethics approvals from Aboriginal and Torres Strait Islander Health Research Ethics Committees (HRECs) in South Australia, Western Australia, the Northern Territory (Top End and Central), Victoria and New South Wales. Another mentor suggested approaching the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) who might be the appropriate national body. In approaching the AIATSIS research section on 29 November 2017, I asked the following question by email:

> Because my research project is a nationally focussed and public policy intervention initiative, I was told that the AIATSIS is that national human ethics body that could be the responsible approving group related to national projects, such as mine.
>
> What I am trying to do, is ensure that my research study is following the correct Indigenous human research ethics processes required of me as an Indigenous researcher. But what I have discovered is that there isn't a national body as such that could provide that HREC endorsement. But instead, I may be required to

> seek ethical approval from the other states/territory Indigenous HREC groups. But again, I have many questions because the nature of my research doesn't fit neatly into those ethical requirements (C. Parter, personal communication, 29 November 2017).

The AIATSIS responded by saying:

> Yes, AIATSIS ethics approval is applied nationally.

and went on to write:

> There are no hard and fast rules about where researchers seek ethical clearance from.
>
> In some instances, applicants are restricted to their institute or organisation's ethics committee initially, then can apply for their project to be considered by other HRECS. In other cases, researchers will seek ethical clearance from local HREC in the area their research is focused. I believe there are over 200 registered HRECs in Australia.
>
> All registered HRECs have to abide by the national statement but what AIATSIS offers in comparison to other HRECs is a consideration in association with the Guidelines for Ethical Research in Australian Indigenous Studies, often referred to as GERAIS. This document was developed by AIATSIS and is used both nationally and internationally as benchmark for Indigenous Research. (AIATSIS representative, 3 December 2017).

I spoke to other mentors, with one helping me to realise that because I was not entering Aboriginal and Torres Strait Islander communities in each state and territory,

it was quite possible that gaining an ethics approval from each of the Aboriginal and Torres Strait Islander HRECs was not necessary. Ultimately, I decided that it was not necessary because my community of focus was the national Indigenous public health sub-domain of Australia's very large public policy domain, which I write about in Chapter 2.

I then struggled with the need to have a community governance mechanism to provide oversight and support, and guidance on the necessary direction of the study, including having evidence that Indigenous people were leading the study. Having an appropriate local community-controlled organisation, and having Indigenous people involved, were requirements of the Aboriginal Health and Medical Research Council Ethics Committee's community control principles (Aboriginal Health & Medical Research Council Ethic Committee, 2019).

Formally, the research study reported to the Poche Centre's Research Advisory Board, Chaired by Professor Tom Calma AO (also Patron of the Poche Centre). The Board had representatives drawn from across the university and a representative from an Aboriginal community-controlled health organisation. Also, all the original members of my PhD academic team were of Aboriginal and/or Torres Strait Islander descent, although this composition changed over time.

The National Health and Medical Research Council, the AIATSIS'S ethical guidelines for undertaking research into Aboriginal and Torres Strait Islander health, and the Lowitja Institute's guide for undertaking Aboriginal and Torres Strait Islander health research, provided some direction, but no firm resolution (Australian Institute of Aboriginal & Torres Strait Islander Studies, 2012; Laycock et al., 2011; National Health & Medical Research Council, 2003). I discovered a significant weakness in such

guidelines and ethics standards, as they failed to account for nationally focused research initiatives such as the public policy qualitative research study that I was about to embark on.

Additionally, the Poche Research Advisory Board mechanism was not an appropriate community mechanism, given my responsibilities for ensuring the voices of Indigenous people were foremost. My cultural obligations meant that I required a mechanism that held me and my research accountable to community. These obligatory accountabilities are grounded in Indigenous philosophies and methodologies, and they are additional to national and state human research ethics committee requirements and standards.

Often, these Indigenist cultural requirements are not acknowledged or fully understood by western science and mainstream researchers, or the higher education sector and its research arms. In fact, a challenge for Indigenous researchers is that we have an additional layer of mandatory accountabilities and obligations that we must be cognisant of. So, in addition to providing reports back to human research ethics committees, I also have an obligation to provide updates and findings to those who supported the research study, in order to fulfil my obligation of being accountable to community.

Given that there were no hard and fast rules, and there was no appropriate national body, I needed an alternative community mechanism. In the case of this research study, the alternative community support mechanism may have been the National Community Controlled Health Organisation's affiliate, or the AH&MRC of NSW. However, these organisations still did not address the scope of my research, given its national policy focus. I then realised that the most appropriate community body was

the NHLF. Thankfully, when I requested their participation as a reference group, they agreed (NHLF representatives, 28 June 2017).

After realising there was a weakness in the available ethics guidelines, and in the requirements of the AH&MRC Ethics Committee application, and following many discussions with ethics committees and other researchers and mentors, I wrote in response to these guidelines the following ethics application statement:

> Unlike most local community health intervention research projects, this study's core target group are the Policy Elites drawn from the Indigenous public health sub-domain of Australia's large and complex public health policy environment. These Policy Elites will come from a diverse range of backgrounds and will be either Indigenous or non-Indigenous participants. Therefore, in the absence of an appropriate Indigenous community-controlled mechanism, this research study has consulted the National Health Leadership Forum (NHLF). This is because the NHLF is a collective partnership of national Indigenous organisations who represent a united voice on Aboriginal and Torres Strait Islander health and wellbeing with expertise across service delivery, workforce, research, healing and mental and social and emotional wellbeing. It also provides advice and direction to the Australian Government about the implementation of the NATSIH Plan [National Aboriginal and Torres Strait Islander Health Plan] with the Chair of the NHLF being the Co-Chair of its Implementation Plan Advisory Group who is leading the Plan's implementation. The NHLF sees value in the worthiness of this research project, have agreed to act as a reference group and are supportive of this research project. A NHLF letter of support is attached (C. Parter, 17 November 2017).

I allude to this challenge in the peer reviewed published research protocol article contained in Chapter 2.

1.5. Chapter 1 Conclusion

In this chapter, I have told the story of why I deliberatively chose to work in government as a policy maker. Essentially, my move from a career as a nurse into policy was a deliberate choice because health policies were not meeting the needs of Indigenous people. Working as a policy maker meant that I could influence the appropriateness of policies targeting Indigenous Australians. I began working in Aboriginal health and then moved into law and justice, followed by child protection systems, and then returned to Aboriginal health in the latter part of 2008.

The research I conducted in 2005 highlighted the difficulties that governments and policy makers face in fully enabling the expression of Indigenous Australians' cultures in policies and initiatives. An 'Our way model' was developed to demonstrate conceptually how governments could include a cultural dimension in policy development (Parter, 2005). I now had an opportunity to contribute to knowledge and continue this work as part of my PhD research study, particularly in relation to the nexus of the knowledges that are at play in the cultural interface where Indigenous and non-indigenous cultures meet.

The *Australian and New Zealand Journal of Public Health* article about whether the CTG refresh should include culture and if so, how it should do so, is included in this chapter. This article further highlights the challenges of implementing culture, including knowledges held by Indigenous Australians.

I have described the support secured from community in preparing for my PhD, and why this was necessary, including the lessons learnt from the experience. I then went on to write about the challenges I encountered when preparing for ethics approval, and how these difficulties resolved themselves. The additional steps expected of a researcher who is Indigenous, and who is applying an Indigenist paradigm and methodology, are not taken into consideration by mainstream researchers or institutions. Due to the national focus of the research, I also identified a significant flaw in the HREC process that I was eventually able to resolve.

Chapter 2 provides further information about the research study, its context, the key policy commitments, and their actors. A published research protocol further describes the research study.

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CHAPTER 2. THE RESEARCH STUDY – STORYING

2.1. Introduction

Chapter 2 begins with a published research protocol that describes the overall study including a research question, an aim, and a summary of the research methods. Although, in Chapter 3 extensive details of the study's methods are provided.

Two amendments to the study protocol were made. Firstly, the term 'elite' was replaced with 'actor' and, secondly historical documents were not collected. These amendments follow including an overview of the study's governance structure and details of the ethics approvals.

The study is then positioned within the broader Indigenous public health policy environment and an in-depth analysis of the national Indigenous health public policy sub-domain is described. Policy actors' relational positionings in the Health Plan's policy context within this Indigenous public health sub-domain are also provided.

I provide an overview of the key policy commitments in Australian Indigenous health, from 1989 to March 2020. This overview is informed by policy actors' stories. There are three main purposes for including this overview. Firstly, a historical context of Indigenous public health policies at the national level is provided. Secondly, the rise of culture and, racism is tracked up to culture's present-day visibility in the form of cultural determinants. Finally, it positions this study within the broader policy context of the Indigenous public policy environment.

2.2. A published research protocol

The research protocol included below was written for a special edition of the Journal of Indigenous Wellbeing that was to coincide with the Eighth International Healing Our Spirit Worldwide Conference held in Sydney, Australia in November 2018 where I presented a poster. The poster presentation is mentioned above in the 'Collection of Output for Examination section.

Reference

Parter, C., Wilson, S., Gwynn, J., Skinner, J. C. and Hartz, L., D, (2020), A research protocol – Indigenous culture saves lives – Australian Indigenous cultural views and knowledges in health policy: a case study – The National Aboriginal and Torres Strait Islander Health Plan 2013–2023. *Journal of Indigenous Wellbeing*, 5(1).

Authors Contribution Statement

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We confirm that Carmen Dorothy Ruby Parter made the following contributions:

The candidate planned and prepared the manuscript that involved several drafts in readiness for publication. Dr Shawn Wilson, Dr Jo Gwynn, Dr John C Skinner and Dr Donna L Hartz contributed to subsequent drafts by reviewing and editing the content, and providing advice. The final draft was reviewed and approved by all co-authors.

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This statement aligns with the requirements of the University of Sydney regarding policy as described in the policy documents:

*Thesis and Examination of Higher Degrees by Research Policy 2015
*Thesis and Examination of Higher Degree by Research Procedures 2015

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A research protocol - *Indigenous culture, saves lives* - Australian Indigenous cultural views and knowledge in health policy: A case study - the National Aboriginal and Torres Strait Islander Health Plan 2013 - 2023

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Abstract

In Australia, an evidence gap exists for governments and policymakers about what it means when the cultures of Aboriginal and Torres Strait Islander people are included in public policies. Specifically, when the cultures of Indigenous Australians have been incorporated in a public health policy like the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (Health Plan), how do policymakers implement - enable, embed, and enact - cultures? More disturbing is the non-recognition of Indigenous culture's innate relationship to the knowledges held by Indigenous Australians. In recognition of the importance of Indigenous cultures to the health and wellbeing of Indigenous Australians, the centrality of culture in the Health Plan represents the first national Indigenous public policy that reflects its relevance. This research protocol describes a public policy qualitative research study that aims to address this evidence gap by using the Health Plan as a case study.

Keywords: Indigenous Cultures, Indigenous Knowledges, Indigenous Cultures and

Indigenous Knowledges, public policy, public health policy, public policy intervention research, qualitative research, Indigenous research methodology.

Note: In recognition of the diversity that exists amongst Aboriginal and Torres Strait Islander Australians, this article respectfully uses Indigenous except during citations or when practice would suggest otherwise.

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Introduction

In Australia, the cultures of Aboriginal and Torres Strait Islander people continue to be incorporated into the decisions and actions of governments – known as public policies (Parter, Wilson, & Hartz, 2018). However, when Indigenous cultures have been incorporated into a public policy, very little is understood about culture's meaning, and how culture is to be implemented. Indeed an evidence gap exists (Parter et al., 2018). Furthermore, Indigenous knowledges and its intrinsic relationship to Indigenous cultures (and vice versa) are absent from the Australian public policy conversations (Parter et al., 2018). Health to Indigenous Australians is about rightfully practising their traditional medicines and cultural knowledges that considers the physical, social, emotional, and cultural wellbeing of the entire community (United Nations General Assembly, 2007). This holistic nature of health is often in conflict with western concepts of health (National Aboriginal Health Strategy Working Party, 1989).

The inclusion of Indigenous cultures in the design and delivery of policies and programs has been a critical and essential consideration to support improvements in the health and wellbeing of Indigenous Australians (Jones et al., 2018). Connection with cultures such as Indigenous languages and country are the fundamental cornerstones for healthier people, lives, and communities (Australian Government, 2017a). However, when Indigenous cultures have been included in an action or a decision of the government, how do they then implement culture?

This article relates to a research protocol about a public policy qualitative research initiative. A case study approach is being taken with the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013 - 2023 (the Health Plan) as a case example because Indigenous cultures are central to its policy framework (Australian Government, 2013). A rationale as to why this study is being undertaken briefly discusses the limitations of culture, including culture's representation in the Health Plan. The research context helps set the scene by providing examples of public policies, public health policies, policymakers, and policy elites of the Indigenous public policy sub-system. Further, system thinking as a practice assists in understanding the inter-relatedness of complex factors at play is discussed. An Indigenous research methodology underpinned by an Indigenous way of being, knowing, and doing is described and demonstrated when securing community support and approval for the research initiative. A research question and aim are canvassed followed by an overview of the study methods, participants, data collection, and analysis process. Finally, finishing with a conclusion.

Rationale

The visibly of culture in the Health Plan represents the first national health policy to acknowledge the centrality of culture when addressing the health disparities and inequities and the social inequalities that are experienced by Indigenous Australians (Australian Government, 2013).

Culture is described in the Health Plan as "Aboriginal and Torres Strait Islander peoples have the right to live a healthy, safe and empowered life with a healthy strong connection to culture and country" (Australian Government, 2013, p. 7).

It further recognises the changing nature of culture, the role that colonisation has had on disrupting the practice of cultures, and reaffirms culture's contributions to improving Indigenous health (Australian Government, 2013).

However, such representation of Indigenous culture in the Health Plan is very limiting (Parter et al., 2018). Pholi, Black, and Richards (2009) argue that Indigenous public health policy discourse tends to blame Indigenous Australians for not being connected to or having a culture. This blaming is evident in the Health Plan.

Culture is also challenging to conceptualise. Nonetheless, several overarching Aboriginal and Torres Strait Islander cultural domains have been identified from the literature, and they are "knowledges and beliefs, cultural expressions, country and caring for country . . . language, self-determination and family, kinship and community" (Jones et al., 2018, p. 2).

Indigenous cultures, and indeed, Indigenous knowledges, has been highlighted as often invisible to public policy processes (Parter, 2005; Parter et al., 2018). Policymakers in governments have previously been asked to provide opportunities for Indigenous people and communities to apply their culture within policy development (Parter, 2005). What is missing from the public policy dialogue and processes is the lack of meaning and understanding when the cultures of Indigenous Australians have been incorporated in a public policy framework. More specifically, how to enable, embed, and enact the cultures (and knowledges) of Indigenous Australians (Parter et al., 2018). Maybe such understanding will contribute towards improvements to the well-established evidence about the poor health and wellbeing of Indigenous Australians.

The Research Context: Setting the Scene

Public Policies, Indigenous Public Health policies, Policymakers, and Policy Elites of the Indigenous Public Health Sub-System

Public policies are the things that governments (or their organisations) decide to do (Buse, Mays, & Walt, 2012; Weible, 2014). A range of policy instruments is used by governments to authorise their decisions such as written community agreements, government-wide agreements, national strategies, laws, and programs.

Examples of national public policies relating to Indigenous health

- The signing of the March 2008 Indigenous Health Equality Summit Statement of Intent between governments and Indigenous and non-Indigenous organisations about working in partnership to address the health of Indigenous Australians (Australian Indigenous HealthInfoNet, 2016).
- The Council of Australian Government's commitment to Closing the Gap (CTG) health agenda and the National Indigenous Reform program in 2007 and 2008 respectively (Australian Indigenous HealthInfoNet, 2016). Also, the Commonwealth Government's CTG Refresh (Australian Government, 2017b).
- The 1989 National Aboriginal Health Strategy, the 2003-2013 National Strategic Framework for Aboriginal and Torres Strait Islander Health, and the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023 are successive national public health policy instruments designed to improve Indigenous Australian's health (Australian Government, 2013; National Aboriginal Health Strategy Working Party, 1989; National Aboriginal Torres Strait Islander Health Council, 2003).
- The legislation, appropriation bills, and regulations executed by the executive government such as the Stronger Futures 2012 Act that aims to strengthen the lives of Northern Territory Aboriginal people, families, and communities.
- Individual government programs such as the Commonwealth Government's Indigenous Health Advancement Program designed to avert the onset of preventable chronic diseases like diabetes, cardiovascular, and respiratory problems (Australia Government, 2014).

In Australia, the National Government, its organisations, and staff make public policies as do state, territory, and local governments. These public policies distinguish themselves from policies that the private, non-government, or civil society sectors develop because they are not governments (Buse et al., 2012). Although these sectors are required to comply with government policies, where relevant.

The policymakers that develop Indigenous public health policies are but one group of many policy actors in Australia's highly political and multi-layered public policy system consisting of Commonwealth of Australia, state, and territory parliamentarians, ministers, departmental policy advisors; and specialist governmental appointed experts. In health, they are sometimes referred to as policy elites (Buse et al., 2012).

Of the many policy actors, these policy elites "exercise considerable influence in the development of health policy" (Baker, 2013, p. 309). They are usually members of a group or a network that have the same knowledge and interests relating to a specific issue (Baker, 2013). The Indigenous health sub-domain of Australia's large, highly complex, and multi-dimensional national policy environment is where these Indigenous and non-Indigenous policy elites interact (Baker, 2013).

Examples of policy elites in this Indigenous health sub-system include the National Health Leadership Forum (NHLF)[1], the Commonwealth Department of Health, their Health Plan Implementation Advisory Group (or previous groups), ministers and advisors (former and current members). Past chairs and members of the former National Indigenous Health Equality Council and the Aboriginal and Torres Strait Islander Health Standing Committee of the Australian Health Ministers Advisory Council (which is a sub-group of the Council of Australia Government's Health Council). The Close the Gap (people's movement) campaign coalition consisting of national Indigenous and non-Indigenous community, and professional organisations drawn from a broad-ranging health field.

These Indigenous and non-Indigenous policy elites are best placed to respond to the research question posed by this study.

Thinking Beyond Health: System Thinking

Given the challenges that governments face to meet the CTG targets (Australian Government, 2018) and the well-documented evidence about the poor health and wellbeing of Indigenous Australians (Australian Health Ministers' Advisory Council, 2017), a new approach to understanding such complex phenomena is warranted. It is, therefore, imperative that the work of this research study adopts systems thinking.

Systems thinking assists in understanding the inter-connectedness and relationalities of the complexities, and sometimes the invisible factors, relating to the wholeness of a social phenomenon (Adam, 2014; Peters, 2014). As opposed to a linear and often limiting public health cause and effect approach, system thinking provides a model of practice that brings greater depths of understanding to policy analysis and research (C. Huckel-Schneider, personal communication, 27 October, 2018).

It is well understood that the issues of achieving health, education, and employment parity for Indigenous Australians are a highly complex social phenomenon. A single solution to address the health disparities, inequities, and social inequalities will be ineffectual (C. Huckel-Schneider, personal communication, 27 October, 2018) because the broader social issues such as unemployment, inadequate housing, lack of educational attainment, or racism contribute to the 10-year Indigenous life expectancy gap (Australian Health Ministers' Advisory Council, 2017). Similarly, lifestyle issues such as smoking, not exercising, unhealthy eating choices, and obesity add to the higher rates of ill health and death (Australian Health Ministers' Advisory Council, 2017). Further, poor access to services such as dentistry, doctors, other professionals, or

[1] The NHLF is a partnership of national organisations that include the Aboriginal and Torres Strait Islander Healing Foundation and the Australian Indigenous Doctors' Association. Also, the Australian Indigenous Psychologists' Association and Congress of Aboriginal and Torres Strait Islander Nurses and Midwives. Further, the Indigenous Allied Health Australia Incorporation and the Indigenous Dentists' Association of Australia. The Lowitja Institute, National Aboriginal and Torres Strait Islander Health Workers Association, National Aboriginal Community Controlled Health Organisation, National Aboriginal and Torres Strait Islander Leadership in Mental Health, National Association of Aboriginal and Torres Strait Islander Physiotherapists, and the Torres Strait Regional Authority (National Health Leadership Forum, personal communication, September 14, 2017).

hospitals adds to these problems (Australian Health Ministers' Advisory Council, 2017).

Additionally, the social, political, economic, and health inequalities experienced by Indigenous Australians relate to structural disadvantages arising from the legacy of colonisation (Kirmayer & Brass, 2016). Finally, past public policies such as the forcible removal of Indigenous children from their families (known as the "Stolen Generations"), continue to have a pervading detrimental impact on the lives, health, and emotional wellbeing of Indigenous Australians (Dudgeon, Milroy, & Walker, 2014).

Given these inter-related complexities, it is, for this reason, that system thinking as a framework of practice will be applied to this research study. As Adam (2014) argues, "mastering our understanding of how things work lies in interpreting interrelationships and interactions within and between systems" (p. 1).

An Indigenous Research Methodology

Methodology in this research study involves the underlying assumptions, concepts, and parameters that guide the practices of discovery. Given this, an Indigenous research methodology directs this research study that is underpinned by an Indigenous way of learning and teaching (pedagogy), an Indigenous way of being (ontology), knowing (epistemology), and doing (axiology; Wilson, 2008). The central positioning of the first author's *"blackness"* and Indigeneity, cultural worldviews and lived experiences including many years of working in government, brings a critical Indigenous perspective to the research study that privileges an Indigenous voice when producing valid knowledge(s) (Moreton-Robinson, 2000; Rigney, 1999). As demonstrated below, at play are those relational community and cultural obligations of reciprocity, respect, and responsibility (Wilson, 2008). As an Indigenous researcher (the first author), who is cognisant of Indigenous cultural and community protocols, an appropriate community governance mechanism that supports this research study was a necessity.

The nation-wide nature of the research study did not fit neatly into local community control and oversight requirements. Those relational community accountabilities and cultural obligations of respect, reciprocity, and responsibilities could have been compromised (Wilson, 2008). It also presented challenges when navigating the Aboriginal and Torres Strait Islander health ethical guidelines that required Aboriginal community control of all aspects of the research project (Aboriginal Health & Medical Research Council Ethic Committee, 2016; Australian Institute of Aboriginal & Torres Strait Islander Studies, 2012). However, the design and low-risk nature of the research study minimised these challenges.

Specifically, the NHLF was considered the most appropriate community body. Subsequently, the research study proposal (with several iterations) was presented to the NHLF on several occasions during 2017. The NHLF agreed to support the research study and to be actively engaged as a reference group (National Health Leadership Forum, personal communication, May 30, 2017).

Also, because the research study is being conducted from the Australian State of New South Wales (NSW), the peak state-wide Aboriginal body representing the Aboriginal Community Controlled Health sector (the Aboriginal Health and Medical Research Council of NSW) also provided their support. Furthermore, because the first author lives, works, and is studying on Bundjalung country, the Gnibi Elders Council at Southern Cross University in Lismore are also supportive of this research idea when it was presented to them in November 2015.

These relational community and cultural obligations are inherent in Indigenous research practices (Wilson, 2008). An additional dimension to the conduct of health research is added when Indigenous people and communities are the focus of attention. More importantly, it is incumbent on Indigenous researchers (their obligatory responsibilities) to respectfully be accountable for the way that research is conducted with or within Indigenous communities (Wilson, 2008).

Research Question and Aim

The main research question of this study is when the cultures of Indigenous Australians have been incorporated in a public health policy like the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013 –

2023 (the Health Plan), how do policymakers – implement - enable, embed, and enact - culture?

Implicitly further questions to be explored are how does the Health Plan represent Indigenous cultures, including Indigenous knowledges? Is such representation of Indigenous cultures reflective of what Indigenous Australian's have said previously, particularly its relationship to Indigenous knowledges? If yes, how? If not, what are the differences? Finally, what are the public policy implications?

This research aims to develop a conceptual framework(s) that assists in bringing meaning and understanding to Indigenous cultures and, indeed, Indigenous knowledges in public health policies. It is envisaged that a model of practice will be developed as part of this framework that enables, embeds, and enacts Indigenous Australian's cultures and knowledges.

Study Methods, Participants, Data Collection, and Analysis

The Methods

As previously mentioned, given the centrality of Indigenous culture in the Health Plan, a case study approach is being taken. A case study is an acceptable form of inquiry that will assist in responding to the research question (Creswell, 2007).

Documents such as consultation reports and written submissions relating to the Health Plan's development and its implementation will be examined. These documents could include publicly released documents obtained from libraries or the internet and other documents revealed during the study and available for public access. Thematic analysis of these documents provides an opportunity to understand any complexities (Creswell, 2013) about Indigenous cultures, cultures meaning and representation, and its relationship to Indigenous knowledges.

Yarning sessions will be held over six months, with 10 to 20 policy elites who contributed to the development or current implementation of the Health Plan. Yarning involves a conversational method of storying telling and will be used to further complement the document analysis. Yarning is an acceptable research method that allows policy elites to tell their story about why culture was included in the Health Plan (Bessarab & Ng'andu, 2010). Policy elites will be prompted about whether any meaning had been bought to culture when discussing its inclusion and whether its relationship to Indigenous knowledges had been mentioned. They will also be asked how they think culture can be facilitated, given its central positioning in a public policy framework like the Health Plan. A yarning script will be used by the researcher to help start the yarning sessions but will not be provided to policy elites.

The research study complies with the ethical standards outlined in the national statement on ethical conduct in human research 2007 - updated May 2018 (National Health and Medical Research Council, the Australian Research Council, and Universities Australia, 2018b) and the Australian code for the responsible conduct of research (National Health and Medical Research Council, the Australian Research Council, and Universities Australia, 2018a). The NSW Aboriginal Health and Medical Research Council (AH&MRC) Human Research Ethic Committee (HREC) have approved this study (AH&MRC HREC Ref No.: 1354/17). Also, the University of Sydney's (UoS) HREC has also provided ethical approval (UoS HREC No.: 2018-69).

Participants: Selection and recruitment

Policy elites have been purposively selected (Mason, 2002). They are drawn from the Indigenous health sub-domain of Australia's national public health policy system.

Examples of policy elites

- The National Health Leadership Forum, including members of its secretariat who were pivotal in finalising negotiations about the Health Plan's content back in 2012-13 and continue to be involved in its implementation.
- Policymakers in government like those in the Commonwealth Department of Health and their Health Plan's advisory group, Health Ministers or their advisors who were previously involved in the Health Plan's development and its continued implementation.
- The former National Indigenous Health Equality Council chairs and its membership

because of their crucial role in leading the development of the Health Plan.

- Members of the Australian Health Ministers Advisory Council's Aboriginal and Torres Strait Islander Health Standing Committee.
- Critical individuals of the Close the Gap people's movement campaign (C. Parter, personal communication, November 23, 2017).

The above policy elites must have been previously involved with the Health Plan's development or its continued implementation. A peer-nomination snowball sampling technique will be applied that involves asking policy elites to nominate others based on those criteria (Baker, 2013).

Letters inviting policy elites to participate in a yarning session will be sent, including a Participant Information Statement and a Participant Consent Form. The study overview, the selection process, maintenance of confidentially, use of material, and information about the next stages of the research study will be included in such a letter (Baker, 2013).

A follow-up email or telephone call will confirm each policy elite's agreement to participate in a yarning session. A convenient time and venue will be organised with a 50-minute face to face yarning session held. As a last resort, other means such as Skype or telephone yarning will be offered on those occasions when a face-to-face session is not feasible.

Clarification about each policy elite's understanding of the research study, how their privacy will be maintained, data secured, and a signed consent form will occur before commencing yarning sessions.

Data collection, analysis, and storage

Following approval from policy elites, yarning sessions will be digitally recorded. These recordings and written transcripts will comply with the University of Sydney and School of Medicine and Health's privacy, record management, and research data management policies such as the development of a research data management plan (RDMP). An approved RDMP details how the study material will remain private, secure, and how the data generated by this research will be protected and disposed of after the required termination period.

Yarning session data will be thematically (Braun & Clarke, 2006) analysed with coding occurring and preliminary themes identified that will be refined at a later stage (Liamputtong, 2012).

Data saturation can be expected when the same points and occurring themes and issues are consistently highlighted by policy elites (Byrne, 2001). Once data saturation has been confirmed, coding will continue inductively (J. Mooney-Somers, personal communication, 26 May, 2017) involving refinement to the themes by "searching … [for] repeated patterns of meaning" (Braun & Clarke, 2006, p. 86). A story begins to be built to assist with responding to the research question (Liamputtong, 2012).

The identifiable themes will be provided to policy elites, the study's academic team, and members of the NHLF. The members of the NHLF will also consider a model of practice aimed to enable, embed, and enact Indigenous cultures, knowledges, and cultural knowledges of ways of being, knowing, and doing held by Indigenous Australians.

Finally, the overall research study will be written up in a thesis with several peer-review publications. Negotiations will be held with those involved with publications and how they would like to be acknowledged.

Conclusion

The cultures of Indigenous Australians continue to be incorporated into public policies. The invisibility of Indigenous knowledges and its absence from the Australian public policy and public health policy arenas are noticeable. More importantly, the lack of Indigenous knowledge's inherent existence with Indigenous cultures and vice visa are disturbing. An evidence gap does exist about meanings of and understanding cultures when culture is incorporated in a public policy instrument like the Health Plan. Specifically, about how policymakers implement - enable, embed, and enact - Indigenous cultures. This impending public policy qualitative research study intends to address such an evidence gap by developing a conceptual framework that brings meaning and understanding to Indigenous

cultures and Indigenous knowledges in public health policies. A model of practice is anticipated that assists to enable, embed, and enact Indigenous cultures once incorporated in public policy.

Owing to the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023 as the first national public health policy that centrally positions culture to its policy framework, it is being used as a case study. Any meaning and understanding of Indigenous cultures and their intrinsic relationship to Indigenous knowledges during the Health Plan's development or implementation will be explored. Additionally, yarning sessions with Indigenous and non-Indigenous policy elites, drawn from the Indigenous public health sub-domain of Australia's public policy environment, will further complement the findings of document reviews. Underpinning such an approach is the practice of system thinking that brings a deeper understanding of the social phenomena and complexities when dealing with the health and wellbeing of Indigenous Australians. Further, a critical Indigenous perspective that privileges an Indigenous way of being, knowing, and doing is vital to policy development and implementation.

Perhaps this research study may be the answer to resolving some of the failings of the Council of Australian Government's CTG initiatives that aim to address the health, education, and employment disparities and inequalities experienced by Indigenous Australians (Australian Government, 2019).

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Dr Shawn Wilson PhD(MONASH), MA(UAF), BSc(UM) is Opaskwayak Cree from northern Manitoba, Canada and now lives on Bundjalung land in eastern Australia. He is Director of Research at Gnibi College of Indigenous Australian Peoples at Southern Cross University. Shawn's doctoral thesis was in Indigenous knowledge, which followed study in psychology and zoology. Through working with Indigenous people internationally, Shawn has applied Indigenist philosophy within the contexts of Indigenous education, health, and counsellor education. In addition to further articulating Indigenous philosophies and research paradigms, his research focuses on the inter-related concepts of identity, health and healing, culture and wellbeing.

Dr Josephine Gwynn is an early career researcher. Her research interests includes a focus on young Aboriginal people and their nutrition, physical activity, wellbeing and related determinants. Also Aboriginal community governance of research, models of Aboriginal community delivered health promotion and, building the capacity of Aboriginal researchers, project officers and community members. Dr Gwynn has just completed a large National Health and Medical Research Council study - The Many Rivers Diabetes Prevention Project (MRDPP). She has mentored a number of Aboriginal project officers to complete their diplomas and degrees as well as attain leadership positions in their communities and in both state and national arenas.

Dr John Skinner worked in public health for over 30 years and was appointed as the Director of the Centre for Oral Health Strategy NSW in 2014 and led the development of both Oral Health 2020 and the Aboriginal Oral Health Plan in NSW. John has been working closely with Aboriginal Community Controlled Health Services, Local Health Districts, Universities and professional groups, to develop effective community partnerships to address inequities in Aboriginal health status in NSW. In March 2018 he commenced at The University of Sydney as a Senior Research Fellow with the Poche Centre for Indigenous Health.

Dr Donna Hartz (RN, RM, M Mid Studies, PhD, FACM) was the former Acting Director of the University of Sydney's, National Centre for Cultural Competence. She is now an Associate Professor in Midwifery, College of Nursing and Midwifery, Charles Darwin University. Donna identifies as a descendent of her grandmother's people; Kamillaroi. She is a midwife and nurse with 33 years' experience as a clinician, educator, lecturer, manager, consultant, and researcher. During this time, she has worked at a variety of tertiary and metropolitan health services and universities within NSW Australia. Her current research foci are on Aboriginal Women's and Maternal Health, Aboriginal Midwifery Workforce Development and Cultural Competence Leadership.

2.2.1. Policy elites versus policy actors – an amendment

Policy elites are described as “those … individuals who exercise considerable influence in the development of health policy” (Baker, 2013, p. 309). Hoppe refers to policy elites as norm entrepreneurs who “actively shape beliefs, values, and expected behaviours important to policy and institutional decision making … they shape ‘governance culture’” (cited by Baker, 2013, p. 309). As researchers we must be cognisant “of the importance of … this level and type of culture” (Baker, 2013, p. 308).

A policy elite is also described as:

> a specific group of decision makers who have high positions in an organization, and often privileged access to other top members of the same, and other, organizations (Buse, May, & Walt, 2012, p. 6).

Policy elite were identified as potential participants in the study as they were the very people involved in shaping governance culture. These policy elites had access to decision-makers that were able to change policy and included members of parliament, senior executives of the Australian public service, and chief executives of critical public health organisations. This is the reason why the policy elite is referenced in the above research protocol publication.

However, during the course of the research the term ‘elite’ was not a favoured word, particularly amongst Indigenous participants in yarning sessions. As expressed at the Yarning Workshop held in December 2019, the term elite is not appropriate because it implies someone being more powerful than another. This is a meaning that is not commensurate with Indigenous people’s cultural ways of being, knowing and doing. The term ‘policy navigator’ was recommended as an alternative term (policy actor

representative, 12 December 2019). When providing a rationale concerning why elite was being used, one participant remarked:

> *You are trying to fit a word according to a white paradigm so maybe use your own word (policy actor representative, 12 December 2019).*

The suggestion here was that I should consider using a word that was representative of Indigenous people's ways of being, knowing and doing. This is indicative of the tension between western and Indigenous science that arose consistently throughout the course of this research study.

As an interim measure, an alternative neutral term is 'actor' or 'policy actor'. Actors in the policy process are described as:

> individuals or collectives, from groups to countries, some of whom actively seek to influence politics and public policy on a given issue (Weible, 2014, p. 5).

So, given the concerns about the term elite, it will now be replaced with 'actor' or 'policy actor' for the purposes of this thesis. The selection of a culturally appropriate term will be further discussed with relevant policy actors at a later date, but this is not in scope for the present study.

2.2.2. The collection of historical documents – another amendment

As mentioned in the published research protocol, historical documents such as written community and organisational submissions relating to the national consultation of the Health Plan (dating back to 2012/13) were to be collected and thematically analysed.

The intent of the analysis of these historical documents was to explore further any issues of relevance about culture and its meaning and representation, including

culture's relationship to knowledges. Unfortunately, all publicly available documents such as community submissions, which had previously been freely available from the Commonwealth Department of Health and Ageing's webpage, had been archived.

The archival process prevented full access to these documents. While some of these documents were found from individual organisation's websites, the incompleteness of the collection meant that the analysis would have been compromised and distorted. Also, to source over 200 publicly available submissions and documents became resource intensive. Lodging a freedom of information application with the Commonwealth Department of Health and Ageing had been considered. However, a significant expense to the study would have been incurred, which was an unjustifiable cost as a PhD student.

Given these issues, I decided that sourcing and analysing such historical documents relating to the Health Plan's development would be limited to documents from the period after the Plan's implementation in 2014. Further, I decided that I would only review documents related to culture as a determinant of health, including culture's relationship to racism. An analysis of these documents is contained in this chapter. The analysis is summarised in Figure 4 – the policy analysis spiral – mentioned below and it concerns the rise of culture as a determinant of health.

The analysis contributes towards the present positioning of my research study and its future input into public policy formulation and implementation. A relational accountability of reciprocating and fulfilling my obligatory responsibilities of giving back to community in a way that influences policy dialogue was an imperative. As one policy actor confirmed, *research is public policy … Indigenous research is public policies* (policy actor representative, 12 December 2019).

Despite the earlier challenges of collecting historical documents, policy actors provided in their stories extensive insights into the Health Plan's development and its implementation. In fact, the Health Plan's development and implementation represents an exemplary case of good practice when co-designing policy in relation to Indigenous Australians. The NHLF has agreed to collaborate and write up such a case study (NHLF representative, personal communication, 18 March 2020).

Stories were heard about the way in which culture was incorporated into the Health Plan, and some participants in this study discussed the question of whether there was any meaning given to culture, and what the policy makers said about culture's relationship to knowledge. One participant in this study commented:

> *Did that Plan really interrogate culture and provide guidance on culture? … There's a whole lot of work around that in a rigorous, intellectual way … It's a fairly superficial treatment of culture, in the sense it's very descriptive … It talks about our connection to culture, culture being protective … those sorts of things, identity in culture (P21, December 2018).*

This participant went on to report that:

> *a decision was made that social determinants and cultural determinants would be in the second plan, the next iteration of the plan (P21, December 2018).*

As will be demonstrated shortly in the analysis below, interrogating culture in a rigorous and intellectual way did indeed occur.

2.3. The research study's project team, governance and ethics

2.3.1. The project team and their roles and responsibilities

Project Team	Role	Responsibilities
Carmen Parter	PhD student	Carmen is the principal investigator of this research and is responsible for leading the achievement of activities associated with the study.
Dr John Skinner	Primary PhD Supervisor	As Carmen's primary PhD supervisor, Dr Skinner is responsible for the provision of advice, guidance and comments about this research study.
Dr Shawn Wilson	Auxiliary PhD Supervisor	As Carmen's auxiliary PhD supervisor, Dr Wilson is responsible for the provision of advice, guidance and comments about this research study
Dr Josephine Gwynn	Auxiliary PhD Supervisor	As Carmen's auxiliary PhD supervisor, Dr Gwynn is responsible for the provision of advice, guidance and comments about this research study
Dr Donna L Hartz	Auxiliary PhD Supervisor	As Carmen's auxiliary PhD supervisor, Dr Hartz is responsible for the provision of advice, guidance and comments about this research study

2.3.2. Research governance

Poche's Research Advisory Board	Oversight body	Poche's Research Advisory Board is made up of Aboriginal and non-Aboriginal representatives drawn from across the University of Sydney and an Aboriginal community representative from one of Poche's community-driven projects. Professor Tom Calma AO (patron of the Poche Centre) chairs this group. This Board is responsible for overseeing and monitoring the progress of Poche's research scholars, such as Carmen, in their research projects. If required, the provision of advice, guidance and comments about the research study can be provided by the Board.
National Health Leadership Forum (NHLF)	Indigenous reference group	The NHLF is the reference group for this study. It has guided the study's direction and provided advice and support. As previously indicated, the NHLF is a partnership of national Indigenous organisations who represent a united voice on Aboriginal and Torres Strait Islander health and wellbeing with expertise across service delivery, workforce, research, healing, and mental, social and emotional wellbeing.
Informal advisors/mentors	Policy professionals and scholars	This study draws on the knowledge and expertise of several professionals and scholars who have agreed to provide informal advice, guidance and knowledge.

2.3.3. Ethics and ethics approvals

Ethics approvals from the human research ethic committees (HRECs) of the University of Sydney (Project No.: 2018/069) and the Aboriginal Health and Medical Research Council (Reference No.: 1354/17) were secured in May 2018 (see Appendix 4).

2.4. An in-depth analysis of the research context

2.4.1. The national Indigenous public health policy sub-domain

As highlighted in the published research protocol above, the national Indigenous public health policy sub-domain of Australia's national public health policy domain is the study's research community of focus (Baker, 2013).

Australia's public health policy environment consists of (but is not limited to): all levels of government, non-government agencies including international agencies, national agencies, state- and territory-based agencies, private sector organisations, professional health associations, civil society organisations, higher education sector organisations, and consumer groups and associations. There are many actors with competing interests and a diverse range of power dynamics playing out in this policy environment (Buse et al., 2012).

2.4.2. The government policy actors

The Council of Australian Governments

Nationally, the Council of Australian Governments (COAG) is made up of heads of governments and it is:

> The peak intergovernmental forum in Australia. The members are the Prime Minister, state and territory First Ministers and the President of the Australian Local Government Association … COAG was established in 1992 … to manage matters of national significance or matters that need co-ordinated action by all Australian governments (Commonwealth of Australia, 2012a).

COAG meets twice a year, and more frequently when required, for example during coronavirus crisis involving the National Cabinet (Commonwealth of Australia, 2012a).

National agreements concerning national reforms involve all levels of government at COAG. For example, the National Indigenous Reform Agreement 2008 – which set out six Closing the Gap targets – is an agreement between the Commonwealth and state and territory governments. A Commonwealth document outlining the organisation of COAG explains that:

> COAG is supported by inter-jurisdictional, ministerial-level Councils. Collectively these Councils constitute the COAG Council systems *(Commonwealth of Australia, 2012b)*.

In June 2020, the COAG has been replaced by a National Federation Reform Council (Australian Government, 2020). At time of writing, details about such change and its impact on other structures of COAG is limited. However, it would appear that expert taskforces will be established such as the Indigenous affairs taskforce (Australian Government, 2020). As this is a recent change with limited information concerning future operations, for the purposed of this thesis the COAG structure will be described and used as a key national governance structure.

The COAG Health Council (CHC)

The COAG Councils support the work of COAG by offering a mechanism for intergovernmental collaboration and decision-making on areas of national priority such as finance, disability, transport and infrastructure, energy, skills, legal issues, education, health, Indigenous issues, and data and digital issues (Commonwealth of Australia, 2012b).

COAG councils are made up of the ministers who hold portfolio responsibilities for these subject areas. For example, health ministers are members of the COAG Health Council (CHC) (Commonwealth of Australia, 2012b).

Each of these councils has a set of priorities that align with the broader COAG agenda.

The health of Aboriginal and Torres Strait Islander people is one of several priorities of the CHC (NATSIHSC representative, personal communication, 30 August 2019). In addition, each COAG council has an advisory mechanism to further the work of COAG. The CHC is supported by the Australian Health Ministers Advisory Council.

Australian Health Ministers' Advisory Council

The Australian Health Ministers' Advisory Council (AHMAC) brings together the heads of government departments from the Australian Commonwealth, state and territory governments as well as the New Zealand Government (South Australian Government, 2014a). They meet to work on health-related issues of mutual interest.

The AHMAC provides advice to the CHC and supports the Council's work against the COAG's strategic plan (South Australian Government, 2014b). AHMAC is supported by six principal committees, with each of these committees having several sub-

committees that they oversee (South Australian Government, 2014c). The Health Services Principal Committee oversees the work of the National Aboriginal and Torres Strait Islander Health Standing Committee (NATSIHSC).

The National Aboriginal and Torres Strait Islander Health Standing Committee of AHMAC

The NATSIHSC, which I mentioned in Chapter 1 above, is a mechanism that provides opportunities for Commonwealth, and state and territory Indigenous health unit heads to work on mutually agreed national Indigenous policy issues that align with priorities established by COAG (NATSIHSC representative, personal communication, 30 August 2018). The NATSIHSC is a pivotal mechanism of the AHMAC and CHC. It provides advice on a range of strategic nationally focused issues relating to the health of Aboriginal and Torres Strait Islander people.

In my role as the Director for Aboriginal Health in NSW, I chaired the NATSIHSC from 2011 to 2015, which was also the period when the National Aboriginal and Torres Strait Islander Health Plan was developed and launched, and its Implementation Plan was being finalised during this period.

The NATSIHSC remains one of several policy actors who are members of the Implementation Plan's Advisory Group that is responsible for providing oversight of the Health Plan's implementation.

Implementation Plan Advisory Group (IPAG)

The IPAG was initially established to assist in the coordination and implementation of the National Aboriginal and Torres Strait Islander Health Plan. It consists of members from the Commonwealth Department of Health, NHLF members according to their

areas of expertise, and other Commonwealth governmental departments such as the National Indigenous Australian Agency (Commonwealth of Australia, 2019a).

Joint Council on Closing the Gap

In addition to the AHMAC and NATSIHSC, in December 2018 the national government agreed to the establishment of a Joint Council on Closing the Gap. This was a historic moment in Indigenous affairs policy because for the first time the COAG's structure and operations included a formal partnership with Aboriginal and Torres Strait Islander people through their respective representative bodies – known as the Coalition of Peaks. Specifically, it is the first COAG Council that has allowed Aboriginal and Torres Strait Islander people from these peak bodies to sit alongside government officials who are also members of the Joint Council (Commonwealth of Australia, n.d). This Joint Council on Closing the Gap has been responsible for assisting governments with the Closing the Gap Refresh (to be mentioned below). This assistance has included the Council being involved in the compilation of a set of revised targets.

2.4.3. The non-government policy actors

The Close the Gap Indigenous Health Campaign – the people's movement

The Close the Gap Indigenous Health Campaign (the People's Movement Campaign) originated from the Aboriginal and Torres Strait Islander Social Justice Commissioner's 2005 Report (Human Rights and Equal Opportunity Commission, 2006). The then Commissioner, Professor Tom Calma AO, wrote in his letter to the than Attorney-General, Phillip Ruddock dated 22 November 2005 that the report

> analyses the current approach to Aboriginal and Torres Strait Islander Health and proposes a campaign to achieve equality in health status *(Human Rights and Equal Opportunity Commission, 2006)*.

According to the Human Rights Commission (2019) the Campaign is:

> a collective of … Australia's peak Indigenous and non-Indigenous health bodies, NGOs and human rights organisations that are … working together to achieve equality in health and life expectancy for Aboriginal and Torres Strait Islander peoples (n.d).

This coalition is one of several policy actor forums of the Indigenous public health sub-domain.

The efforts of the Campaign were the catalyst for a national statement of intent agreed to by the Rudd Government and the Leader of the Opposition, Brendan Nelson, in partnership with the members of the Campaign in March 2008 (Australian Human Rights Commission, 2008b, 2019). Later in the same year, the COAG:

> set measurable targets to track and assess developments in the health and wellbeing of Aboriginal and Torres Strait Islanders. These targets include achieving Aboriginal and Torres Strait Islander equality within a generation and halving the mortality rate gap for children under five years old within a decade.

Unfortunately, twelve years on, some of the COAG National Indigenous Reform health, education and employment targets are not on track, with only a few being met. I highlight this issue in the CTG Refresh article included in Chapter 1.

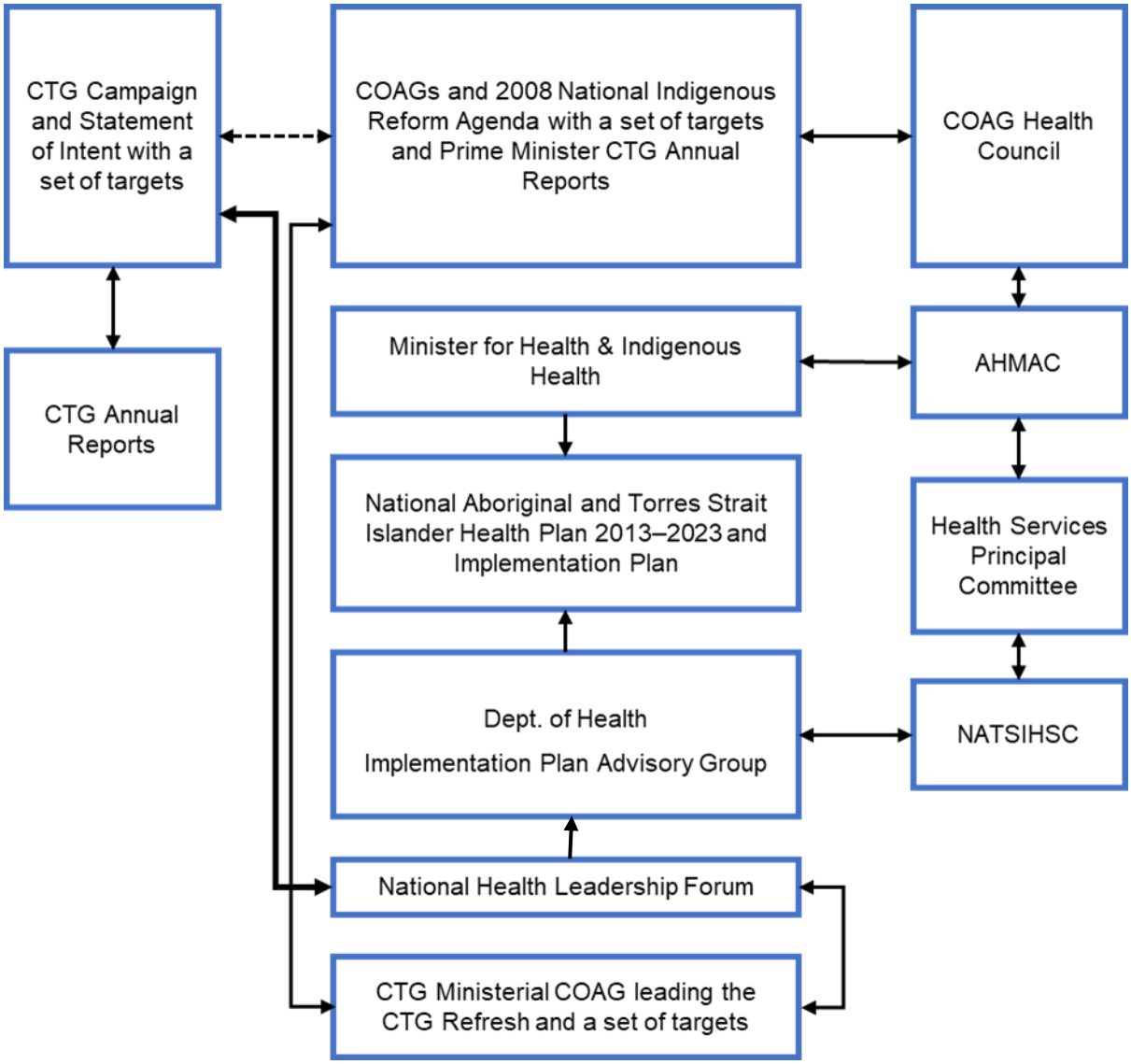
The National Health Leadership Forum

The National Health Leadership Forum (NHLF) is a collective of Australia's national peak Aboriginal and Torres Strait Islander national health bodies. I also mention this group in the research protocol article as being one of several policy actors of the Indigenous public health policy sub-domain of Australia's public health policy domain. I refer to this group in Chapter 1 and they later became the study's reference group.

In fact, the NHLF is a critical policy actor that has led the development of the Health Plan's consultations in collaboration with the First Peoples National Congress and the Australian Government. They have remained a critical partner over the course of the Plan's implementation, including leading the policy work in relation to culture as a determinant of health.

The abovementioned government and non-government bodies made up of many policy actors, interact within the Indigenous public health sub-domain of the national public health policy space. These policy actors have been drawn from this domain to participate in the research study, which is summarised in the following diagram.

Figure 2: Policy actors of the national Indigenous public health policy sub-domain and their relationships to the Health Plan



The diagram provides a visual representation of the policy actors in the Indigenous health public policy sub-domain and their relationships to the Health Plan. In this sub-domain there are diverse layers of diverging views, interests and political persuasions. They relate to governmental interests, community interests, professional interests and broader public health interests in what remains a highly politicised space. The Indigenous public health policy sub-domain is one of many sub-domains (Baker, 2013).

Beyond the scope of this study are the many layers and other policy actors of the broader Australian political public policy environment.

2.5. International Indigenous health policy environment

In the sections to follow, a historical overview of the key national Aboriginal and Torres Strait Islander health policy commitments will be provided for three main purposes. Firstly, to provide a historical context concerning the rise of Indigenous public health policy commitments generated at the national level by governments that was inspired by policy actor's stories. Secondly, to trace the rise in the attention given to culture and its present-day visibility in references to cultural determinants, including culture's interplay with racism. Finally, to clarify how the current research study fits within the broader policy work that is underway. Before I present the historical overview, however, I provide an overview of the international policy context that reinforces an approach to the health of Indigenous peoples that upholds their right to be self-determining, particularly in the practice of their cultures and knowledges.

2.5.1. The international policy context

Internationally, by the early 1980s the United Nations (UN) began proceedings designed to protect the interests of Indigenous peoples globally. The level of discrimination and injustice being experienced by Indigenous people worldwide had been highlighted by the Cobb report that became a catalyst for global action for change (as cited in United Nations, 2014).

At the time that I entered the Aboriginal health NSW public policy arena, efforts to have an international declaration of the rights of Indigenous people were well underway. Unfortunately, significant delays had been experienced because some nation states

had concerns about acknowledging the rights of Indigenous people to be self-determining and in control of their affairs. Some of these concerns were related to the rich resources available on their lands. Nevertheless, the UN work continued to progress the development of a Declaration of the Rights of Indigenous Peoples. The UN declared an International Decade of the World's Indigenous Peoples from 1994–2004. In December 2004, the UN General Assembly declared a second International Decade from 2005–2015. By 2007, most nation states of the UN General Assembly endorsed the Declaration of the Rights of Indigenous Peoples. However, Australia, New Zealand, Canada and America did not, with 11 other countries abstaining (United Nations, 2007).

Following the election of the Rudd Government in 2007, the Declaration of the Rights of Indigenous People was finally endorsed on 3 April 2009. As Professor Tom Calma indicated, the endorsement by the Australian government of the Declaration of the Rights of Indigenous Peoples was a watershed moment that reset the relationship between Indigenous peoples and governments, and created an opportunity for governments in Australia to lead the world in how nations relate to and work with Indigenous peoples (Australian Human Rights Commission, 2008a, 2009).

2.5.2. The Declaration of the Rights of Indigenous Peoples

The Declaration of the Rights of Indigenous Peoples provides a framework for nation states such as Australia to respect Indigenous peoples and honour their right to be self-determining in how they conduct their lives and run their affairs (United Nations, 2007). Importantly, the Declaration asserts that "respect for indigenous knowledge, cultures and traditional practices contributes to sustainable and equitable development" (United Nations, 2007, p. 2). Further, Article 3 of the Declaration states:

> Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development (United Nations, 2007, p. 8).

Article 31 states:

> Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts (United Nations, 2007, p. 22).

and goes on to affirm:

> They also have the right to maintain, control, protect and develop their intellectual property over such cultural heritage, traditional knowledge, and traditional cultural expressions (United Nations, 2007, pp. 22 - 23).

The Declaration of the Rights of Indigenous People remains the international policy instrument to enact the knowledges and cultures that are held by First Nations peoples such as the Aboriginal and Torres Strait Islander peoples of Australia. Importantly, the Declaration is supported by other UN international human rights conventions and instruments such as the International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of All Forms of Racial Discrimination (Australian Government, 2019).

The Astana Declaration is an international policy instrument that also provides opportunities to bring into practice Indigenous cultural ways of being, cultural ways of

knowing and cultural ways of doing (World Health Organisation & United Nations Children's Fund, 2018, p. 8) .

Whilst attending the World Health Organisation's (WHO) Global Conference on Primary Health Care in October 2018 in Kazakhstan, I was witness to a global renewal of the charter on Primary Health Care (PHC) – the Astana Declaration. Astonishingly, the Astana Declaration reinforced the relevance and value of traditional knowledge and traditional medicines. This international instrument legitimises traditional medical practice and affirms the value and contribution that the practices of traditional medicines have in the health of Indigenous Australians (World Health Organisation & United Nations Children's Fund, 2018).

Unfortunately, international instruments such as these have proven to be difficult to apply in nation states such as Australia (Panzironi, 2013). A participant in this study's yarning workshop said:

> *We talk about a rights-based approach in policy all the time and we invested in the [Health Plan's] Implementation Plan … so, what does that look like in practice and ... It's about us asserting our rights and self-determining what that future is but there's no real capacity within a government framework to actually do that (policy actor representative, 12 December 2019).*

In recent years, Australia has seen the rise of traditional healers who practice traditional medicines. The Ngangkri healers of South Australia have been mentioned in Chapter 1 CTG article including by a policy actor in Chapter 4.

However, when considering the status of Aboriginal traditional medicine in Australia:

> Australia sits at the end of that spectrum occupied by countries in which the policy process on TM [traditional medicine] has not yet started (Panizironi, 2013, p. 15).

Some of the stories told by policy actors (in Chapter 4) in yarning sessions also support this view. Panizironi (2013) argues that her assessment:

> Is grounded on the analysis of data provided in the international literature which exclusively refers to the legal recognition, regulation and financing of Chinese traditional medicine in Australia, but has no relation whatsoever to the only traditional medical system which fulfils the WHO's [World Health Organisation's] definition of TM in Australia, that is Aboriginal traditional medicine (p. 15).

The WHO's (2013) definition of TM states that traditional medicine:

> Is the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to the different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness (p. 15).

The WHO (2013), in their TM Strategy 2014–2023, also define complementary medicine (or alternative medicine), which is often the term used in Australia:

> [as] a broad set of health care practices that are not part of that country's own tradition or conventional medicine and are not fully integrated into the dominant health-care system. They are used interchangeably with traditional medicine in some countries (p. 15).

While these international instruments acknowledge the right of the Earth's 370 million Indigenous people to practise their knowledges and cultures, disturbingly they remain

the sickest and most disadvantaged populations with the lowest life expectancy rates when compared with their non-Indigenous counterparts.

A global population study on Indigenous and tribal peoples' found significant inequities in life expectancy between Indigenous people and the general populations (Anderson et al, 2016). The life expectancy for Maasai in Kenya is 43.5 years compared to 56.6 years for other Kenyans – a gap of 13.1 years (Anderson et al., 2016). The Baka in Cameroon have a gap of 21.5 years, with a life expectancy of 35.5 years compared to 57 years for other Cameroons (Anderson et al., 2016). The Inuit from Greenland have a life expectancy of 70.3 years compared to 79.5 years for the general population – a 9.2 gap in life expectancy (Anderson et al., 2016). In Australia, there is a life expectancy gap of 10 years for Aboriginal and Torres Strait Islander people compared to other Australians (Anderson et al., 2016). While the life expectancy gap between Maori and other Aotearoa New Zealanders is 7 years (Anderson et al., 2016).

These appalling statistics raise the question of whether nation states' public policies can support the rights of Indigenous peoples to practise their knowledges and ways of being, knowing and doing. Clearly, there is a mismatch between rights-based approaches to public policy and public health policies designed to address the poor health status of Indigenous people such as Australia's Aboriginal and Torres Strait Islander people.

2.6. Key Australian public health policy commitments – 1989 to March 2020

In this section, I provide some historical context to investigate how culture as a determinant of health has become embedded into public policy instruments as we know them today. History has its place, as pointed out by one policy actor:

> *So, the [Health] Plan was happening at a really interesting time … it opened my mind – eyes up into more history (P6, July 2018).*

Understanding the historical context is important because it sheds light on present-day factors. As one participant of the yarning sessions said:

> *We still have the One-Australia policy … so it's looking at it from a longer-term, historical point of view (P5, June 2018).*

In the following figure, I have summarised the key national public health policy commitments in relation to Indigenous Australians since 1989.

Figure 3: Trajectory of Australia's national Indigenous health policies from 1989 to the March 2020.

Year	Policy commitment	Timeframe
1989 - 2003	A national Aboriginal health strategy prepared by the National Aboriginal Health Strategy Working Party	14 years
2003 - 2013	National Strategic Framework for Aboriginal & Torres Strait Islander Health 2003-2013 and Implementation Plan 2007-2013	10 years
2005 - 2006	Aboriginal and Torres Strait Islander Social Justice Commissioner 2005 Report	
2008	Close the Gap National Summit and National Statement of Intent between peak community bodies, health professional bodies and Australian Government	
2008 - 2013	Council of Australian Government's National Indigenous Reform Agenda with Indigenous Health National Partnership Agreements	
2013 - 2023	Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013-2023 and Implementation Plan 2015-2018	7 years
2017	'My Life My Lead' National Consultation on the cultural determinants and social determinants of health for the National Aboriginal and Torres Strait Islander Health Plan.	
2013 - 2017	Abbot Government's Closing the Gap response, including the Closing the Gap Refresh	
2018	Morrison Government's CTG Refresh response	
2018 - 2020	Second Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan	
Total number of years of national government policy interventions		31 years

The above list involves key national Indigenous health public policies. Many other Indigenous affairs policies such as housing or education also play out in the Australian public policy environment. Additionally, other mainstream non-Indigenous policies such as fiscal and economic policies for example also interact in this national public policy environment as does international policy commitments such as climate change or human rights conventions (to be discussed shortly). However, these are beyond the scope of the present study.

Recently, all levels of government have agreed to a new national Closing the Gap Agreement that I write about briefly in the CTG refresh, section 2.6.7 below. This Agreement is not included in Figure 3 above. Although, in Chapter 7 I write about such an agreement in my concluding remarks. Nevertheless, the following section will now describe each of the key national Indigenous health public policies listed in Figure 3.

2.6.1. The 1989 National Aboriginal Health Strategy

The above figure commences with the landmark 1989 National Aboriginal Health Strategy (the Strategy). One policy actor, when referring to culture and racism being a game changer for Indigenous policy, went on to say:

> *When I say it's a game changer what I actually need to do is acknowledge that the 1989 original version of the National Aboriginal Health Strategy … says that Aboriginal health is not just about the well-being of individuals but refers to the social, emotional, and cultural well-being of the whole community in which each individual is able to fulfil their potential as a human being there by bringing about the total well-being of the community … so that was 1989 (P4, June 2018).*

The Strategy was the first nationally focused, comprehensive, public-health policy response that articulated what actions were necessary to address the health of Indigenous Australians. Calls for a partnership approach between governments and communities were central to the Strategy, which included a range of structural reforms and research priorities that were needed to address the specific health needs of Indigenous Australians (National Aboriginal Health Strategy Working Party, 1989). Inter-sectoral collaboration was paramount if the social determinants of health such as employment, education and the environment were to be addressed (National Aboriginal Health Strategy Working Party, 1989).

Significantly, the Strategy highlighted the differences in worldviews between Indigenous Australians and non-Indigenous western models of health. Specifically, the Strategy stated that:

> Aboriginal culture is the very antithesis of Western ideology. The accent on individual commitment, the concept of linear time, the switch in focus from spiritual to worldly, the emphasis on possession and the pricing of goods and services, the rape of the environment and, above all, the devaluing of relationships between people, both within families and within the whole community, as the determinant of social behaviour, are totally at variance with the fundamental belief system of Aboriginal people. Health to Aboriginal people is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity (National Aboriginal Health Strategy Working Party, 1989, p. ix).

To explain cultural ways of being (ontology), cultural ways of knowing (epistemology) and cultural ways of doing (axiology), the Strategy went on to say:

> Medical practitioners must attempt to understand some of the concepts of health, cultural background and the history of oppression that Aboriginal people have faced. Much more understanding could be gained by medical practitioners, if they would get to know Aboriginal people, develop mutual trust and respect, and show their acceptance of Aboriginal ways (National Aboriginal Health Strategy Working Party, 1989, p. 132).

The Strategy adds that:

> such knowingness needs to be built into health professionals' educational programs in drawing their attention to the … relevance of cultural, traditional, political, and socio-economic factors of Aboriginal history and Aboriginal society to Aboriginal health and well-being (National Aboriginal Health Strategy Working Party, 1989, p. 132).

The Strategy Working Party called for a national assessment of Aboriginal cultural and social well-being. This assessment must be led by community:

> who commonly pointed to their collective and individual desire and capacity to assert their identity as indigenous people, their right to be free from racism and their dissatisfaction with 'their lot' as barriers to the achievement of good health (National Aboriginal Health Strategy Working Party, 1989, p. 230).

Further, the Strategy stated that:

> such a national assessment [should apply] … subjective and qualitative indicators … of cultural and social wellbeing (National Aboriginal Health Strategy Working Party, 1989, p. 230).

Thirty-one years on, Australia still does not have these subjective and qualitative indicators of cultural and social wellbeing, despite the efforts of the Overcoming Indigenous Disadvantage report that commenced consideration of cultural indicators in the early part of 2000s, when I worked for the Aboriginal Justice Advisory Council. Similarly, while I was working in NSW Health, national attempts were being made by the Australian Health Minister's Advisory Council's Aboriginal and Torres Strait Islander Health Performance Framework regarding community functioning indicators. Such early work proved to be a challenge though.

By 1994, an evaluation of the Strategy found very little evidence of it being implemented, and called on governments to re-commit to the principles espoused in the 1989 National Aboriginal Health Strategy (National Aboriginal and Torres Strait Islander Health Council, 1994).

2.6.2. The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013

In response to the NAH's evaluation of the Strategy, the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013 (National Aboriginal Torres Strait Islander Health Council, 2003) and its Implementation Plan 2007–2013 (Strategic Framework) (Commonwealth of Australia, 2007) were introduced. The Strategic Framework represented an overarching policy initiative that continued to provide directions as to how the health of Aboriginal and Torres Strait Islander people

should be addressed across jurisdictional boundaries (Commonwealth, State & Territory Governments) and in partnership with community.

The Strategic Framework describes culture in the following way:

> Aboriginal cultures are numerous and diverse, made up of hundreds of different kinship and language groups that have adapted to enormously diverse living conditions throughout Australia over many thousands of years. Torres Strait Islanders are a separate people with distinct identity and culture. Aboriginal cultures and Torres Strait Islander cultures are still dynamic and evolving and, for Aboriginal and Torres Strait Islander individuals and community, form the context for the development of health policy (National Aboriginal and Torres Strait Islander Health Council, 2003, p. 3).

And, further that:

> [the] sense of grief and loss experienced by generations of Aboriginal and Torres Strait Islander peoples in relation to dispossession, to the disruption of culture, family and community and to the legislated removal of children has contributed to ongoing problems in emotional, spiritual, cultural and social well-being for Aboriginal and Torres Strait Islander individuals, families and communities (National Aboriginal and Torres Strait Islander Health Council, 2003, p. 5).

Racism is referred to twice in the Strategic Framework as a risk factor and a barrier to access to services (National Aboriginal and Torres Strait Islander Health Council, 2003, pp. 3, 68).

The 2007–2013 Implementation Plan for the Strategic Framework referred to culture in the statement of its overarching goal:

> To ensure that Aboriginal and Torres Strait Islander peoples enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice (Commonwealth of Australia, 2007, p. 1).

But this is the only time that culture is mentioned, while racism is mentioned twice in the context of social and emotional wellbeing (Commonwealth of Australia, 2007).

2.6.3. 2005 Aboriginal and Torres Strait Islander Social Justice Commissioner Annual Report

During the course of the development of the Strategic Framework, and in 2005, the Aboriginal and Torres Strait Islander Social Justice Commissioner, Professor Tom Calma AO, released his annual report - Achieving Aboriginal and Torres Strait Islander health equality within a generation: A human rights-based approach" (Human Rights and Equal Opportunity Commission, 2006).

Calma's report called on the Australian Government to take immediate action given the health crisis that was being experienced by Aboriginal and Torres Strait Islander people and their communities (Human Rights and Equal Opportunity Commission, 2006, p. iii). In his opening remarks Calma wrote:

> Improving the health status of Aboriginal and Torres Strait Islander peoples is a longstanding challenge for governments in Australia. While there have been some improvements since the 1970s, overall progress has been slow and inconsistent. The inequality gap between Aboriginal and Torres Strait Islander peoples and other Australians remains wide and has not been significantly reduced … the overall data remains bleak and shows only slow improvements in

some areas of health status, with no progress on others over the past decade (Human Rights and Equal Opportunity Commission, 2006, p. 1).

In 2006, a Close the Gap coalition (the CTG coalition), consisting of highly influential Indigenous and non-Indigenous community and professional bodies, was established (Australian Human Rights Commission, 2008b). Together with over 200,000 signatories, the CTG coalition urged the Australian Government to act urgently and tackle the crisis of Indigenous health. The Government then entered into a national statement of intent with the CTG coalitions (Australian Human Rights Commission, 2008b).

2.6.4. The Close the Gap National Health Equality Statement of Intent

In March 2008, the Rudd Government signed the National Health Equality Statement of Intent (the Statement) that marked a new era for Indigenous health (Australian Indigenous HealthInfoNet, n.d). This led to the development of a set of targets aimed at addressing the inequities in health, education and employment, including the social, economic and political inequalities that Indigenous Australians were experiencing (Human Rights and Equal Opportunity Commission, 2008).

The Statement aimed “to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and their non-Indigenous Australians by year 2030” (Australian Human Rights Commission, 2008b, p. 1). The Statement highlighted the need to address the social determinants of health, and to build the capacity of the primary care sector as well as support and develop the Aboriginal community-controlled health services (Australian Human Rights Commission, 2008b). The Statement also mentioned requiring mainstream services to improve their access and achieve desired outcomes for Indigenous Australians (Australian Human Rights

Commission, 2008b). The investigation of what works and why became an imperative, as did the introduction of measuring, monitoring and reporting (Australian Human Rights Commission, 2008b). The Statement concluded that a rights-based approach must underpin these efforts that aligned with the aspirations of International human rights conventions of the United Nations, including the Declaration of the Rights of Indigenous Peoples (Australian Human Rights Commission, 2008b).

As a rights-based policy instrument, the Statement continued to support the need for Indigenous Australians to achieve parity with other Australians and also to "enjoy living conditions that support their social, emotional and cultural well-being" (Australian Human Rights Commission, 2008b, p. 1).

The CTG coalition presented to governments a set of national Indigenous health equality targets (Human Rights and Equal Opportunity Commission, 2008). These targets relate to addressing the high rates of Indigenous child mortality and the multiple chronic disease issues that contribute to a lower life expectancy. However, there is barely a mention of culture and racism in the document that contains these targets.

2.6.5. The Council of Australia Government's National Indigenous Reform Agenda – Closing the Gap

By November 2008 the Rudd Government obtained agreement from the Council of Australian Governments (COAG) to a wide ranging National Indigenous Reform Agenda (NIRA) known as the Closing the Gap program (Holland, 2018). I write about the NIRA commitment to the health, education and employment targets in the Closing the Gap Refresh article contained in Chapter 1.

The health targets related to closing the life expectancy gap in a generation and halving the gap in infant mortality rates in a decade became the responsibility of the COAG Health Council.

In 2008, I re-entered the Indigenous health policy environment in NSW just after COAG's NIRA was signed by all governments. As Director for Aboriginal Health in NSW, I was responsible for coordinating and implementing the life expectancy and infant mortality responses to Closing the Gap on behalf of the NSW Government via the Indigenous Health National Partnership Agreement.

There remained no mention of culture or racism in these policy responses.

2.6.6. The Indigenous Health National Partnership Agreements

As a demonstration of COAG's NIRA commitment, each state and territory government signed an Indigenous Health National Partnership Agreement (NPA) with the Commonwealth Government for a period of four years. The NPAs set the policy context for closing the health gap (Commonwealth of Australia, 2019b). These NPAs further supported the COAG NIRA CTG objectives with a $1.58 billion investment over a period of five years.

A 2013 review of the NPAs indicated that to measure successful outcomes against the investment provided by the Commonwealth and the state and territory governments, further time was needed for health improvements to be realised. The review also made a strong recommendation that the investment should continue (Commonwealth of Australia, 2013).

However, with the arrival of the new Coalition Government in 2013, the Closing the Gap commitments were eroded, with an estimated $534 million diverted, primarily to

what became known as the Indigenous Advancement Strategy (IAS) (Commonwealth of Australia, 2017). The Close the Gap Campaign Steering Committee's ten-year review of the Close the Gap strategy reported that:

> The IAS consolidated more than 150 individual programmes and activities, many previously components of the NPAs, into five broad-based program streams coordinated from the Department of Prime Minister and Cabinet (Holland, 2018, p. 25).

Funding decisions were now driven by supply as opposed to what the demand was, and the introduction of a competitive tendering process began:

> The Indigenous affairs priorities of the Federal Government were recalibrated in 2014 as 'getting your children to school; getting adults to work; and building safer Indigenous communities' (Holland, 2018, p. 25).

The Strategy had in recent years proved to be controversial after the Commonwealth Auditor General uncovered significant flaws in the administration of the funding and financial accountabilities of the IAS (Commonwealth of Australia, 2017).

The Closing the Gap Strategy had been effectively abandoned by the Coalition Government and:

> [it] persists in name only with the closing the gap targets being used to measure 'national progress being pursued by fragmented jurisdictional effort, with no national leadership (Holland, 2018, pp. 22, 26).

The health components of Closing the Gap were moved into the Indigenous Health Advancement Program managed by the Commonwealth Department of Health's Indigenous Health Division (Holland, 2018).

Culture and racism remained invisible in these policy commitments.

During this period the Health Plan had been developed and launched by a Labour Government in 2013 and its implementation plan was launched by a Coalition Government in 2015 (see below).

2.6.7. The Closing the Gap Refresh

Based on the slow progress in meeting the initial health, education and employment targets, by December 2016 COAG formally agreed to a refresh of the Closing the Gap NIRA, with national consultations occurring in 2017 through to the early part of 2018 (Australian Indigenous HealthInfoNet, n.d). These national consultations sought input from stakeholders about what was required to reset the policy agenda of Closing the Gap. Importantly, the discussion paper used to inform conversations about a refreshed Closing the Gap contained five questions, with one of these questions asking "Should Aboriginal and Torres Strait Islander culture be incorporated in a Closing the Gap Refresh? How?"

I was involved in some of the CTG Refresh national consultations when I was on the Public Health Association of Australia board, advising them on national policy issues (from 2015 to 2019). Also, when undertaking some outside earning activities for the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, I represented them at the 2018 CTG refresh national forum, along with their chairperson, to discuss

the CTG refresh and its new targets. At this meeting, despite community calls, culture was not considered for inclusion in any refreshed policy framework for the CTG.

The call for the inclusion of culture in a refreshed Closing the Gap was a consistent message in all consultations, yet such calls fell on deaf ears, and a complete absence of culture in a revised national Indigenous affairs policy platform was evident.

Since the initial Closing the Gap Refresh was announced and commenced, Australia has seen three new prime ministers: Tony Abbott, Malcom Turnbull and Scott Morrison. In the latter part of 2018, the Morrison government made significant commitments concerning the Closing the Gap prior to a national election.

Following the national election, the Morrison Government made additional commitments concerning the Closing the Gap Refresh. Remarkably, agreement was reached to work with a national coalition of Aboriginal and Torres Strait Islander peaks, who became members of the historic Closing the Gap Ministerial Council of the CAOG policy and operational structures (mentioned above). Also, in a significant step forward for Australia, the Honourable Ken Wyatt became the first Aboriginal person to be appointed as the Minister for Indigenous Affairs, with oversight responsibility for national Indigenous affairs policies.

On 31 July 2020, the Prime Minister, Minister Wyatt and Pat Turner (Chair of Coalition of Peaks) launched a new national agreement on closing the gap, with 16 targets in relation to health, education, employment, wellbeing, justice, housing, land and waters, and languages (Australian Government, 2020). This was also a historic moment because the new agreement prioritises Aboriginal and Torres Strait Islander cultures and their importance for achieving improvements in health and wellbeing. The agreement states:

> Parties agree to implement all activities under this agreement in a way that takes full account of, promotes, and does not diminish in any way, the cultures of Aboriginal and Torres Strait Islander people (Australian Governments, 2020, p. 4).

Cultural factors are embedded throughout the agreement, with references to aspects of culture such as language and connection to country (Australian Governments, 2020).

Additionally, for the first time a national policy signed by all governments referred to institutional and systemic racism with a transformational goal of identifying and eliminating racism (Australian Governments, 2020).

2.6.8. The National Aboriginal and Torres Strait Islander Health Plan 2013–2023 – re-visited

In 2013, the National Aboriginal and Torres Strait Islander Health Plan was released by Minister Snowden, the then Minister for Indigenous Health in the Gillard-Rudd Governments, just prior to the 2013 national election process.

In 2013 I was still the chair of the NATSIHSC of AHMAC and recall the highly political environment when the launch of the Health Plan occurred just prior to the Commonwealth's caretaker conventions in the lead-up to the election.

To release the Health Plan prior to the national election was a significant achievement. As expressed by a yarning session participant, to have culture and racism in the Health Plan was:

absolutely amazing in that it is the first national framework that I think recognises two things: one is culture at the heart of the Plan, and the other is racism … I think that that is a first for a Commonwealth Government to acknowledge racism in a framework. So, getting these two things has been a game changer in health for dialogue of health in a lot of ways (P4, June 2018).

Culture's central position in the Health Plan affirms its significance, although culture's portrayal is questionable, as was confirmed by a policy actor:

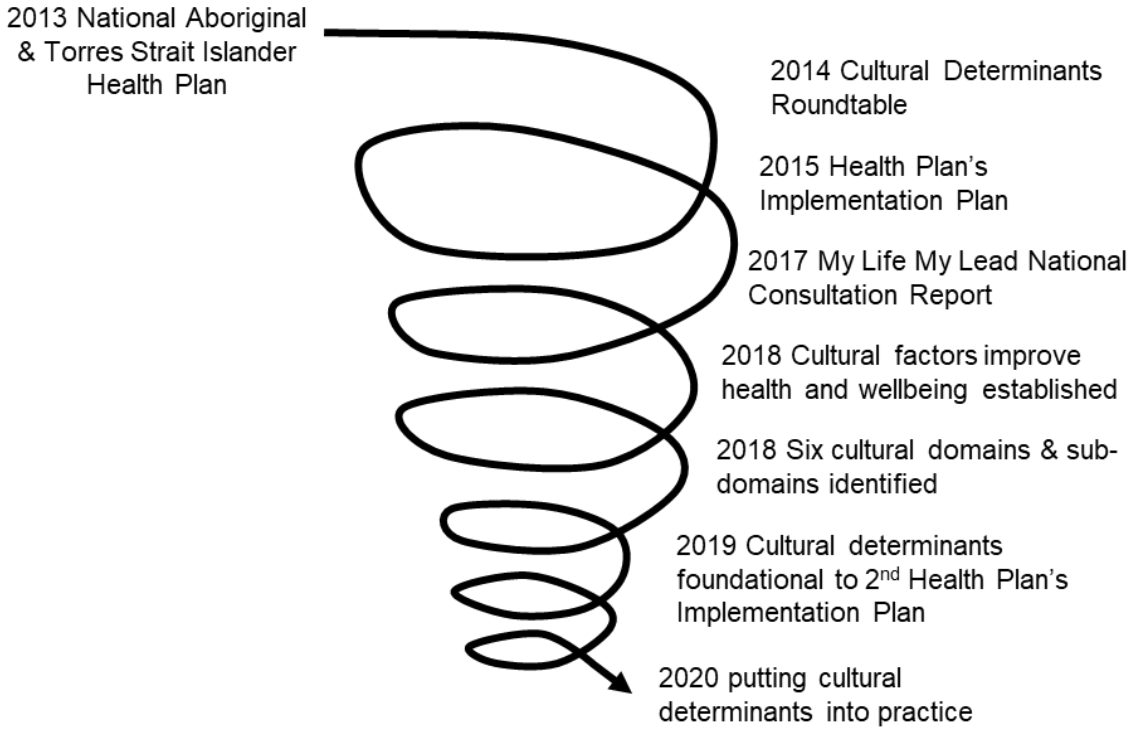
The Plan itself doesn't interrogate [culture] in any great detail and it signals the need for further work to be done (P21, December 2018).

This is when culture as a determinant of health became increasingly prominent following the launch of the Health Plan.

2.7. The rise of culture as a determinant of health

Since the Health Plan's inception, a significant amount of policy work involving rigorous and intellectual interrogation has led to a stronger understanding of culture as a determinant of health. This work is summarised below in Figure 4 in what is being termed as a policy analysis spiral. This figure is based on Creswell's data analysis spiral (Creswell, 2013, p. 183).

Figure 4: The policy analysis spiral relating to the rise of culture as a determinant of health



The policy analysis spiral identifies the critical pieces of work that have occurred since the release of the Health Plan in 2013. It is a representation of the swirling nature of the formulation of a policy position in response to a policy issue.

The limitations of the references to culture in the Health Plan meant that a policy issue existed. The Aboriginal and Torres Strait Islander health leaders understood the challenge they faced, and then played an instrumental role in formulating a policy response. It is a policy response that has meant culture as a determinant of health is well considered and is now embedded into the Health Plan's (second) Implementation Plan for 2020 (Department of Health, 2019). The following commentary provides an overview of the rise of culture as a determinant of health.

2.7.1. The 2014 Lowitja Institute Cultural Determinant Roundtable

Professor Ngiare Brown argues that:

> Cultural determinants originate from and promote a strength based perspective, acknowledging that stronger connections to culture and country build stronger individual and collective identities, a sense of self-esteem, resilience, and improved outcomes across the other determinants of health including education, economic stability and community safety (cited by The Lowitja Institute, 2014b, p. 2).

However, very little was known about Indigenous culture when it was included as a determinant of health (The Lowitja Institute, 2014b). So, in 2014, a Lowitja Institute Roundtable (the Roundtable) on culture and the cultural determinants of health was held. Bond and Brough (2004) reaffirm the difficulties of understanding culture in a public health context by pointing out that:

> Interest in culture has traditionally been the domain of anthropology, sociology and, more recently, cultural studies, rather than medicine and public health (p. 229).

They argue that:

> [The] public health literature generally offers very little in the way of meaningful understandings of the culture concept … the idea of culture tends to be employed uncritically, with reliance on assumed understandings of culture and the cultural practices implicated in health (Bond & Brough, 2004, p. 229).

They add that:

> Culture within a public health context is constructed … within the context of race and ethnicity as the foundation for public health's imagination of Aboriginal and Torres Strait Islander culture (Bond & Brough, 2004, p. 230).

While acknowledging that further work was required, Bond and Brough (2004) conclude that:

> Conceptually, research remains restricted to the study of cultures, and rarely engages in the culture concept itself and how it matters to health. Without this deeper reflection, culture is static and stereotypical, disguising as much as it reveals. Much of the public health rendering of Aboriginal and Torres Strait Islander culture is not concerned with how it matters to Indigenous people, but rather how it matters to risk-factor epidemiology. Culture then becomes little more than a branding device to denote research amongst cultural 'others' (p. 235).

The Roundtable highlighted the need for further research on:

1. The ownership and ethical management of, and interpretation of research on, culture and cultural determinants
2. Describing culture and articulating the cultural determinants of health
3. Examining examples of good practice about the positive impacts of culture on health and wellbeing, and the impact of racism
4. Culture's relationship to those protective factors to improvements in health and wellbeing (The Lowitja Institute, 2014a).

A fundamental question here is: 'What are the system-level changes required to better enable culture to have a positive impact on health?' (The Lowitja Institute, 2014a, p. 6). System-level changes are what this present research study will be recommending, and they will be further discussed in Chapter 5 in relation to a systemwide translational model of practice that has been developed as a result of my study.

2.7.2. The Health Plan's 2015 Implementation Plan

By 2015, cultural determinants of health, along with social determinants, had become a domain in the Health Plan's (first) Implementation Plan (Department of Health, 2015). Culture, however remained undefined. The federal government's published response to the consultation on the social and cultural determinants of health – My life my lead - attempted to bring further meaning and understanding to the concept of culture (Australian Government, 2017). Culture as an enabler of health continued to be reinforced (Australian Government, 2017).

2.7.3. Culture's relationship to improvements in health and wellbeing confirmed with six cultural domains identified

As mentioned in the published research protocol, a 2018 evidence review found that improvements to the health and wellbeing of Indigenous Australians had an association with cultural factors (Bourke et al., 2018). In 2018, six cultural domains were identified in another literature review (Salmon et al., 2018), and mentioned in the above research protocol. These six cultural domains have now been included in the most recent iteration of the Health Plan's (second) Implementation Plan national consultations for 2019 – 2020 (Department of Health, 2019).

2.7.4. Implementing the cultural determinants of health

Finally, the Commonwealth Health Department commissioned the development of an implementation framework aimed to put culture and cultural determinants into practice with a formal policy response imminent (policy actor representative, 12 December 2019). My research study will add value to this commissioned work because the study offers strategies to support implementation of culture as a determinant of health.

The last seven years have seen the rise of an awareness of culture as a determinant of health. Thus, efforts to bring meaning and understanding to culture has progressed significantly, and it is the implementation of culture and its determinants of health that is the subject of this study. Although, in Chapter 4 I explore the need to reframe culture so that it is understood by those who make policies related to Indigenous public health.

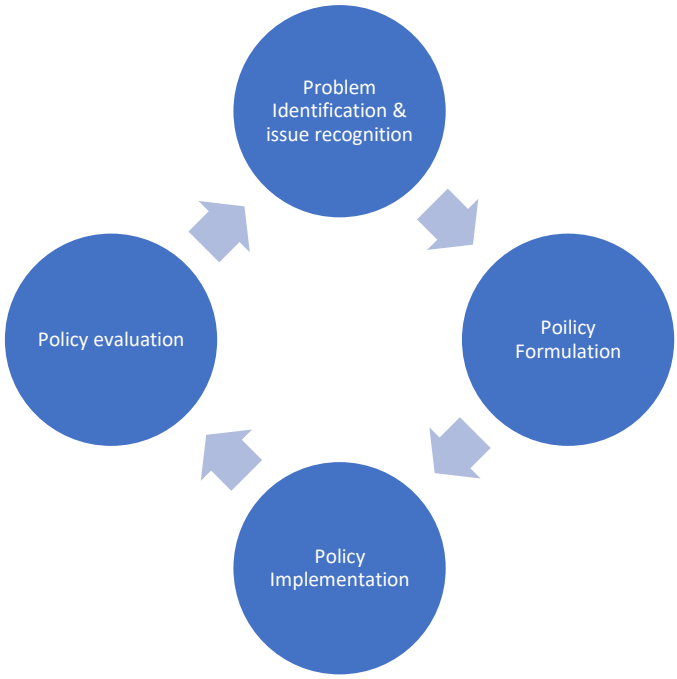
So, given the above analysis, where does my research study fit within the present policy environment? And most importantly: How can its findings contribute to furthering the policy formulation that is currently underway, particularly in relation to implementing responses to the cultural determinants of health.

The latter aspiration is a responsibility that I have as an Indigenous researcher. It is a responsibility to respectfully give back to those who have supported this research study, and to give homage to community. I write about these responsibilities in Chapter 3.

2.8. Situating the study into the current policy environment

To explain how my present research study fits into the current policy environment, I will use Buse et al.'s policy cycle (2012, p.13).

Figure 5: The policy cycle

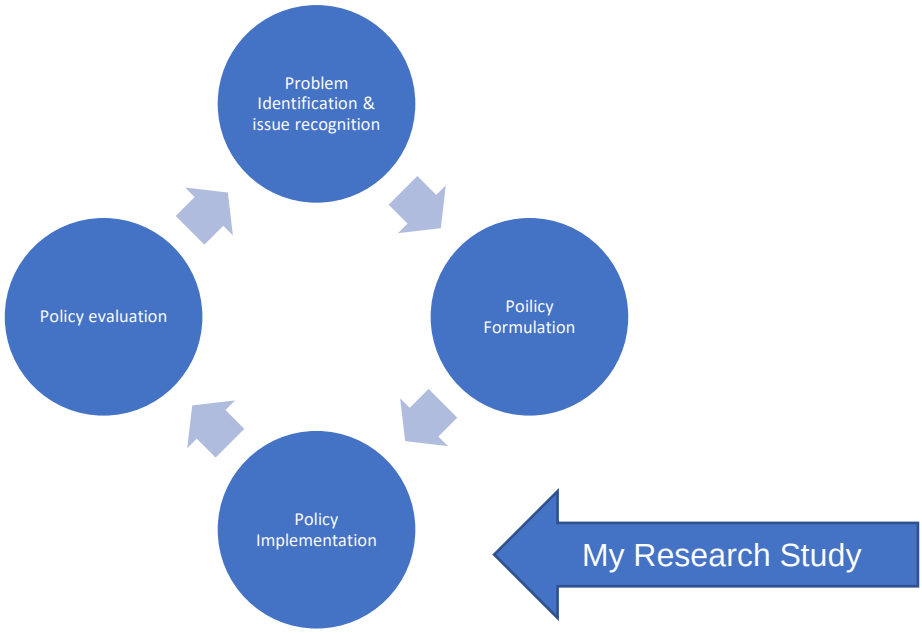


Source: Buse et al. (2012, p.13)

The identification of a policy issue and the formulation of a policy response has been discussed in the preceding section and are the first two stages of the policy cycle.

The third stage of policy development concerns implementing a policy response. The unpublished commissioned work concerning implementation of the cultural determinants of health (policy actor representative, personal communication, December 2019) is critical at this point. Similarly, my study is also about implementation, and will be vital to the future work about implementing the cultural determinants of health, as indicated in the representation of the policy cycle below.

Figure 6: Positioning of my research study at the policy implementation stage



Source: Buse et al. (2012, p.13)

Implementation concerns how policy makers in governments implement or give effect to culture now that it's firmly become a determinant of health. Also, otherwise known as the 3Es of implementation: enable, embed and enact. I introduce these processes in Chapter 3 and write about them further in Chapter 5 in relation to the systemwide translational model of practice.

2.9. Chapter 2 Conclusion

The published research protocol included in this chapter provides an overview of the research study and its question and aim. Amendments to this published protocol are provided and the study's project team, governance and ethics approval details are given.

Inspired by policy actors' stories, this chapter has positioned this study within the broader policy context. A short examination of the rise of culture as a determinant of health is provided along with a discussion of the role played by racism.

This scoping of the policy environment and the rise of the cultural determinants of health has determined the current positioning of this study. Importantly, my research will have input into the implementation of the cultural determinants of health. The contribution that my research will make in the current policy environment fulfils a cultural responsibility that I have to the study's reference group and the broader community. It is a responsibility that I write about further in Chapter 3.

Chapter 3 will provide a discussion concerning my positioning as a researcher, and the relevance of my Indigeneity and Indigenous standpoint.

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CHAPTER 3. THE STUDY'S THEORETICAL AND METHODOLOGICAL UNDERPINNINGS AND METHODS – STORYTELLING

3.1. Introduction

Chapter 3 provides a short discussion on the relevance of theory and concepts underpinning the research study.

Theory is "a set of ideas, based on evidence and careful reasoning, which offers an explanation of how something works or why something happens, but has not been completely proved … [also considered as] the ideas or abstract knowledge relating to something" (CollinsHarper Publisher, 2009, p. 1077). I cautiously apply theory according to this definition. Also, concept or concepts are used inter-changeably with theory as well. Concept is similarly "an abstract or general idea" (CollinsHarper Publisher, 2009, p. 203). While this chapter writes about theory and concepts, my whole thesis draws from a body of abstract knowledge and many ideas have been woven throughout the written material through storytelling and stories.

In drawing from the many theories and concepts though, ontological, epistemological and axiological challenges are unavoidable (Brayboy 2005; Rigney, 1999, 2001, 2006; Smith, 1999; Wilson, 2008). When my Indigeneity and standpoint had been authenticated, the challenge of navigating such tensions were minimised but were ever present.

The chapter goes on to discuss briefly the detrimental impacts of theories and concepts on Indigenous people; when knowledge through research informed actions

and decision of governments – public policies. I demonstrate such impacts in the enclosed manuscript - My research is my story - that is under second review by Qualitative Inquiry journal. Despite these historical challenges, the chapter emphasises that theories and concepts have a place in research, as do stories that contain theories (Brayboy, 2005). Specifically, *research is public policy [as is] Indigenous research is public policies (policy actor representative, 12 December 2019).*

I demonstrate the use of theories and concepts to explain the theoretical and methodological underpinnings of this study. Collectively, these conceptual frameworks are known as Carmen's theory that had been affirmed by the following story

> A few months ago, a colleague asked about the progress of my PhD. With interest, she asked, "What theory are you using?" and she exclaimed, "I use realist theory".
>
> As I pondered an answer, I wasn't quite sure how to respond! I was thinking, well actually I am probably using many concepts or maybe theories.
>
> When asked again, what theory am I using? I responded,
>
> "Carmen's Theory!" and laughed *(personal journal entry, 30 June 2019).*

I articulate and provide clarification about the relevance and positionality of my worldview, and how it influences how I learn and teach, and how new knowledge is created. I also discuss my ways of being, knowing and doing. The centrality of my Indigeneity and standpoint, and the knowledges bought to this research process, are emphasised. An Indigenist paradigm, standpoint, methodological and methods

conceptual approach has been developed to further explain my framework of inquiry – contained in the enclosed manuscript below.

The chapter then provides further detail of the study's methods. I describe how the yarning sessions were designed. Also, the participants – the policy actors – are discussed and how they were recruited. I then write about how the data was managed and organised including how I undertook the analysis process using the policy triangle (Buse et al, 2012). The policy triangle is further applied when discussing the three themes arising from the policy actor's stories contained in Chapter 4.

The 3Es of Implementation is also introduced but their application when describing the systemwide translational model of practice in Chapter 5 will be expanded. The Intervention Level Framework – ILF (Malhi et al, 2009) is also introduced, and is similarly applied in the impending systemwide translational model of practice contained in Chapter 5.

I go on to then write about the cultural obligations and protocols when using an Indigenous research methodology like Storywork (Archibald, 2008).

3.1.1. The relevance of theories and concepts in research

From the outset of my research study I was told that I should have a theory (personal journal entry, 8 April 2016 and 3 November 2017). Reeves, Albert, Kuper, David and Hodges (2008) say that theories are useful because they help us to understand complex situations, social phenomena or insidious interactions. System thinking, is an example of such a theory, as described in the above research protocol publication (Parter, Wilson, Gwynn, & Hartz, 2020).

Importantly, Reeves et al. (2008) write that:

> theories give researchers different “lenses” through which to look at complicated problems and social issues, focussing their attention on different aspects of the data and providing a framework within which to conduct their analysis (p. 631).

Additionally, they argue that theories:

> make it possible for researchers to understand, and to translate for policy makers and healthcare providers, the process that occur beneath the visible surface and so to develop knowledge of underlying (generating) principles. Importantly, theory can help people move beyond individual insights gained from their professional lives to a situation when they can understand the wider significance and applicability (Reeves et al., 2008, p. 634).

Whilst theories are useful for the discovery of new knowledge (Reeves et al., 2008), they have had harmful effects on Indigenous peoples, and they have been used to colonise and oppress us (Smith, 1999).

Linda Tuhiwai Smith (1999) writes:

> Any consideration of the ways our origins have been examined, our histories recounted, our arts analysed, our cultures dissected, measured, torn apart and distorted back to us will suggest that theories have not looked sympathetically or ethically at us (p. 38).

Although she does argue that “theory at its most simple level is important for Indigenous people” (Smith, 1999, p. 38) and reaffirms that theory can help us to:

> deal with contradictions and uncertainties … it gives us space to plan, to strategize, to take greater control over our resistances (Smith, 1999, p. 38).

She adds:

> The language of theory can also be used as a way of organising and determining action. It helps us to interpret what is being told to us, and to predict the consequences of what is being promised (Smith, 1999, p. 38).

She concludes that:

> Theory can also protect us because it contains within it a way of putting reality into perspective. If it is a good theory it also allows for new ideas and ways of looking at things to be incorporated constantly without the need to search constantly for new theories (Smith, 1999, p. 38).

I agree with Smith's proposition about the relevance of theory and its use to help bring meaning and understanding to situations or social phenomena. In this thesis, many theories and concepts have been utilised. Importantly, "our stories are our theories" (Brayboy, 2005, p. 426), and:

> theory is not simply an abstract thought or idea that explains overarching structures of societies and communities; theories, through stories and other media, are roadmaps for our communities and reminders of our individual responsibilities to the survival of our communities. These notions of theory, however, conflict with what many in the "academy" consider "good theory". At the heart of this conflict are different epistemologies and ontologies (Brayboy, 2005, p. 427).

In this chapter I write about theories and concepts relating to a researcher's ontological, epistemological and axiological, and pedagogical stances. The paradigms and methodological concepts which I draw from literary and oral knowledges resonate

with my worldviews of ways of being, knowing and doing. I demonstrate this through storytelling and the stories that follow.

3.2. The theoretical and methodological underpinnings

3.2.1. What is an Indigenous research paradigm and standpoint?

As Wilson (2008) points out:

> an Indigenous research paradigm is made up of an Indigenous ontology, epistemology, axiology and methodology … includes a distinct way of viewing the world and of "being" … The research methodology needs to incorporate their cosmology, worldview, epistemology and ethical beliefs (p. 13).

These Indigenous ways of being, knowing and doing prevail in this research study. As Wilson puts it, "I assert my Indigeneity" (2008, p. 13). However, such ways of being, knowing and doing continue to be in tension with the expectations of western science that presently dominate the research agenda (Smith, 1999; Wilson, 2008). This is an insight I had about two-and-a-half years into my PhD journey of discovery.

The stories woven together in the following article authenticate the centrality and validity of my Indigeneity and Indigenist standpoint. The article contains interrelated obligatory knowledges and cultures of ways of being, knowing and doing that hold me accountable to country and communities (Wilson, 2008; Yunkaporta & Shillingsworth, 2020). Importantly, when referring to my Indigeneity, I am talking about our sovereign knowledges and cultural knowledges that are intrinsic to being Indigenous (Rigney, 2001; Rix, Wilson, Sheehan, & Tujague, 2018).

Also, when applying an Indigenist standpoint I refer to Yunkaporta and Shillingsworth's (2020) relationally responsive standpoint that is about:

> Our relationships to people, law, and place [that] shape our obligations, ethics and boundaries regarding what and how we investigate in the world. These relational protocols determine what we know, how we know it and what we do with that knowledge (p. 1).

They continue:

> You have to work backwards in this process, from Law to relations to knowledge to practice (Yunkaporta & Shillingsworth, 2020, p. 2).

This involves having a set of values based on an Indigenous worldview:

> What we can know is determined by our obligations and relationship to people, ancestors, land, Law and Creation; what we know is that the role of custodial species is to sustain creation, which is formed from patterns of complexity and connectedness; the way we know this is through our cultural metaphors; and, the way we work with this knowledge is by positioning, sharing and adapting our cultural metaphors (Yunkaporta & Shillingsworth, 2020, p. 2).

I apply such cultural metaphors (Yunkaporta, 2019) in a contemporary manner with the use of stories, diagrams, text boxes and posters – the visual stories – contained in this thesis (Martin, 2008).

I will demonstrate an Indigenist paradigm, standpoint and methodology in the following article.

3.3. My research is my story

Reference

Parter, C. and Wilson, S., My research is my story, *Qualitative Inquiry Journal* – under second review for publication

Authors Contribution Statement

Poche Centre for Indigenous Health
University of Sydney

Publication Statement

As co-author of the published work:

Parter, C. and Wilson, S. (2020). My Research is My Story – A methodological framework of inquiry told through Storytelling by a Doctor of Philosophy Student, Qualitative Inquiry Journal – under review.

I confirm that Carmen Dorothy Ruby Parter made the following contributions:

The candidate planned and prepared the manuscript that involved several drafts in readiness for publication. Dr Shawn Wilson contributed to subsequent drafts by reviewing and editing the content, and providing advice particularly in relation to the theoretical underpinnings of the article. I reviewed and approved the final draft article.

Signed [REDACTION] Date 06/08/2020
Dr Shawn Wilson

This statement aligns with the requirements of the University of Sydney regarding policy as described in the policy documents:

*Thesis and Examination of Higher Degrees by Research Policy 2015
*Thesis and Examination of Higher Degree by Research Procedures 2015

https://www.sydney.edu.au/students/prepare-thesis.html

Introduction:

As my cultural responsibility and protocols would have me to do in the first instance,

I begin with story.

The story of my ancestors is the story of my beginning as a person.

Who am I?

I begin by acknowledging the Bundjalung people as the Traditional Owners of the land that I work, study and live on. Also, I pay my respects to Elders who have passed and those present and emerging. Further, I acknowledge the Traditional Owners of the lands that readers are on as they read this paper.

I am a proud descendant of the Darumbal and Juru clans of the Birra Gubba nation in the Australian state of Queensland (Qld). I am also of South Sea Islander heritage from Tanna Island of the Republic of Vanuatu. I have been actively reclaiming my culture, identity and stories for well over 25 years because I am a *colonisee* (French for colonized).

The story of my family places me within my kin and my community.

Born in the small town of Bowen, Qld, I am the daughter of DE-IDENTIFIED (the second of four girls and one brother who was adopted through Torres Strait Islander cultural practices). My maternal grandparents are DE-IDENTIFIED while DE-IDENTIFIED are my

1

paternal grandparents. In my mum's lineage, I am the great granddaughter of DE-IDENTIFIED and great great grand-daughter of DE-IDENTIFIED. Louise does not have a recorded surname (L. H. Yasso, personal communication, 27 April 2019). On my dad's side, I have many stories associated with Joskeleigh, a predominantly South Sea Islander community on the coast of Australia not far from Rockhampton, Qld (State Library of Queensland, 2019).

I am a proud godmother with three beautiful grandchildren and an Aunty to many. I live, work and study on Bundjalung Country in northern New South Wales (NSW), Australia, with my partner.

> The story of a colonized country places me within a historical context in a first world country.

I come from a colonized first world country (Australia) and with that come many traumatic stories including stories of the 'blackbirding' era. Due to my first-world positioning, I have a lifestyle of privilege and wealth, particularly when compared with my Vanuatu family who live in a third world Pacific Island country.

> The story of my professional experiences places me within a sociopolitical and economic context.

I have been a clinician, educator, and researcher working as a registered nurse, a registered midwife, and a women's health nurse practitioner. Additionally, I have worked in

many government roles formulating policies, implementing significant programs, managing small teams, and as a senior executive servant working on state and national Indigenous public policies in the areas of child protection, law and justice, and health.

I am currently a Poche-Wingarra Mura Academic Fellow at the University of Sydney undertaking a Doctor of Philosophy (PhD). Dr DE-IDENTIFIED is a co-author to this paper and one of my four PhD supervisors. DE-IDENTIFIED is an Opaskwayak Cree researcher from Canada, and has been mentoring me on Indigenous research methodologies. But it is my story that is the main focus here.

For those who are not aware of Aboriginal and Torres Strait Islander protocols and worldviews, I am culturally obligated to:

1. Responsibly and respectfully acknowledge Country, the traditional owners of the land and my Elders both past, present, and emerging when introducing myself on another's land. This involves providing information such as where I work, study, and live.
2. Tell you my ancestry that positions me as an Aboriginal and South Sea Islander person. First and foremost, this locates my Indigenous heritage centrally.
3. Claim my genealogy. This allows others, particularly Indigenous people, to locate me within my family, extended family and Indigenous community.
4. Situate myself as a *colonisee* from a first world country who has worked as a nurse, policy maker and now, researcher and author. This confirms my social world positioning (Smith, 1999; Walter & Andersen, 2013).

These obligatory accountabilities begin to establish the elements of an Indigenist research paradigm. Wilson (2001) defines a paradigm as 'a label for a set of beliefs that go together that guide my actions … a set of beliefs about the world and about gaining knowledge that go together to guide your actions as to how you're going to go about doing your research' (p. 175). I use this definition when explaining an Indigenist paradigm that has its origins in the centrality of my Indigeneity, my blackness, and the cultural worldviews that come with sovereign and autonomous ways of being (ontology), ways of knowing (epistemology), ways of doing (axiology), and ways of learning and teaching (pedagogy) (Rix, Wilson, Sheehan, & Tujague, 2018).

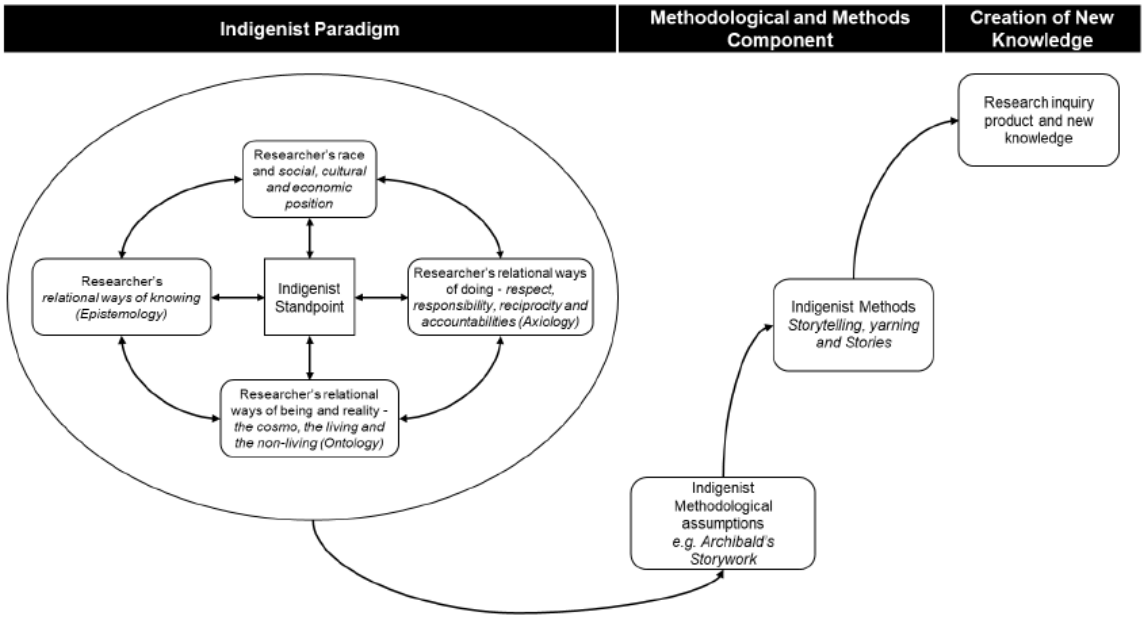
Acknowledging Country, the traditional owners, and past, present, and emerging Elders is an acknowledgement of an Indigenous way of being (ontology). This ontology demonstrates an understanding of the connected relationships between Country, people – the living and non-living, and the entire cosmos – the known and unknown (Wilson, 2001, 2008). My positioning as an Aboriginal and South Sea Islander person, my place in family, extended family and community, and my social, cultural, and economic positioning are about relational ways of knowing (epistemology) and the accountabilities that come with such relationality (Wilson, 2001). Similarly, as demonstrated above, the way that I am expected to behave, particularly given my Indigenous reality and knowledge, is directed by a set of values (axiology) involving respect, responsibility, reciprocity, and relationality (Wilson, 2008).

Collectively, my ontology, epistemology, axiology, and social positioning, as aspects of an Indigenist paradigm, inform an Indigenist standpoint represented in Figure 1 below. When

applying an Indigenist standpoint, I make reference to Yunkaporta and Shillingsworth's (2020) relationally responsive standpoint that involves the interrelatedness of value-based, obligatory knowledges and cultures of ways of being, knowing, and doing. These obligatory values of ways of being, knowing, and doing hold me relationally accountable to country and communities (Yunkaporta & Shillingsworth, 2020; Wilson, 2008).

Figure 1 has been adapted from Walter and Andersen's (2013) conceptualisation of a research methodology, and Carter and Little's (2007) figure that describes the contribution of method, methodology, and epistemology to qualitative research. Through describing my standpoint, a set of methodological assumptions (Walter & Andersen, 2013) such as those seen in Archibald's (2008) Storywork methodology, become explicitly revealed through the research. These methodological assumptions influence the use of techniques (or methods) such as storytelling, yarning, and stories. The interrelatedness of an Indigenist paradigm and its methodological and methods approach, collectively create new knowledge (Walter & Andersen, 2013; Wilson, 2001).

Figure 1: An Indigenist paradigm, standpoint and methodological and methods approach



This conceptual Indigenist paradigm, standpoint, and methodological and methods approach contributed to the development of a framework of inquiry that is described below. In the same way as Martin (2008), I have used visual story to explain complex ideas as demonstrated in Figure 1. Visual stories remain consistent with Indigenous ways of being, ways of knowing, ways of doing, and ways of learning and teaching.

Undeniably, my research is truly a ceremony (Wilson, 2008) that rightfully honours Indigenous ways of being, ways of knowing, ways of doing, and ways of learning and teaching.

Indigenous Culture, Saves Lives – My PhD and Research Question

I begin with story.

The story of my Indigeneity is the story of my being as an Indigenous person.

From the moment I entered the public policy space (in 1990), communities consistently told me of the relevance and significance of our cultures to the health and wellbeing of Indigenous Australians. The knowledges gained from communities about our culture were incorporated in several policy initiatives that I led.

However, when the cultures of Aboriginal and Torres Strait Islander people were included in public policy instruments, governments and policy makers did not fully understand Indigenous people's worldviews and cultures of ways of being, knowing and doing. These public policies demonstrated a wide gap between cultural expectations and policy development (Parter, Wilson, & Hartz, 2019).

In 2005, governments were encouraged to provide the means for Indigenous communities to apply their cultural understandings within policy development (Parter, 2005). To enable this cultural dimension to be brought to policy development, the central positioning of Indigenous people in the policy development cycle was critical (Parter, 2005). A cultural fusion involving the mingling of Indigenous and non-Indigenous cultural worlds, side-by-side and as independent and valid domains, could create innovative solutions (Parter, 2005).

In Australia, the relevance and importance of Indigenous cultures has emerged as a critical element of several significant national public health policies (Australian Government, 2013; Commonwealth of Australia, 2017). Culture is central to the policy framework of the Australian Government's 2013–2023 National Aboriginal and Torres Strait Islander Health Plan (the Health Plan) (Australian Government, 2013).

However, when the cultures of Aboriginal and Torres Strait Islander people have been incorporated into public policies such as the Health Plan, how do policy makers implement – that is, enable, embed and enact – culture? This became my PhD research question. Figure 2 below is a representation of my PhD research study containing many stories, including invisible stories of my reality. Importantly, my 'black' image tells my story of the centrality of my Indigeneity and standpoint.

Figure 2: A visual representation of my PhD

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Overview of Storywork – An Indigenous Research Methodology

I begin with story.

The story of my research is the story of my beginning as an Indigenous researcher.

I have struggled this week trying to surf my way through readings about theories and ideas.… but I struggle because what I am reading is making no sense to me. It means nothing to me and it's hard to understand what they are trying to say … I am this morning reading Karen Martin's work, and how refreshed I feel. As I [am] read[ing], I am recalling what Juanita said in one of our PhD supervisor meeting … that my thesis is about telling my story. As I reflect on this statement, and as I am reading Karen Martin's work, it suddenly [occurs] to me [that] for the last 51 years of my life I have had to do things the way that they – 'white man' - would have me do. In school, I have had to learn the way that they want us to learn. [It is a] way that is not conducive to Indigenous ways of knowing, being, and doing … a way that dismisses our learning styles and continues to disrespect who we are as Indigenous Australians. Similarly, in my [work life] I have had to apply the knowledge and theories of the 'white man' and their ideas of how you need to work, particularly how you need to work and think … I have had to learn their way of doing business, their way of working, knowing, and doing … I have been indoctrinated by their worldviews and ways of operating (personal journal entry, 25 August 2016).

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I was initially introduced to Storywork by Karen Martin's (2008) formative work about regulating outsiders undertaking research in Indigenous communities. Martin's (2008) work inspired me, and I concluded my reflections on it with the poem contained in the text box below.

Text Box 1: Decolonizing my mind, healing my spirit and validating my 'blackness' (poem)

Oh when will you stop?

When will you know?

How will you know that you need to stop?

Stop working the way of the 'white man', stop thinking in their way, the way that they would want you to be? the way that they have indoctrinated you?

Stop! Stop taking on the knowledge of the 'white man'.

Learn and sit with your own Indigenous knowledges

The knowledges that is just as important to what your writing about

A knowledge system that is ancient and has been around for millions of years

A knowledge system that places you first in everything that you do and respects reciprocates makes you responsible and accountable to your obligations

The obligations of challenging the dominant paradigms of the western ways of things

A responsibility to liberate our beings, our families and our communities

You have a responsibility to share your story, a story that has a valid place in this world … a story that needs to be told.

The story of my healing authenticated my 'blackness', my knowledges and Indigeneity.

The poem challenges my colonized and indoctrinated 'white' ways of being, knowing, and doing. It was one small part of my personal journey involving a process of decolonizing my mind, healing my spirit, and validating my 'blackness', which I write about below. It was an important healing journey to authenticate my Indigeneity. This journey of reclaiming and revitalizing my knowledge and cultural ways of being, knowing, and doing became central to the way that I behaved and conducted my research study – it became my Indigenist paradigm.

Martin (2008) described Storywork as a 'meta-process that enables the many smaller Stories … to be woven together in the overall research process' (p. 21). Martin's work led me to Archibald (2008a) who established Storywork as an Indigenous research methodology. She coined research as storytelling (Archibald, 2008b).

Several principles direct the practice of Storywork. They include the four Rs of respect, responsibility, reverence and reciprocity including holism, interrelatedness and synergy (Archibald, 2008a, 2008b). The process of story readiness is an essential step in Storywork (Archibald, Lee-Morgan, & De Santolo 2019). I found myself reflecting critically on the practicality of Archibald's (2008a, 2008b) four Rs and their applicability to cultural and ethical obligations. Importantly, I reflected on my responsibility to respectfully and reverently honor the stories being told by storytellers such as those who were participants in my research

study. Similarly, as a recipient of such stories, I had to be emotionally prepared, and I had to possess a willingness to listen attentively and humbly learn through the relational relationship established between the storyteller and the listener (Archibald, 2008b). Importantly, a range of cultural obligations are integral to how the knowledges that are told through storytelling are to be managed and re-told (Archibald, 2008b). Specifically, such knowledge is not owned by the researcher or listener, and nor can such stories be appropriated dishonestly (Archibald, 2008b). As a researcher, it is incumbent on me to accurately and respectfully present the storytellers' stories by giving voice to the knowledges they contain (Archibald, 2008b). As Wilson (2008) puts it, I need to be relationally accountable.

In addition, as Archibald points out

> Wholism, interrelatedness and synergy shape the quality of the learning process. Indigenous wholism comprises the spiritual, emotional, physical and intellectual domains of human development. Wholism also addresses the relationships among the self, family, community, wider world, and the environment (2008a, p. 3).

These principles resonate with Indigenous ways of being (ontology), ways of knowing (epistemology) and ways of doing (axiology). The transmission of knowledge through storytelling adds value to the learning and teaching process (pedagogy) (Archibald, 2008a).

Storywork resonated with me because I recall as a child being taught of ways of living off the land and from the sea. It was through these stories that Indigenous oral knowledges and

cultural practices were often passed on to other generations. This storying practice still exists in contemporary Indigenous Australian society but is rarely recognized by mainstream Australia.

However, the use of text to retell stories comes with its limitations 'because it cannot display the storyteller's gestures, tones, rhythm, and personality' (Archibald, 2008b, p. 17). Nonetheless, textualized stories can still captivate the reader through the interweaving of the storyteller's stories with that of the context of the reader (Archibald, 2008b). I will demonstrate this shortly (Archibald, 2008a).

The stories contained in this paper are my personal and professional stories. I describe my family, community, and ancestral connections, and the stories below tell of significant historical events in Australia that demonstrate Storywork in practice. Visual stories in the form of figures and images complement the many relational stories that are equally important in the storytelling process, and in learning and teaching processes (Martin, 2008).

Storywork and visual stories brought understanding to my positioning in research, and the centrality of my Indigeneity informed my framework of inquiry. In presenting a framework of inquiry I respond to the thought bubble (contained in Figure 2) that asks: Where is my Indigeneity placed in this policy analysis research project? (personal journal entry, 7 November 2016).

A framework of inquiry – demonstrated through stories and visual stories.

I begin with story.

Because I am story.

I was two-and-a-half years old when the successful result of the 1967 referendum meant that my family, community, and I were considered worthy enough as human beings to be counted in the Australian census. Prior to 1967, Aboriginal people were counted as part of the native flora and fauna, or as exotic objects to be studied (DE-IDENTIFIED, personal communication, 20 March 2015).

Just over 100 years earlier, in 1861, Aboriginal people of the lands of my mother's Country (in and around the Bowen district) were being invaded and exterminated (Loos, 1970, 1982). It is understood that the Aboriginal population in our region was at least 2,000 to 3,000 people strong. By 1867, diseases, murderous violent massacres, and lifestyle changes had reduced the population to around 200 (Loos, 1970). However, the Aboriginal resistance movement meant that by 1868, Aboriginal people of the Bowen district were allowed to live on pastoral stations and the town fringes – they 'let the 'blacks' in (Loos, 1982, p. 44).

By second half of the nineteenth century, Pacific Islanders were being brought into the state of Qld to be sold as slaves for the sugar industry (National Archives of Australia, n.d). In Queensland, the *Aboriginals Protection and Restriction of the Sale of Opium Act* 1897 was introduced. It was an Act designed "to make provision for the better protection and care of

the aboriginal and half-caste inhabitants of the Colony" (Australian Institute of Aboriginal & Torres Strait Islander Studies, n.d). Also, to reduce the harmful effects on individuals and communities, the sale, distribution, and consumption of opium was regulated (Australian Institute of Aboriginal & Torres Strait Islander Studies, n.d). This Act also meant that my great, great grandmother, Louise and her family were forcibly removed from Country to relocate and live on reserves at Hopevale in the northern part of Qld (J. Mallie, personal communication, 9 February 2019).

The Australian Constitution and the *Immigration Restriction Act* 1901– also referred to as the 'White Australia policy' (National Museum of Australia, n.d), were introduced. This meant people of colour were no longer able to migrate to, or work in, Australia, and this included the Pacific Islander indentured labour workforce (National Archives of Australia, n.d). The Immigration Restriction Act was eventually repealed in 1973 (Moreton-Robinson, 2015) but its introduction had meant that some South Sea Islanders were forcibly deported back to the Pacific, others moved further south into NSW, and some were hidden by sugar plantation farmers and continued to work in fear of deportation (Moore, 2000). By the end of the 1970s most state and territory Aboriginal protection acts had been revoked to stop the actions that created what we now know as the 'Stolen Generation'. The *Bringing them Home* report states that

> between one in three and one in ten Indigenous children were forcibly removed from their families and communities in the period from approximately 1910 until 1970. In certain regions and in certain periods the figure was undoubtedly much greater than one in ten. In that time, not one Indigenous family has escaped the effects of forcible

> removal (confirmed by representations of the Queensland and WA Governments in evidence to the Inquiry). Most families have been affected, in one or more generations, by the forcible removal of one or more children (Commonwealth of Australia, 1997, p. 37).

These government decisions and actions are part of my stories, and they have inescapably become my stories.

The stories highlight the decisions and actions of governments – known as public policies – that dismantled our cultures and knowledges. Essentially, these policies enforced the notion that races of colour were inferior to the white race (Moreton-Robinson, 2015). A range of policy instruments, including international laws of "conquest or cession" (Moreton-Robinson, 2015, p. 4), British conventions that declared Australia unoccupied – *terra nullius* (Moreton-Robinson, 2015, p. 4), and legislation aided the continuation of the dispossession and oppression of Indigenous Australians (Moreton-Robinson, 2015, p. 4). Also, programs of dispersion and policy statements about extermination occurred on the Country of my mother's lands, and policies such as 'letting the blacks in' are further examples of public policies. These public policy tools have been used to authorise colonisation through racially motivated policies that continue to play out in the norms and behaviours of institutions and within society (Moreton-Robinson, 2015, p. 6). Grace Skoogstaf, in her lecture on historical institutionalism, which she delivered at the International Public Policy Winter School in Grenoble, France, also made this assertion (personal communication, 9 January 2018). She later expressed the view (over lunch) that these historical ingrained institutional rules of dominance can be changed (personal communication, 9 January 2018).

It is because of these stories that I chose to work in the public policy domain and, it is my interest in these stories that is now driving my research topic because indeed:

My Research is My Story.

These stories enable me to "express self as part of others and others as part of the self within and across generations" (Moreton-Robinson, 2000, p. 2).

And, central to these stories is my Indigeneity, my blackness, my culture, my cultural knowledges, and lived experiences that inevitably inform an Indigenist research paradigm, as mentioned above. The centrality of my visibly black image (in Figure 2 above and Figure 3 below) gives credence to the relevance and positionality of my Indigeneity.

Figure 3: A framework of inquiry

These stories are my Indigenist standpoint.

The methods – authenticating my Indigeneity and designing a framework of inquiry

I read, I wrote reflective journals, I thought, I cried, I yarned … I ate, slept and woke and, did it all over again! (personal journal entry, 27 January 2017)

When understanding the central importance of my Indigeneity and of designing a framework of inquiry, several methods were evident and in the sections that follow I use storytelling to explain the methods.

1. Decolonising my mind, healing my spirit, and validating my blackness – the Doctor of Indigenous Philosophy program

In 2015, when I had been preparing to undertake a PhD, an opportunity arose where I was invited to participate in tutorials of the Doctor of Indigenous Philosophy (DIPh) program taught at Gnibi College of Australia's Indigenous People (Gnibi), Southern Cross University, in Lismore, NSW. The tutorials aroused in me an urgent desire to understand my positionality and the relevance of my Indigeneity as I prepared myself for a PhD research project. The relationship established with Gnibi continued when I formally commenced my PhD in January 2016.

The DIPh is the first of its kind in Australia, and possibly globally. It is designed to equip individuals with the practical skills and knowledge needed to apply Indigenous philosophies when the work that they do involves Indigenous Australians (Gnibi Australian College of Indigenous Australians, n.d). My active participation in the program validated what I had intuitively known about Indigenous philosophies related to ways of being, knowing, and doing that had been denied by the public sector's whiteness.

My references to whiteness are not about the colour of one's skin; rather, whiteness is the conquering force of 'power, authority, and structural dominance' (Moreton-Robinson, 2000, p. 2) inherent in institutions like those found in the public sector. In my case, whiteness played out in the public policy environment and attempted to undermine my Indigenous worldviews and knowledges. This was evident in a journal reflection when I wrote, 'whiteness, you tried to destroy me, whiteness, you've tried to overpower me, whiteness you've wanted me to be like you. Yet I stood my ground' (personal journal entry, 5 August 2016).

A process that I would describe as 'decolonising my mind, healing my spirit and validating my blackness' was inevitable because the dominant whiteness of the public policy environment had attempted to oppress and possess my Indigeneity (Moreton-Robinson, 2000). Similarly, my understanding of colonisation of the mind emerged whilst reading Frantz Fanon's book *Black Skin, White Masks* (1952).

My journey of discovery inescapably brought healing to my spirit and being, and validated the relevance of my Indigeneity and Indigenous worldview. Wilson (2008) argues, "if research doesn't change you as a person, then you haven't done it right" (p. 135). My Indigeneity and its importance had been authenticated.

2. Theoretical Indigenist paradigms, Indigenous methodologies and Indigenous worldviews

The DIPh program and the healing process I underwent created a curiosity. I began reading the work of other scholars, particularly relating to theories about ontology, epistemology,

and axiology, including the analyses of the tensions between Indigenous knowledges (or epistemologies) with those of Western scientific knowledges, plus accounts of the tensions between quantitative and qualitative approaches (Carter, Ritchie, & Sainsbury, 2009; Durie, 2004; Ellison, 2014; Johnson, Long, & White, 2001; Nakata, 2003; Reeves, Albert, Kuper, & Hodges, 2008; Saldana, 2014; TEDx, 2016). Also, I read about Indigenist paradigms, Indigenous standpoints, and methodological concepts and methods such as reflectivity, yarning, stories, and storytelling (Bessarab & Ng'andu, 2010; Carter & Little, 2007; Creswell, 2007; Foley, 2006; Geia, Hayes, & Usher, 2013; Kovach, 2009; Martin, 2008; Moreton-Robinson, 2013; Nakata, 2007; Rigney, 1999; Rigney, 2001, 2006; Rix, Barclay, & Wilson, 2014; Walter & Andersen, 2013; West, Stewart, Foster, & Usher, 2012; Wilson, 2008). I especially found Smith's (1999) writing that refuted 'european imperialism and colonialism' (p. 1) incredibly important.

These scholars informed my framework of inquiry and influenced my early thinking. Critical to such scholarly work is an Indigenous way of being, knowing, and doing that resonated with my worldview. A consistent reality was the connectivity of this Indigenous worldview, which brought my underpinning relational beliefs and ways of working to my research study.

3. Peer support and yarning with other higher degree research (HDR) students, mentors, and advisers

Being purposive and deliberate in forming relationships with other Indigenous higher degree research (HDR) students and mentors was a critical move in my learning process. I'd often meet to yarn with them about the insights and challenges we had encountered. Car

yarnings, for example, were a weekly event as I travelled for an hour to attend the DIPh program meetings with another HDR student. Our own experiences and challenges of understanding Indigenous philosophy, methodologies, and paradigms were insightful, and such car yarning sessions were critical in helping me to explore and understand Indigenist concepts.

The Gnibi weekly student support gatherings have been my lifesaver because they have provided a safe environment, something that is usually missing in the higher education system, to yarn about Indigenous research philosophies and methodologies. Also, yarns with mentors were similarly valuable as I travelled through my journey of discovery. Importantly, my PhD academic advisers were all Aboriginal (until very recently) and they were cognisant of the tensions between the approaches of Western scientific research and those of Indigenous research methodologies. Significantly, Dr Shawn Wilson, a Canadian First Nations scholar, brought depth to philosophical ideas, theories and Indigenist research paradigms.

These yarns informed my thinking and those of others.

4. Critical reflective journaling

Vital in my process of discovery was writing critical reflective journals about what I was reading, feeling, and thinking. Also, there were numerous occasions when I audio recorded critical reflections. These critical reflections took me on an emancipatory journey of discovery that involved understanding colonisation and its impacts on Indigenous people.

They provided me with a deeper understanding of my Indigeneity, and of Indigenous philosophies and their relevance to dismantling the forces of colonial oppression.

5. Just write and write and write

I was strongly encouraged to regularly set aside time in my day to write, regardless of whether the written material made any sense (personal journal entry, 26 August 2016). Also, when participating in the DIPh program we'd spend 10 minutes of writing at the beginning of the classes, and we were consistently reminded that writing was part of our professions as academics. This practice enabled me to write freely and assisted with my thinking when developing a framework of inquiry. I continued to write thereafter, and set time aside each day to do so.

6. Opportunistic yarning

There were many opportunities presented to yarn, often about my research with others. One significant learning related to understanding and demystifying the 'ologies' like one's ontology (reality), one's epistemology (ways of knowing) and one's axiology (ways of being). Understanding the relational reality of these 'ologies' was critical to appreciating my Indigeneity and its positioning in my research study.

7. Storytelling and yarning through presentations

During my journey of discovery, I also had many opportunities to present on my topic at forums, masterclasses, and conferences that elicited conversations about my research and enabled me to clarify my Indigeneity and positioning.

Attendance at the National Research and Indigenous Knowledge Network masterclasses led by Distinguished Professor Aileen Moreton-Robinson brought a critical Indigenous perspective to my critical thinking when I presented on my research topic on several occasions.

8. Dreaming, listening and learning from my ancestors

There were many dreams and early mornings that I spent in silence, listening to the knowledges and wisdom of my ancestors. This connection to the spiritual world is my reality (ontology) and it remains real as my ancestors teach me on this journey of knowledge (epistemology), discovery, and production.

The above methods were critical in providing the clarity I required to understand my Indigeneity that informed the framework of inquiry presented in Figure 3 above.

Discussion

My framework of inquiry (shown in Figure 3) helped me to understand the centrality of my Indigeneity and Indigenist standpoint as a PhD student. This framework is a useful methodological tool and conceptual framework that is of benefit to other higher degree research students and qualitative researchers. The framework challenges students and researchers to critically reflect on their realities and ways of being (ontology), how and why they know the things that they know (ways of knowing or epistemology) and the values they hold that influence their behaviour, actions, and why they do the things they do (axiology). Importantly, when they understand their social positioning and lived experiences, students and researchers begin to recognise the systemic, in-built, usually unconscious biases of racialisation and privilege that are at odds with an Indigenist paradigm and an Indigenist standpoint and methodology. As students and researchers, we have a responsibility to contribute to the scholarly knowledge base that challenges the status quo of the dominant whiteness and Western scientific ways of knowledge production. Furthermore, as a student and researcher who is Indigenous, I must rightfully claim and express my ways of being, my ways of knowing, my ways of doing and my ways of learning and teaching in the academy.

Similarly, my framework of inquiry authenticates Indigenous people and Indigenous Communities' Indigeneity and Indigenist worldviews, and it validates the knowledges they hold and bring to the ceremony of research. The substantiation of their positioning as Indigenous people, and the many relational stories they tell, provide clarity to Indigenous ways of being (ontology), ways of knowing (epistemology) and ways of doing (axiology). Without this realisation, perhaps we (as Indigenous people) would continue the denial of

our Indigeneity and Indigenist worldviews that sustains the process of colonisation and maintain the coloniser's interest in the oppression and dispossession of our cultures, knowledges and practices.

Non-Indigenous researchers, as well as policy makers, could also benefit from adopting the framework used in this study . The framework of inquiry offers a methodological tool to further understand Indigenous people's ways of being, ways of knowing, and ways of doing that need to become normalised praxis when conducting and interpreting research or solving complex policy problems, particularly those faced by Indigenous Australians.

To espouse our Indigeneity and Indigenist worldview in the academy and the public policy spaces of government, it is imperative that Indigenous Australians are centrally positioned in a way that authorises rightfully our Indigenous ontology, epistemology, axiology, and pedagogy. This is mandatory if real sustainable change is to occur that addresses the socioeconomic and political impoverishment that Indigenous peoples experience in Australia.

Within an Indigenist worldview and relational ontology, our stories enable us to share our personal understanding of reality with others. But stories do more than that. Stories are our theory (Brayboy, 2005). Within Storywork, stories are our method (Archibald, 2008b). Stories are our reality. My story is my research.

Conclusion

I begin with story.

This story reaffirms my Indigeneity as I embark on a PhD journey of discovery. I used Storywork and visual stories to tell the reader several interconnecting stories relating to my ancestry, genealogy, lived experience, family, community, and ancestral relationships. These stories helped me to convey complex concepts relating to my Indigeneity and the worldview that I bring to a research project such as a PhD. During the process of my journey of discovery, the central positioning and relevance of my Indigeneity and Indigenist ways of being (ontology), knowing (epistemology) and doing (axiology) were legitimised. A framework of inquiry that applies an Indigenist research methodology that confirms my standpoint is inevitable. All these stories inform my framework of inquiry.

I begin with story.

> The story of my ancestors is the story of my beginning as a person.
> The story of my family places me within my kin and my community.
> The story of a colonized country places me within a historical context within a first world country.
> The story of my professional experiences places me within a sociopolitical and economic context.

I begin with story.

The story of my Indigeneity is the story of my being as an Indigenous person.

I begin with story.

The story of my research is the story of my beginning as an Indigenist researcher.

The story of my healing authenticated my 'blackness', my knowledges and Indigeneity.

I begin with story.

Because I am Story.

I begin with story.

My Research is My Story.

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3.4. The research study's methods

The following is a much more detail account of the study's methods.

3.4.1. Designing the yarning sessions – Preparing and doing

The yarning sessions held with policy actors were designed to allow them to tell their stories. As Bessarab and Ng'andu (2010) state:

> Yarning enables the unfolding of information through the process of story-telling (narrative) in a relaxed and informal manner that is culturally safe (p. 47).

This is the case because research is storytelling (Archibald, 2008).

Prior to the yarning sessions being conducted, a script (contained at Appendix 5) was developed to assist in directing the focus of the stories being told by policy actors. The script was never intended to be provided to the storytellers; rather, it was used to guide and direct the yarning sessions (Baker, 2013).

A draft script had been developed initially and then tested with other higher degree students at Southern Cross University, Gold Coast Campus in a role-play situation (Gnibi representatives, personal communication, 16 May 2018). The script was amended based on feedback provided at the role-play. A further amendment to the script was made following the first yarning session to ensure that the storytellers' stories were nationally focused and related to the storytellers' involvement in the Health Plan. Thereafter, very little change to the script was required that organically matured overtime.

Twenty-one policy actors provided their informed consent by signing consent forms to participate in yarning sessions. Of the 21 policy actors a total of 19 participated in

yarning sessions as participants who willingly found time in their busy schedules to participate in a forty- to fifty-minute session. Despite the remaining two policy actors' (P10 & P20) willingness to participate in a yarning session, it was difficult to find a convenient time to meet face-to-face or over the telephone. The human research ethic committees had approved between 10 and 20 yarning sessions.

Seventeen face-to-face yarning sessions with policy actors were held in their places of work in Canberra, Sydney and Melbourne. The remaining two policy actors were interstate participants who were interviewed face-to-face while in Canberra attending a national meeting. Two of the yarning sessions were conducted via telephone. All yarning sessions were recorded on an audio digital recorder.

The policy actors confirmed their roles and responsibilities within the National Indigenous public health sub-system of the national public health policy environment. Attention to their role when the Health Plan was being developed or implemented was an emphasis. Further, they were asked to tell their story about why culture was included, whether any meaning was given to the term culture, and whether the knowledges of Indigenous peoples were discussed during the Health Plan's development. Additionally, the storytellers were asked to talk about whether challenges were encountered when culture was being incorporated into the Health Plan. They were also asked of their own experiences of implementing culture and any other challenges they experienced.

3.4.2. Participants – The policy actors

3.4.2.1. Identifying and recruiting policy actors

Initially, the research study's reference group, the National Health Leadership Forum, identified some eligible policy actors. In addition, policy actors who participated in yarning sessions were also invited to identify others through a peer snowballing technique previously mentioned in the research protocol at Chapter 2.

In total, 26 policy actors were identified and eligible to participate in a yarning session. Of the 26 identified eligible policy actors, 21 were approached via an email inviting them to participate in a yarning session. An invitation letter, a participant information statement describing the research study, and a consent form, were included in the invitational email. A copy of the invitation letter, participant information statement and consent form, are provided in Appendix 4.

In line with the University of Sydney's Research Development Management Plan policies, the audio recordings were securely stored. These audio recordings were transcribed and remained secure throughout the research project.

3.4.2.2. The characteristics of the policy actors

Of the 19 policy actors, 13 were Indigenous and 6 were non-Indigenous. Eight were females with the remaining 12 males. All held senior positions in the Indigenous national public health policy sub-system. Seven of the 19 participants were no longer heavily involved in this sub-domain but had been critical to the Health Plan's development. Nearly all participants of the yarning sessions contributed names towards the snowballing technique. However, saturation had clearly been reached by the twelfth participant.

3.4.2.3. Categories of policy actors

The list of participants was composed of:

1. Seven non-governmental policy actors who worked in the Indigenous public policy sub-system
2. Eight policy actors who were drawn from Commonwealth, state and territory governments. They included senior executive and middle management policy makers and members of parliament.
3. Two policy actors who were former ministerially appointed experts.
4. One policy actor who was drawn from Australia's broader Indigenous affairs public policy domain for Close the Gap.
5. One policy actor who no longer worked in the Indigenous public health policy space but was instrumental in the Health Plan's development and had recently returned to the Indigenous affairs public policy environment.
6. One policy actor who remains in government as a policy maker in a senior position of government working in Indigenous affairs and was crucial to the Plan's development.

3.4.3. Procedures - Transcribing, managing data, coding and analysis

3.4.3.1. Transcribing

Three audio recordings were transcribed to test the private transcription service and the actual audio recording quality in June 2018. The recordings and transcription service were satisfactory. From November 2018 onwards, the transcription commenced fully, particularly after I was awarded a Cross-Cultural Public Health

Research Award (totalling $1,600) that helped pay for the transcribing. Also, following each yarning session, audio recorded or written critical reflections were done.

3.4.3.2. Preparing and managing the data

As an early career academic and researcher, I had not prepared myself for the huge amount of data generated from the 19 yarning sessions with policy actors as well as data collected from other sources such as reflective journals (Creswell, 2013, pp. 182 - 183).

Initially, the amount of data collected was overwhelming and for a moment I entered what I would term as a debilitating paralysis where it felt like I was doing nothing, and nothing was getting done.

However, I soon discovered that in fact I had been pondering the stories that were told to me by policy actors, and these stories had informed my first article (included in Chapter 1) about whether culture should be incorporated in the CTG Refresh, particularly the use of the 3Es of implementation to be described below. Also, the Katherine Hospital case study was mentioned by two policy actors and the content of the article contained in Chapter 6 was informed by several policy actors' stories, as was the article, "Talking about the r words" in Chapter 5 below.

To manage the voluminous data generated, NVivo was utilised.

3.4.3.3. NVIVO – a computer assisted qualitative data analysis tool

As indicated by Liamputtong (2012), computer-assisted qualitative data analysis (CAQDA) tools are available to assist and facilitate qualitative researchers with data analysis (p. 258). Creswell writes that:

> the process used for qualitative data analysis is the same for hand coding or using a computer; the inquirer identifies a text segment or image segment, assigns a code label, searches through the database for all text segments that have the same code label, and develops a printout of these text segments for the code. In this process the researcher, not the computer program, does the coding and categorizing (Creswell, 2013, p. 201).

Liamputtong (2012) warns that CAQDA tools are not able to analyse the data because the analysis and coding remains the responsibility of the researcher.

Those who are vehemently opposed to CAQDA tools like NVivo argue that the researcher becomes disconnected from the data, and this could limit the interpretative analysis process (Creswell, 2013; Liamputtong, 2012). I experienced such a distancing and became concerned about compromising my cultural obligations and responsibilities as espoused by Storywork (Archibald, 2008). Further, the retrieval of large amounts of data using a CAQDA tool could impact on the contextualisation of the data. Nonetheless, in recognising these challenges regarding disconnection and contextualisation, I continually went to and from the data in NVivo to the yarning session transcripts and audio recordings to ensure that what I was writing was respectfully honouring the policy actors' knowledges contained in their stories.

I continued to use NVivo with trepidation, with the greatest challenges being finding the time needed to learn to use the tool and sourcing a training provider, which is a disadvantage identified by Creswell (2013). I became confident in the use of NVivo but intuitively kept reading and re-reading the transcripts, listening and re-listening to audio recordings, mindfully pondering the contents of the stories, doodling and writing

reflective journals (or memo would be the term used in the qualitative literature) and doing the initial descriptive coding (Creswell, 2013).

3.4.3.4. The coding and analysis process

An inductive analysis and reflective process began from the moment the first yarning sessions commenced back in June 2018. As Liamputtong (2012) argues, qualitative data analysis

> should commence from the beginning of the research … and be treated … as part of our research design, the literature review, the formation of theory, the data collection, the ordering of data, and the writing process … with all these matters [having] significant ramification in how we do our data analysis … (p. 242).

Coding is an inductive practice of immersing oneself within the collected data – in this case the transcriptions of the policy actor yarning sessions (Liamputtong, 2012). I found myself listening to audio recordings continuously, reading and re-reading transcripts and mindfully reflecting on the stories. As indicated, NVivo was used to order and manage my transcribed data, a choice which I quietly regretted but persisted with.

Initially, I put stories into descriptive categories. During this initial categorisation of data into descriptive groupings (Liamputtong, 2012), I began to search the literature for a framework to assist in the organisation process. Eventually, the policy analysis triangle became the instrument I used to assist in organising and contextualising the stories into substantive categories (as discussed below). Using NVivo, several in vivo statements were identified that used verbatim the words used by the storytellers (Creswell, 2013).

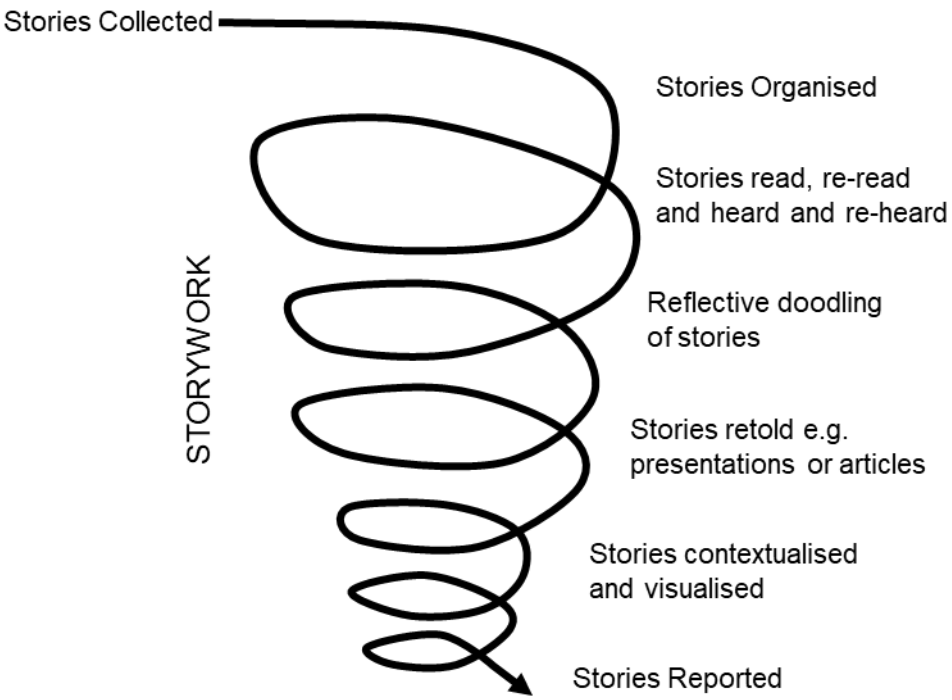
3.4.3.5. The data analysis spiral

There were several stages in the data analysis process that are described below

1. Collection of data – Audio recordings, transcribed policy actor stories, my critical reflections and other documents of relevance mentioned during the course of interviews were uploaded into NVivo
2. Organising policy actor information, audio recordings and transcripts
3. Reading, re-reading and listening and re-listening to audio recordings
4. Reflective doodling by writing reflective journal entries, writing manuscripts and presenting on research material at several forums such as Poche's Research Advisory Board meetings
5. Contextualising data into a framework of analysis by applying and adapting the policy triangle and Intervention Level Framework (mentioned below)
6. Representing and visualising into a bigger and collective story using visual stories.

These stages remind me of the data analysis spiral that Creswell (2013) talks of so, I have adapted his spiral accordingly below (p. 183).

Figure 7: The data analysis spiral



3.4.4. A framework of analysis to organise codes and themes

While Archibald (2008) argues that it's up to the listener to make meaning of the stories, I found myself searching for an instrument to assist in organising the data and findings arising from the policy actors' stories. The policy triangle (Buse et al, 2012) became the tool I used to organise findings once initial coding had occurred.

Buse et al. (2012) argue that the policy triangle is useful for analysing policy retrospectively or prospectively. I use the policy triangle in a similar manner that were placed into codes, categories and eventually themes.

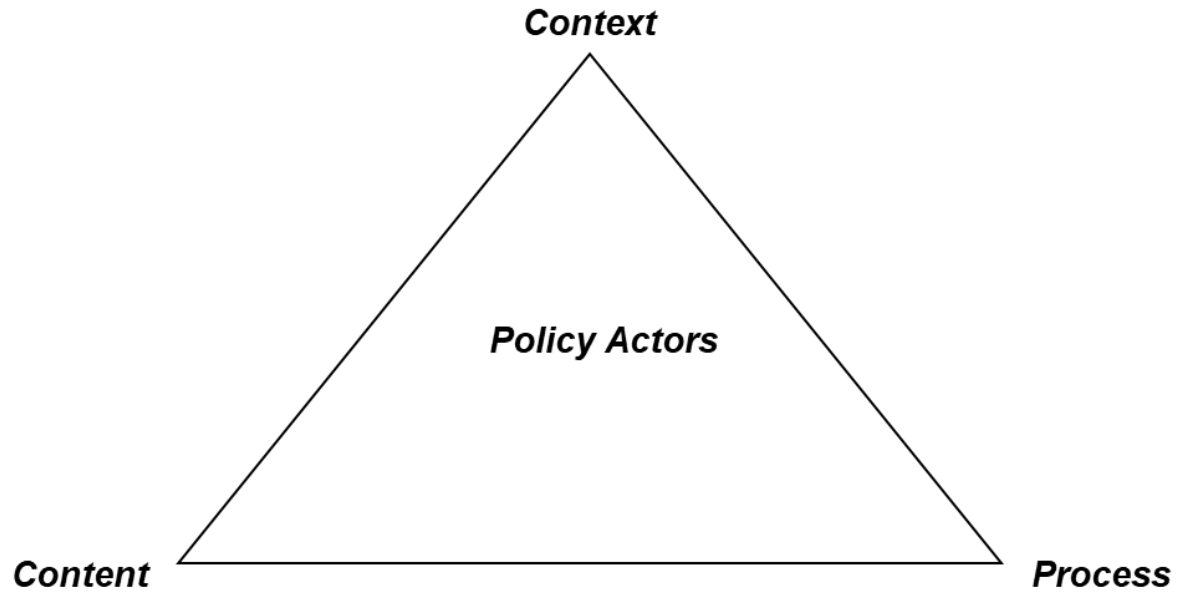
Essentially, the use of the policy triangle assisted with the organisation of my analysis of the data and its findings into meaningful groupings. This approach matured as I told and retold stories at presentations, or wrote them into articles, particularly when writing up the research study's preliminary findings report that was distributed to participants

of the yarning sessions (Appendix 5). I also used the policy triangle to present on my findings at Poche's Research Advisory Board meetings. I will now introduce the policy triangle.

3.4.4.1. The policy triangle introduced and adapted

The policy triangle is replicated below that contains a context, content and process at its three points with policy actors at its centre (Buse et al., 2012, p. 9)

Figure 8: Policy triangle



The policy actors of the policy triangle will be replaced with Indigenous Knowledges and Indigenous Cultures (IKs and ICs) of ways of being, knowing and doing. This central placement of IKs and ICs is the first adaptation of the policy triangle.

The use of IKs and ICs relates to the discussion contained in Chapter 4 about the need to reframe culture so that culture is better understood by policy makers. Suffice to say here that when referring to culture, it's about the knowledges of cultural ways of being, knowing and doing that are held by Indigenous Australians.

IKs and ICs is centrally positioned in the policy triangle because it's the primary topic of discussion in relation to the research study.

Figure 9: Adapted policy triangle with IKs and ICs

When describing the policy triangle elements, Buse et al. (2012) write that context relates to the circumstances of the situation(s) surrounding a policy issue(s). Structural circumstances and cultural situations are also taken into consideration when exploring the context of a policy issue (Buse et al., 2012). Context in this research study relates to issues arising from stories about IKs and ICs in a public health policy environment, although many of the stories told by policy actors went beyond the public health policy arena. The study's context also considered socio-political and broader cultural and structural societal issues such as system paradigms and goals which are discussed in the Intervention Level Framework (ILF) below. The ILF is another tool used to assist in organising and bringing understanding to the findings of the study that will be discussed shortly. Context relates to Theme 2 that is discussed in Chapter 4.

Content described by Buse et al (2012) was ambiguous. Nonetheless, in this thesis, content relates to how IKs and ICs, as a subject matter, is valued, represented and considered within the public health policy space. Content may also highlight any strengths, limitations or challenges about IKs and ICs. Issues relating to content have been captured in Theme 1 to be discussed in Chapter 4 below.

Process relates to the policy cycle (example contained in Chapter 1) in which the four steps are: identification, formulation, implementation and evaluation of a policy issue (Buse et al., 2012).

Process in this study will only relate to implementation of the policy cycle. As demonstrated in Chapter 2, policy identification and formulation has resulted in culture being firmly integrated into a policy instrument as a determinant of health – the Health Plan's second Implementation Plan. Implementation of these cultural determinants is now a significant challenge with a gap in evidence apparent. The stories told by policy actors will inform the formulation of a policy response for the implementation of culture as a determinant of health. Process relates to Theme 3 that will also be discussed in Chapter 4.

3.4.4.2. The 3Es of implementation – enable, embed and enact - introduced

Throughout the stories told by policy actors three common terms were consistently used: enable, embed and enact. They were used in different ways by policy actors and this created a need to consider their meaning. The Collins dictionary defines these 3Es in the following ways:

1. **Enable**: enabling or enablement is about providing "someone with the means or opportunity to do something [or] to make possible: *to enable the best possible*

chance of cure" (HarperCollins Publisher, 2009, p. 322). The 1983 Collins dictionary definition of enable is also about providing "adequate power, means, opportunity, or authority (to do something), and to make possible or easy" (Williams Collins and Sons, 1983, p. 365). Enable for this research study is about providing Indigenous Australians with the means, power, authority and opportunity to express their knowledges and cultures of ways of being, knowing and doing in the production, implementation and evaluation of public health policies and programs.

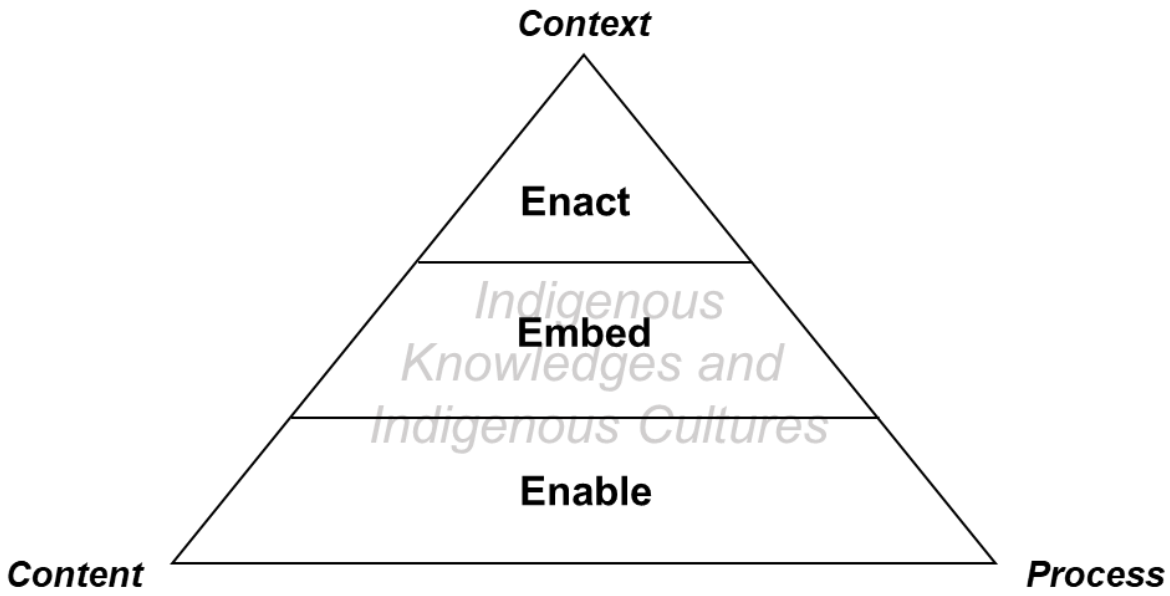
2. **Embed**: Embedding or embedment is about fixing "permanently into place or cementing [something] solidly into place" and it's also about "fixing (an attitude or idea) in someone's mind" (HarperCollins Publisher, 2009, p. 320). In the case of the research study, it's about integrating permanently into place IKs and ICs held by Indigenous Australians into the design and delivery of policy, programs and services.

3. **Enact**: Enacting or enactment "is to establish by law' or make a decree that makes something happen" ("enact", 2009). In this research study, enact are the things that make something happen and they include policy instruments such as laws, statements and plans, described in the research protocol contained in Chapter 2. The use of such policy instruments aims to support the implementation of giving effect to IKs and ICs into public health policies.

The 3Es of implementation will be further explored below when writing about process in Chapter 5 in relation to the systemwide translational model of practice that has been developed. I also write about the 3Es in the Closing the Gap article contained in Chapter 1 above.

Here, I adapt the policy triangle again to capture the 3Es of implementation.

Figure 10: The 3Es of implementation contained in the policy triangle



As the analysis continued, I discovered that I required another framework to assist in organising data relating to the process of implementation. This is when the ILF (Malhi et al, 2009) became the tool I chose to assist in further organising the data and major findings. More importantly, the ILF (Malhi et al, 2009) assisted in bringing further understanding to the challenges involved to implement – enable, embed and enact – IKs and ICs of ways of being, knowing and doing within a public health policy environment. I talk more about these challenges in Chapter 5 when writing about the systemwide translational model of practice that I have developed.

The ILF (Malhi et al, 2009) utilises concepts arising from system thinking. System thinking as a concept of practice is underpinned by the assumption that hard-to-solve problems could be viewed using a different lens of operation, as opposed to the limiting public health responses such as epidemiological approaches to Indigenous health (Bond & Singh, 2020; Peters, 2014; Taghreed, 2016).

The ILF takes into consideration the interrelated relationships of a range of variables at play within a system (Malhi et al., 2009). The ILF has become a useful tool to assist in bringing further understanding to the findings of the policy actors' yarning sessions, including the themes arising from the 12 December 2019 Yarning Workshop. The Figures 14, 15 and 16 – At a glance – in Chapter 5 explores the use of the ILF and the 3Es of implementation.

3.4.4.3. The intervention level framework introduced

Malhi et al. (2009) states that:

> Tackling a complex problem requires a different approach, one that accepts the problem as complex and seeks solutions appropriate for complex problems (p. 468).

As highlighted in Chapter 2 above, the health of Indigenous Australians and the futile efforts of governments to close the life expectancy gap between Indigenous and non-Indigenous Australians by 2031 highlights a need to accept that we're dealing with a complex problem requiring solutions appropriate for such a complex problem. This involves:

> leverage points … places within a complex system (a corporation, an economy, a living body, a city, an ecosystem) where a small shift in one thing can produce big changes in everything (Meadows, 1999, p. 1).

This type of approach may well be the answer to addressing such complex problems such as improving the health of Indigenous Australians. As Meadows (1999) goes on to write:

> This idea is not unique to systems analysis – it's embedded in legend. The silver bullet, the trimtab, the miracle cure, the secret passage, the magic password, the single hero or villain who turns the tide of history. The nearly effortless way to cut through or leap over huge obstacles. We not only want to believe that there are leverage points, we want to know where they are and how to get our hands on them (p. 1).

Meadows (1999) asserts that "Leverage points are points of power" *(p. 1)*. Meadows (1999) goes on to identify such leverage points or places to intervene in a system, and they are replicated in the table below.

Places to intervene in a system **(in increasing order of effectiveness)**
i. Constants, parameters, numbers (subsidies, taxes, standards (9)
h. Regulating negative feedback loops (8)
g. Driving positive feedback loops (7)
f. Material flows and nodes of material intersection (6)
e. Information flows (5)
d. The rules of the system (incentives, punishments, constraints) (4)
c. The distribution of power over the rules of the system (3)
b. The goals of the system (2)

a. The mindset or paradigm out of which the system – its goals, power structure, rules, its culture – arise (1)

Source: Extract from (Meadows, 1999, p. 2)

Using Meadows' leverage points identified above, Malhi et al. (2009) explain:

> At one end of the spectrum are "constants, numbers and parameters, leverage points that are relatively easy to change and by themselves generally only have a small impact. At the other end are the goals of the system and the paradigm under which the system operates, leverage points that are often very difficult to change but if changed can have a large impact. These "places to intervene" arose out of Meadows' years of experience working with complex systems and out of her frustration for our tendency to seek simple solutions that seem intuitively correct but are often wrong (p. 468).

Perhaps these simple solutions are evident in the problem of how to close the life expectancy gap to meet the major goal of the Council of Australian Government's National Indigenous Reform Agenda.

Using Meadows' (1999) leverage points of places to intervene in a system, Malhi et al. (2009) reduced them to a five-level framework – known as the Intervention Level Framework – that is replicated below. The framework "can be used to sort qualitative" data (Malhi et al., 2009, p. 468). These five levels of intervention points correspond to Meadows initial leverage points and are identified as a, b, c, d, e, f, g, h, and i.

Intervention Level Framework
PARADIGM (a) • Systems ‘mindset’ • Deepest beliefs, often unspoken beliefs about the way the system works • Goals, rules, and structures arising out of the paradigm • Actions and ideas at this level aim to either shift or reinforce the current paradigm • It is very difficult to intervene at this level but can be very effective
GOALS (b) • Conform to system’s paradigm • Are targets that need to be achieved for the paradigm to shift • Actions at this level focus or change the aim of the system • The levels below conform to and enable the system’s goals
SYSTEM STRUCTURE (c) • All the elements that make up the system, as a whole, including the subsystems, actors, and interconnections between these elements • Conforms to the system goals and paradigms • Actions at this level will change the entire system structure by changing the linkages within systems or incorporating novel types of structural elements or incorporation novel elements • System structures gives rise to the dynamic behaviour of the system over time

Intervention Level Framework
FEEDBACK & DELAYS (d) • Feedback allows the system to regulate itself by providing information about the outcome of different actions back to the source of the actions • Feedback occurs when actions by one element of the system affect the flows into or out of that same element • Can be simple and direct or involve multiple variables • Can be self-regulating/balancing or self-reinforcing • Actions at this level attempt to create new, or increase the gain around existing, feedback loops • Adding new feedback loops or changing feedback delays has the potential to restructure the system
STRUCTURAL ELEMENTS (e) • Subsystems, actors, and the physical elements of the system connected through feedback loops and information flows. Actions at this level affect specific subsystems, actors, or elements of the system • Many actions at this level are usually required to create system-wide change.

Source: Extract from Malhi et al., 2009, p. 469

(a) Interventions at this level correspond to Meadows' level 1 (the power to transcend paradigms) and level 2 (the mindset out of which the system arises).

(b) Interventions at this level correspond to Meadows' level 3 (the goals of the system).

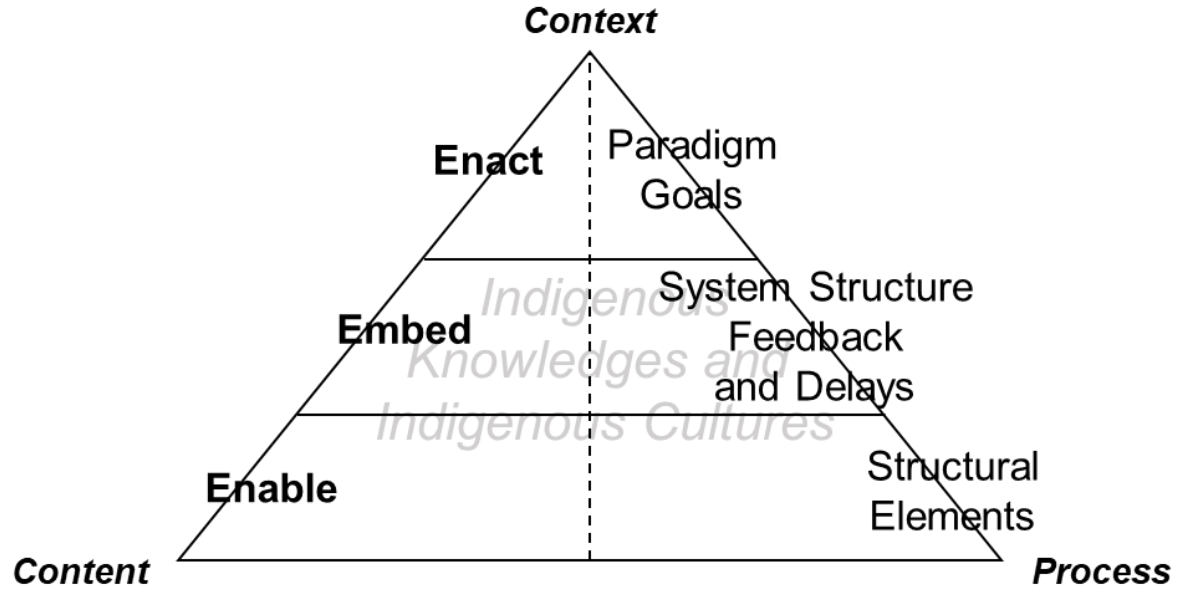
(c) Interventions at this level correspond Meadows' level 4 (organise system structure), level 5 (the rules of the system) only if the rules affect multiple subsystems, and level 6 (information flows) only if the flows occur between multiple subsystems.

(d) Interventions at this level correspond Meadows' level 7 (positive feedback), level 8 (negative feedback), and level 9 (length of delays).

(e) Interventions at this level correspond Meadows' level 5 (the rules of the system) only if the rules affect a particular subsystem or a specific type of actor, level 6 (information flows) only if the flows occur within a specific subsystem, level 10 (physical structure), level 11 (size of system stabilizers), and level 12 (constants and parameters).

I similarly used Malhi et al (2009) five-level ILF to sort my qualitative data relating to process of the policy triangle. In Chapter 5, I use the ILF when developing a systemwide translational model of practice aimed to contribute to the implementation of IKs and ICs. I adapt the policy triangle again to capture these five Intervention Level Framework system leverage points.

Figure 11: The five Intervention Level Framework points of the policy triangle



Indigenous Knowledges and Indigenous Cultures

I will come back to the above details of this triangle when discussing the findings which emerged from the policy actors and their stories.

3.5. Putting an Indigenist paradigm, standpoint and Storywork into action

During my initial coding, and while I was writing the manuscript “My research is my story”, I found that I needed a much greater in-depth understanding of the underlying ontological, epistemological and axiological underpinnings. This understanding is expected of researchers who are applying Archibald’s (2008) Storywork methodology in their research. I realised that fulfilling my obligatory and cultural responsibilities would require a level of reverence in honouring the stories being told, and that I needed to respectfully give voice to the knowledges contained in the story tellers’ stories (Archibald, 2008). When honouring these stories reverently in this way, I am fulfilling my obligatory responsibilities. Doing so is a cultural imperative (Archibald, 2008). I am unavoidably held accountable to the Indigenous policy actor community. In the first instance this means being accountable to the NHLF, but collectively I am accountable to all Indigenous Australians because the work that is being done will benefit the whole Indigenous community (Archibald, 2008; Wilson, 2008).

The Indigenist ontological, epistemological and axiological underpinnings of the approach I have just described cannot be separated from the coding, classification and thematic analysis processes that inform the way that I reflect on, analyse and re-tell the stories contained in data that is producing new knowledge (Mauthner & Doucet, 2003). Yunkaporta and Shillingsworth (2020), when talking about relationally responsive standpoints, also confirm that:

> You incorporate different cultural activities, expressions, images and practices to shape and guide the way you organise knowledge in your research practice, even in your literature review and data analysis. You adapt the stages of cultural

processes like weaving, or a land-based process like the cycle of seasons to inform the structure and spirit of your inquiry (p. 9).

3.5.1. Cultural obligations of re-telling stories

When re-telling each policy actor's story, the storyteller will be represented by a P followed by a number, and their identity will be kept private because the ethics requirements mean that they must be de-identified. They will also be referred to as participants as I tell you their stories. Additionally, to honour the participants' knowledges and voice, their stories will be italicised and indented.

Where relevant, the names of places, people and any other reference that may identify an individual, community or a place, have been de-identified. Also, some knowledges provided during storytelling have been deliberately omitted to ensure the de-identification of policy actors or local communities. If a story referred to a local community, a level of caution was applied to ensure that the knowledges provided did not contravene any cultural protocols or ethical and obligatory responsibilities required of me as the user of an Indigenous research methodology like Storywork (Archibald, 2008).

Further, during the telling of the stories many examples were provided to explain an issue or situation. In some of these examples, the storytellers named communities and their projects were de-identified. Given my obligatory responsibilities of respecting the knowledges entrusted to the study, a level of caution when re-telling examples to convey a point was applied. Specifically, identifiable communities or community projects were deliberately omitted because additional permission would be needed to do so because the knowledge freely provided during storytelling does not belong to

the research study, and exercising caution in this area is a mandatory cultural obligation of Storywork (Archibald, 2008).

When one participant was asked if the knowledge provided in their story was sacred, and should such knowledge be kept sacred, they responded:

> *Well you just attribute some of it just to [de-identified name] … this is my learning (P7, July 2018).*

To attribute such knowledge to a participant had its challenges, particularly because ethic committee's approval requires that human subjects involved in research must be de-identified. I reflected that perhaps future research involving Indigenous people might re-consider such an ethical requirement so that the knowledges provided in the stories are honoured and attributed to the storyteller, which is a form of reciprocity and respect. Barlo, Boyd, Pelizzon & Wilson (2020), in their research study successfully secured ethical approval to identify and name their human research participants in contrast to expected research practice. Barlo et al. (2020) argued that:

> De-identifying participants is both disrespectful (breaching principles in the Australian National Statement on the Ethics Conduct of Human Research (National Health and Medical Research Council (NHMRC), 2015)), and culturally inappropriate. The Elders, furthermore, insisted on being fully identified (p. 91).

When another policy actor was telling their stories, I inquired about the use of the knowledges contained in those stories. This participant responded by saying:

> *Let me look at the transcript and I'll give you an alternative … because I can relate it to stuff that's already, probably been printed … because [we've]*

published and there's bits and pieces around that stuff that's already out in the public domain (P1, June 2018).

When writing up my thesis, I did follow up with P1 about some of the knowledges contained in the stories that were shared. Given that the nature of the knowledge identified a family member who had passed and given that the story related to community knowledges requiring further community permission, we decided that such a story would not be re-told (policy actor representative, personal communication 3 August 2020). This is an example of respectful and responsible relational obligatory accountability (Archibald, 2008; Wilson, 2008) that is not considered in mainstream ethical practice. If a story contained information about a community, I chose not to use it because of my obligatory responsibilities which involved being held accountable to community concerning the re-telling of what is essentially their story, and not the research study's story or knowledge.

In some cases, if information was in the public domain, the study used that information, particularly to enhance the point being conveyed in the story such as the Katherine Hospital Radio National audio case example contained in Chapter 6. In most cases however, a level of caution remained in how such examples were applied.

Caution was also applied when participants referred to their cultural knowledges of ways of being, knowing and doing as traditional owners of their country, including any mention of bush medicine. This is because the stories entrusted to the study contains knowledges belonging to the storyteller and their nation. So, it's not the study's right to own or re-tell those stories without the full permission of the storytellers or Elders of that nation. This is because there remains a range of community cultural protocols that must be adhered too and ensuring adherence to these protocols was beyond the

scope for this PhD research study as it is a process that requires additional time. Perhaps, after submission of this PhD, I may consider seeking community approval to write such examples.

An Indigenist paradigm, Indigenist standpoint and Storywork mandate researchers to respectfully be accountable and responsible for the knowledges willingly and trustfully provided. As a researcher, studies need to rightfully go back to those communities and make sure that they are happy for such a study to tell those stories and examples. Due to these ethical and moral obligations of ways of being, knowing and doing, not all the stories, particularly examples of implementing culture, have been included when retelling stories, which is a binding requirement when reverently using an Indigenous research methodology like Storywork. Nonetheless, there remain sufficient data that captures the essence of the stories being told.

The cyclic and intertwined nature of stories bring with them many knowledges (Archibald, 2008; Martin, 2008; Wilson, 2008; Yunkaporta, 2020). As I re-tell the stories of policy actors in Chapter 4, some stories have been used a couple of times based on the situation being discussed because a story contains many parts, knowledges and theories (Archibald, 2008; Brayboy, 2005; Yunkaporta, 2019). This was reaffirmed when I confirmed with a participant during their yarning session that "the way that you spoke, is our culture. You told stories, and in those stories, there are critical messages" (C. Parter, personal communication, September 2018).

Yunkaporta (2019), who was teaching a young girl about time and deep time in a sand symbol, also experienced additional knowledge:

> 'Why can't you see the flowers?' The young girl said to me. I was teaching her this image in the sand, teaching her about time and deep time, and she humbled

> me, made me see a different way. A beautiful way that was right now, where now-time was all time and filled with joy. Old man Juma made me see it a different way too, put my cheek to the ground and see the 'ant's view' *(p. 43)*.

Due to the cultural obligatory and accountability practices inherent in an Indigenous research methodology like Storywork, and an Indigenist paradigm and relationally responsive standpoint, potential limitations are minimised (Archibald 2008; Archibald, Lee-Morgan & De Santolo, 2019; Martin, 2008; Rigney, 1999, 2006; Wilson, 2008; Yunkaporta & Shillingsworth, 2020).

3.6. Chapter 3 Conclusion

Chapter 3 commences with a discussion about the relevance of theory. It goes on to draw from a range of theories when establishing the relevance of my Indigenous positioning, demonstrated by an Indigenist paradigm, standpoint, methodology and methods conceptual framework described in the 'My research is my story' article. My central positioning in the research study confirms and authenticates my Indigenous standpoint. Indeed, this is Carmen's Theory, with new knowledge created on such a premise.

In the methods section of this chapter, I write a bit more about my obligatory responsibilities and relational accountabilities when re-telling stories from storytellers. Importantly, there are some details of knowledges, including examples, that I deliberately do not include in this thesis. In cases where I have included such details, they have been de-identified.

Also, the chapter goes on to discuss the research study's methods, such as details about the policy actors, and the yarning sessions, including the collection of data and

data analysis. The chapter introduces the policy triangle including the 3Es of implementation, and the Intervention Level Framework, two tools that I use to organise my data and findings. I will write further about these frameworks in Chapter 4 and 5 that follows.

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CHAPTER 4. STORYTELLERS' STORIES FROM POLICY ACTORS – THE STUDY'S FINDINGS

4.1. Introduction

Chapter 4 is concerned with the themes arising from policy actor's yarning sessions including the workshop. Their stories contain knowledges, and sometimes theories, that have informed the study's results here in Chapter 4 and, also in Chapter 5 and 6 to follow (Archibald, 2008; Brayboy, 2005). Their voices are being privileged by utilising direct quotes from their stories that contain such knowledges.

As discussed earlier, Storywork methodology has a range of cultural obligations to reverently and respectfully tell policy actor's stories (Archibald, 2008). Also, to reciprocate those stories as honourably as possible, I have a relational accountability conferred on me to re-tell those stories including the knowledges, as responsibly as possible (Archibald, 2008). A set of cultural requirements that sometime clashed with non-Indigenous ways of being, knowing and doing of conducting research is unavoidable (Durie, 2004; Smith, 1999; Wilson 2008). I found this to be the case when thematically analysing policy actor's stories (Braun and Clarke, 2006). However, soon discovered that ontological, epistemological and axiological tensions between thematic analysis and an Indigenous research methodology like Storywork was challenging. Nonetheless, being mindful of such tension assisted in being able to navigate such a challenge while maintaining my cultural obligations and accountabilities (Wilson, 2008).

Content, context and process follow each of the identifiable theme titles. As previously discussed back in Chapter 3 concerning a framework of analysis; content, context and

process are the three points of the policy triangle that I use to help organise my data. I revisit such a triangle at the end of this chapter that contains the three themes.

The first theme, which relates to the content of the policy triangle, aims to bring meaning and understanding to culture so that the cultures of Indigenous Australians are further understood by policy makers. Specifically, culture is about the knowledges held by Indigenous peoples and communities. The second theme, which relates to the context of the policy triangle, calls on policy makers to have a knowingness about Indigenous people's cultural worldviews of ways of being, knowing and doing, including an appreciation of the impacts of colonisation. Importantly, policy makers must have open hearts, open minds, and open ears to listen and learn. A set of soft skill attributes is required of policy makers who are facilitating and making policy regarding Indigenous Australians and their health (policy actor representative, personal communication, 5 June 2018). Importantly, Indigenous leadership is central to policy making, particularly when implementing the culture and knowledges of Indigenous Australians.

The third and final theme, which relates to the process of the policy triangle, establishes that while policy makers are prepared to accept the importance of culture and its relevance in addressing the health of Indigenous Australians, there remain some significant challenges requiring redress. Hence, the need for a willing readiness of accepting culture as a critical factor in addressing the health and wellbeing of Indigenous Australians is evident. However, there remains a deep-seated resistance ingrained in systems, organisations and individuals that plays out in the way that they behave and prevent improvements to the health and wellbeing of Indigenous Australians.

The chapter ends with some concluding remarks before proceeding onto Chapter 5 which presents a systemwide translational model of practice.

4.2. Policy actors' stories – the three themes

4.2.1. Theme 1: Our culture is our knowledges, and our knowledges count – content

Text Box 1: Extract from P16, September 2018

> *Our culture is to share knowledge. That's why we survived. Because if you didn't share knowledge, you didn't survive. That's how we bring up our children. We teach them how to do all the things they had to do, hunt and, where they could go, couldn't go, or respect, the ceremonies, all of that … that knowledge was passed down to the people, that are teaching you, was passed down from someone else. So, that's our currency. And that's knowledge, that's how people survive. That's what the economy was. It was a knowledge economy*

When referring to culture it was also about knowledge:

> *You know, Aboriginal culture at the centre of a thing like that Health Plan, and having Aboriginal people there to prosecute it or to keep it on the agenda, helps us to tap into those knowledge's that are out there (P16, September 2018).*

Another policy actor verified this view:

> *So, when we talk about Indigenous knowledges … we gotta get to the heart of not just looking at the published literature but looking at what's in the grey literature or in the community stories (P21, December 2018).*

Another reaffirmed that:

We're the only ones who can really inform them [policy makers], you know, we're the only ones who can tell people what our experience of racism is. And we're the only ones that connect, can connect our, understanding of culture within our communities with what a policy might do. So, yeah, I think you know we have amazing knowledge in our communities (P16, September 2020).

When differentiating the differences between social determinants to those of cultural determinants during discussion with government officials, another policy actor affirmed that the Health Plan:

became a political document because it always had to be signed off by the Minister at the time (P12, September 2018).

This participant said:

I certainly recognise that it [the Health Plan] didn't reflect all the feedback that we'd necessarily put (P12, September 2018).

Nonetheless, one policy actor said:

We were trying to leverage the knowledge systems that are explicit within our own customary clan groups, family groups, extended family groups, that way of networked thinking, communal activity, um, place-based, um, points of connection. We thought that we could evolve that into the Plan (P19, October 2018).

This participant went on to say:

So, what we were trying to do, was leverage the opportunity for place-based, um, allocations, based on need, um, that culture could be well expressed, and service

delivery should, in lots of ways, reflect as close as possible the separate nations of First Nations people in Australia (P19, October 2018).

and then proceeded to provide an example:

The ATSIC [Aboriginal and Torres Strait Islander Commission] regional councils, for example, and that regionalisation approach, all of those different hubs were as close to those kind of nations as they could be and they were really important go-to points and we wanted the health service delivery system to be able to regionalise in that way so that it could provide employment opportunities for people to bring their knowledges into those healthcare systems and kind of transform it in that way (P19, October 2018).

This policy actor added that:

The other thing that we were also really cognisant of was the power of Elder thought, wisdom and leadership and Ngangkaris and all of those kinds of things and how you could integrate those Elder wisdom knowledges and other ways of thinking about health and wellbeing into healthcare delivery systems, and I think the Ngangkaris in (de-identified) Health and in the South Australian hospitals, for example, is a really good exemplar of how that's happened … (P19, October 2018).

And this was because:

We wanted to be able to think through issues that were impacting on our health and wellbeing and in my experience it's around understanding and appreciating these extended family networks both biological and non-biological but how people are connected and who needs to be involved in decision-making and why

they need to be involved in decision-making about the health and wellbeing of an individual, or about a family, or about placements or about procedures, all of those sorts of things, um, was really important, and that could be expressed in terms of people having access to translators so that they could talk in their own first language and make sure that they were giving them informed prior consent (P19, October 2018).

P16 affirmed that:

The knowledge we acquire in our work, isn't our knowledge really. It's stuff we've learned from others through work and communities and things (September 2018).

And went on to say:

I've been around for such a long time, I think these are things that I see, I know won't work. And, I know things will work, I just know it instinctively … but I've built that knowledge base up over 20-odd years, but I didn't have that knowledge when I started. I've learnt from communities (P16, September 2016).

Although P16 cautiously warned that:

You've got to be careful with knowledge … that's why it's like a little bit of ambiguity is not a bad thing (September 2018).

P16 said earlier:

I'm cautious about saying we share everything (September 2018).

Another participant alluded to the inherent dismissal of Indigenous Australians' knowledges, as referenced below (P21, December 2018). A community example of how Indigenous knowledges are devalued was provided by a policy actor as follows:

> *We have people in our communities that know what to do and they can create solutions to problems that no government can do. And, I saw an example of that … there was this teenager and she was in a small community out [place and state de-identified]. She was self-harming and she was suicidal. And she was in a remote community which was a couple of hours away from [a major regional town] and the big mental health team that was in there …*
>
> *But, these women in the community they recognised when she was … having a crisis, she wanted to kill herself … so what they did, this group of women got together and they set up like a 24-hour watch sort of thing around her … they rostered each other on … to be with this girl around the clock until the crisis passed …. she started to come out of whatever she was going through but they saved her life.*
>
> *Now, mental health centre couldn't have done that … because the mental health team from [town de-identified] only visited once a week. So, there is no other solution for that kid … I mean she would have been dead, if those women hadn't of took ... taken the leadership and responsibility to support her.*
>
> *Now, it sounds like a very simple thing to do but it's quite a sophisticated response, and it comes from their culture.*

When we told this story … with the mental health system … the mainstream public health system … they started to refer as an informal response, an informal approach.

So, they immediately use language that diminishes what those women had done, and those women were, they were women, they were senior women in the community, they were cultural leaders. They're the ones who came up with a solution, that the mainstream system couldn't …

And yet, …. the recognition of their knowledge, and their ability to wrap around this young kid, gets diminished by some … person who's some 35-year old, non-Indigenous person with very little experience, very little culture, but gets reduced to, oh, it's an informal response, an informal approach (P16, September 2018).

P16 confidently said:

In our communities … we can solve a lot of problems …. I've watched them do things, that sometimes you scratch your head over …. you know, their wisdom, their abilities … it's very apparent (September 2018).

And P16 reiterated:

So that's why I always say communities have the solutions … if it's not being recommended … coming from a mental health worker or a psychiatrist or psychologist it invalidated those women in that community, what they'd done. And yet, they're the ones that came through for that kid. Saved her life. They never (September 2018).

P16 concluded adamantly:

You know our knowledge is … it comes from thousands of years of being on this planet, being in this country … it should be respected, and it should have a role in forming policy and forming program and service delivery … you know, if you look in now, it's people like CSIRO, Bureau of Meteorology, there's a few of them around, they're starting to recognise Aboriginal science …. And they're engaging with it, because it's enhancing their own knowledges, the knowledge, it's enhancing western knowledge …. They can still access it {Indigenous knowledge] … it hasn't been totally destroyed by colonisation (September 2018).

Although another participant warned:

that the way our knowledges gets played out in the delivery of health in these discriminatory healthcare service delivery systems, which privilege need … we get commodified through the entire process rather than thinking about our health, which is celebrating our culture, our connection, our languages, our wonderful ceremonies, our revitalised ways of being … all the things that we do well in communities and our aspirations for our children, you know, those kinds of things just never get heard (P19, October 2018).

While another policy actor said:

I think we've still got a reasonably wide gap in being able to articulate through some kind of western scientific methodologies our Indigenous knowledges (P21, December 2018).

P21 reasoned that perhaps:

that's where I would really hope to see things go in the next say, five, ten years … where we can potentially look at … through implementations and

interventions, we put the science – white fella science around it so that it's indisputable but it's all framed in an Indigenous knowledge framework (December 2018).

Although P21 commented inquisitively:

And I think that's the challenge to putting scientific process around what we do. I'm just wondering in that though; does it challenge the dichotomy between obviously the different worldviews that come out in the play when you start to pull out our knowledges and then western scientific knowledge? (December 2018).

and then added:

Yeah, it naturally does, And, so the impediments or the barriers to that is the continuing devaluing of Indigenous knowledges (P21, December 2018).

P21 then concluded by saying:

So we, we've actually got to create spaces where the conversations can be heard and western systems can be challenged and where we can take the good but also, and not overly romanticise our self as well (December 2018).

This was demonstrated by one Indigenous policy actor who talked about how the knowledges held by an Elder were embedded into a program:

where [the Elder] brought actually the Indigenous knowledge to that, the traditional knowledge, and I brought more mainstream paradigms that we deconstructed and reconstructed to include that, sort of, Indigenous knowledge … [they] got [their] traditional knowledge from [another Elder] … [who] was the

cultural library and [who] would have to keep going to [the other Elder], well how does this work, how does that work? (P1, June 2018).

Another contributor said:

Our culture and the way we do our business should be integral to everything because what we also have in that cultural, um , in the cultural elements as they're expressed in the Health Plan is the capability to deal with complexity. And complexity and uncertainty are two of the mainstays now of these new times (P19, October 2018).

and went on to attest:

What we can deal with through health services is deal with a limited version of [an] approach but it's quite lineal and very simple, whereas the level of complexity that we're able to cope with, deal with, live with, interrogate, leverage good results out of, protect, enshrine and all of those kinds of things are really important skills and really important methods and they're disallowed in how we train up our professional staff who then populate and take up positions in the public and private healthcare service delivery system (P19, October 2018).

P19 declared that the knowledges owned by Indigenous peoples:

can empower and inform new technological breakthroughs that will happen in the context of health and wellbeing from a very solid cultural viewpoint, which just gives you a different lens and a different landscape to operate from. And it's just so amazing, the privilege of going around and talking about bloody microbiome and second stomachs … our second brains being held in our stomachs … and the complexity of that, and molecular decolonisation, all these

kinds of amazing things, that's all come from a cultural knowledge base … [mainstream] ….. are interested in finding out the origins of disease and we're really interested in finding out about the intergenerational transmission of resilience (October 2018).

P19 concluded:

That is how culture plays itself out and it's all been made permissible because of its inclusion in that Plan (October 2018).

The cultural knowledges held by Indigenous people must also be acknowledged. As one participant said:

it's all very challenging but having the cultural knowledge and support … is really a strength and provides me with the ability to see things differently (P7, July 2018).

P7 went on to affirm:

When you're treating Aboriginal and Torres Strait Islander people, you're bringing something that nobody else can bring, that is, not, a non-Aboriginal or Torres Strait Islander person themselves, but in a sense you're still unique because I would be bringing [nation de-identified] knowledge of what I know, you would be bringing your cultural knowledge of what you know … that's really special, and that's how we've operated for tens of thousands of years. Not everyone had the same knowledge (July 2018).

Another participant said:

You know if a [traditional] healer does things and fixes your fingers or something because you've got arthritis. There's not a basis for that. There's not a lot of understanding about it … there could be a lot more coming together of the western medicine and knowledge, you know Bush knowledge and cultural knowledge … both from a spiritual sense but also actual tangible medicines (P11, September 2018).

This participant also pointed out that:

The United Nations did give rights to Indigenous people and then we've got other policy instruments. What else needs to be done though to make it happen? (P11, September 2018).

And poignantly called for:

more research and funding for that as well … because I don't think this will happen without some support … too often though you know the community group aren't being engaged in that … so, it's much more the pharmacological companies doing the research about a certain plant and they've got the rights to it. Whereas we should be out supporting our own people to actually be doing that Bush medicine stuff (P11, September 2018).

Although another participant warned that:

If you behaved in a way, say for example you wouldn't share food, share knowledge where particular food was, you would be breaking the law. You could be punished so that's a completely different approach to a western approach which is all about knowledge is power and you're an individual, you hang onto that …. Black fellas said 'no you don't, you've got to share that knowledge, you've

got to share that power, because that's our purpose, is to help each other survive …. That' some of the reasons why we're different … we have a different way of looking at those sort of things (P16, September 2018).

Another participant said of the Aboriginal workforce and Aboriginal health workers, especially Aboriginal health practitioners:

They're the people with cultural knowledge and background as well as the primary care knowledge (P9, August 2018).

Another participant said in relation to an Indigenous policy maker:

[I] don't think we pay enough homage really to the fact that a lot of people have got experience they've developed outside the department. And, for me, it's the lived experience that's actually, really important (P6, July 2018).

And went on to say:

The young fellow that was in my team, he'd worked in a health service. And, then he piped up and said "Actually, that program that you've got me working on, I think my wife came through that program" … And, so, there are all these different experiences there that we could have kept, yeah … I think we couldn't have done it better (P6, July 2018).

These cultural knowledges relate to the realities of what is real to Indigenous Australians – known as ways of being (ontology). They also relate to how Indigenous Australians know the things that they know – their ways of knowing (epistemology). Similarly, they relate to why Indigenous Australians do things in the way they do – known as ways of doing (axiology). I wrote about such ways of being, knowing and

doing in Chapter 3, which has relevance to Chapter 4 concerning an Indigenous worldview.

Several Indigenous participants expressed their cultural knowledges of ways of being, knowing and doing in the way that they lived their lives within their communities and as leaders within the Indigenous public health policy environment. Clearly, inherent cultural obligations, including community responsibilities and accountabilities, underpinned the way that they did the work that they did in the way that is expected of them by their families and communities.

One policy actor said:

> *I feel very privileged to be in this position, seriously. So, I take it very seriously … every-day I am honoured to do the stuff that I do and if ever my [de-identified] Elders or my family say, [name de-identified], you're doing the wrong thing, oh, I would be devastated … like seriously would be devo'd (P7, July 2018).*

These Indigenist knowledges and cultural ways of being, knowing and doing are often in opposition to western scientific values and ways of being, knowing and doing. Western knowledge currently dominates the public policy production processes, with the knowledges and cultures of ways of being, knowing and doing held by Indigenous Australians having no place in evidence-based practice, as confirmed by one participant:

> *Our ways aren't reflected in public policy, they're never actually going to be beneficial to us, right? 'Cause public policy is based on dominant culture (P8, July 2018).*

This participant added:

Until government's prepared to hand over control and trust the community then culture will simply be a word on a page (P8, July 2018).

With another saying:

We need to find ways to get them [Indigenous people] even more … at the beginnings of and following through on policy, development and then implementation (P12, September 2018).

The devaluing of Indigenous knowledges and cultural knowledges of ways of being, knowing and doing is one of several public policy dilemmas encountered in policy actors' stories. Indigenous people's knowledges and cultures are at variance to those of western non-Indigenous ways of being, knowing and doing.

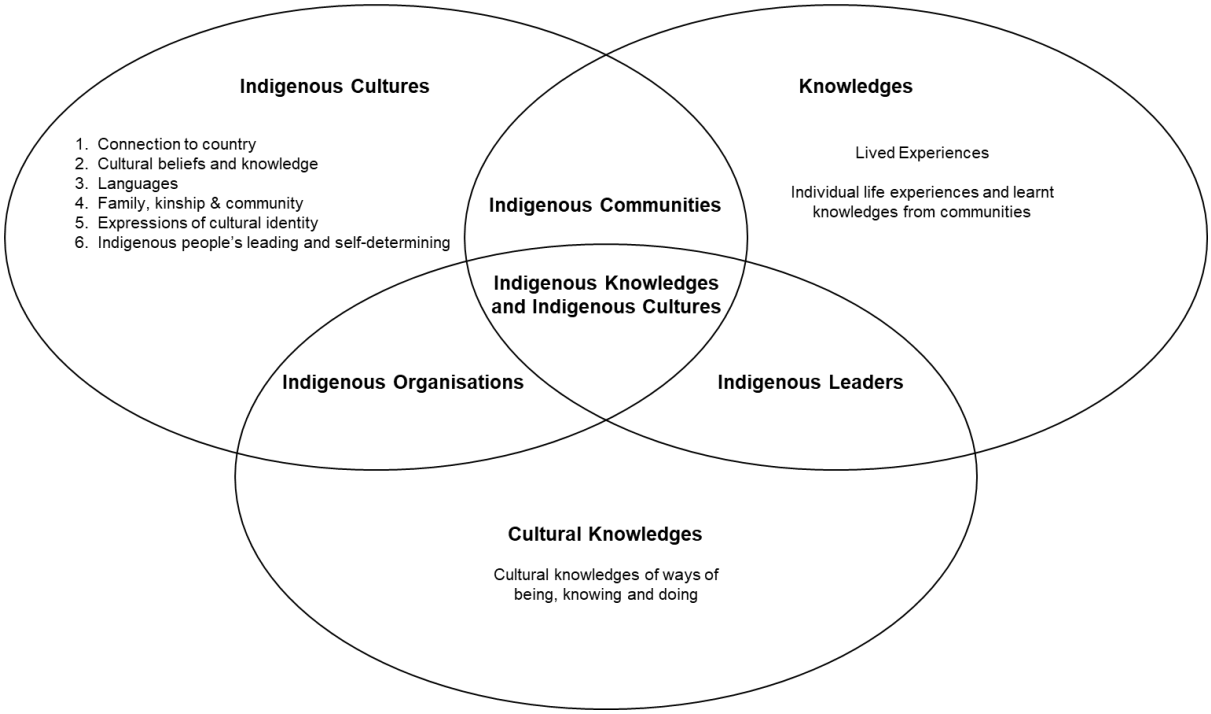
The dominance of non-Indigenous western scientific ways of being, knowing and doing continues to inform and direct public policies regarding Indigenous Australians and their health.

Policy makers need to concede that their knowledge must give way to Indigenous knowledges, and they need to ensure that mechanisms are in place that allow IKs and ICs to be front and centre in public health policy responses. Some of these mechanisms are discussed in Chapter 5 in the section concerned with the enabling of IKs and ICs.

Further, when referring to Indigenous people's knowledges, it should be clear that they are the knowledges that are contained in community and ancestral stories and lived experiences related to Indigenous ways of being, knowing and doing. Figure 12 summarises these knowledges together with the six cultural domains of the cultural determinants of health. Critically, the knowledges that are held by communities, their

organisations such as community-controlled services; and, their leaders, must be captured in policy and service design and delivery.

Figure 12: Knowledges, cultural knowledges and Indigenous cultures captured.



Governments must relinquish their power and control, and trust Indigenous people to be able to share their stories and knowledges, and cultures of ways of being, knowing and doing when formulating policies aimed at improving their health. Because, indeed culture is the knowledges of ways of being, knowing and doing that Indigenous Australians possess.

4.2.2. Theme 2: Open hearts, open minds and open ears, to listen and learn – context

Text Box 2: Extract from P8, July 2018

> *There's this song that Deborah Cheetham and her choir sings about, and it's like "I know you, but do you know me?" … and when you look at linguistics, right? There's some words that don't translate across cultures … that nexus of what I know, for example cultural safety and being able to express that to non-Indigenous peoples is really, really, hard. So, the only thing I can do is take them on a journey with me. It's not just the words. It's actually them walking with me*

The need for policy makers to have an understanding of the nuances of culture that is expressed through Indigenous people's connection to country, languages, laws and lores and traditional healing practices, remained a consistent message in stories told by policy actors. As one policy maker said:

> *I think the right people to do policy are the people who are curious, and who are open minded. And, who also acknowledge that they don't have all the answers. And, particularly if you're working in a space like Indigenous affairs, um, I'd say especially if you're not Indigenous, but also if you are Aboriginal or Torres Strait Islander, you can't … speak on behalf of all Indigenous people in Australia, you [policy makers] have to ask questions (P3, June 2018).*

This understanding is a prerequisite when supporting the implementation of Indigenous knowledges and Indigenous cultures within a public health policy context. These cultural expressions are often in tension with non-Indigenous worldviews and values. One participant said:

How do we take those next steps to ensuring that we are operating on the same values? So, where there is government expenditure, we're starting to operate off those same values, how do we make sure our regional decision making is co-designed but it's of equal power (P2, June 2018).

First and foremost, there must be an understanding though of the historical legacy of colonisation. One policy actor said:

When I look at the National Aboriginal Health Plan and I see culture at the centre of it, I think that helps to put Aboriginal and Torres Strait Islander people at the centre of Aboriginal culture … Aboriginal communities and Aboriginal people and their history (P16, September 2019).

This participant went on to say:

Our history goes back thousands of years, and to see that knocked out by a couple of hundred years of colonisation and assimilation … you know, the biggest tragedy (P16, September 2018).

Further adding:

I don't look back at, you know, things like massacre's and stolen children and, you know, people being shut down on missions, all of that, I don't look back at that and say, oh that's in the past we need to get over it, I say, look that still hurts (P16, September 2018).

And that's why another participant said:

As a scene setting, that's the sort of environment that we live and work in, at the moment. In dating back 230 years, to historic dating back 50 years, to current

day … it's so critically important for a lot of policy makers and influencers to gain that understanding as well … (P15, September 2018).

This participant went on to affirm that:

You also have, you know, the legacy of colonisation … we see places like Melbourne, Sydney, Hobart, Adelaide … to an extent were colonised long before other parts of Australia (P15, September 2018).

And added:

Throughout the education of Aboriginal people in the 50s and 40s and even before where people were restricted from using their language and practicing their own culture and with the endeavour to learn English, and to become much more Europeanised … were in that environment … that's really important to think about and listened too … across the nation (P15, September 2018).

P15 went on to say:

Why that becomes important is because associated with that is also the inability to practice culture and language, which was part of a concerted effort when people were removed (September 2018).

And added that:

Colonisation has had an impact on culture and language, and just people's basic understanding of life and ability to practice their culture and language … and it's very important to consider that (P15, September 2018).

P15 highlighted that:

Very recently a report by the Australian Institute of Health and Welfare looked at intergenerational traumas, and the impacts of the people being forcibly removed … the stolen generation … and the current manifestations of that where kids are placed in out of home care … these are impacts that haven't really been considered (P15, September 2018).

With another participant confirming:

I know like a lot of the trauma experiences are a result of the complete dissection and otherwise of culture (P5, June 2018).

With another saying:

[those people being] removed from their families, then being institutionalised and then going through what happened in the institutions, which was primarily abusive, um, physical, sexual abuse, neglect ... not being nurtured, not being shown love, not being given any kind of education … just generally treated really badly, and not the way children should be treated (P16, September 2018).

P16 went on to say:

But those experiences aren't just sad stories, and they aren't just horrific stories, they're more than that … those events had an impact on people's physiology, so it changed the way their bodies operated and it had an impact on their psychology, so it changed the way their brains function … those impacts don't resolve easily, you can't resolve them with a pill or a tablet or counselling session, they're long lasting … so the way people function and see the world, they then pass that same kind of experience onto their families (September 2018).

P16 then referenced clinical evidence, saying that:

> *There's some pretty powerful research that's come out of the United States, called Adverse Childhood Experiences [ACE], which goes a long way to explaining why people who have experienced traumatic events in their childhood, struggle throughout their lives (September 2018).*

P16 reiterated that:

> *They struggle on a range of ways. They struggle to form strong relationships. They struggle with their health, they're more likely to be affected by common chronic diseases, cancer … they're more likely to participate in risky health behaviour, like drug and alcohol abuse … they are more likely to be violent ... there's a whole range of other things (September 2018).*

This participant said that the ACE study identifies:

> *around ten different traumas, experiences … and, if you transpose those experiences onto the experiences of Aboriginal and Torres Strait Islander people in Australia, they're all the things we struggle with (P16, September 2018).*

And went on to argue:

> *They're all things that are sending us into jails, at alarming rates. Sending us as kids into juvenile detention and removing children from families. It's all driven by those adverse experiences (P16, September 2018).*

As one participant said, the solution is that:

Governments … have to feel guilty as they are the perpetrators of why we are in our position as we know, and as they were the perpetrators, they have to be the solution (P15, September 2018).

Importantly, governments:

have to reinvest in our affairs, to ensure that we do reach our full potential even in the future (P15, September 2018).

Further, governments:

have to recognise that it's their practices, it may not be the individual politicians here … but the ones in the past who had created policies that put us in the position that we're in (P15, September 2018).

A policy maker who works in government actually said:

I can jump in and put out a trauma policy saying that will help inform culture, but it's not really the issue. We're looking at many intergenerational issues and I think some of the work around … the genomics sort of work around impacts linking with intergenerational trauma … that's quite amazing, the findings coming out (P5, June 2018).

One policy actor said the funding of culture is not recognised as a funding priority of governments (P6) with another confirming that:

The colonisers worked so hard to wipe out our culture, but what have they done to restore it? Have they really funded culture? (P8, July 2018).

Another participant reaffirmed that our communities need assistance by saying:

> *The impact of colonisation is still being felt today. Those things reverberate down through the ages, and we are struggling, many of us are struggling, many communities are struggling, because we haven't understood that (P16, September 2018).*

Another participant argued for the need for nation building that is driven, owned and informed culturally by community (policy actor representative, 12 December 2019). While a participant went on to say:

> *So, to build our nation we're revitalised our language, but in revitalising our language, we revitalised our culture because that has our laws/lores that has our being, that has our way … right, embedded in the language (P7, July 2018).*

This participant continued to say:

> *It's learning this deeper meaningful construct of who we are and how we live [our] way … and, so in our nation building, we've, we've really centred and we like do it our own way … it's really centred not on the economic, the economic development sense just yet. [because] we're starting with the wealth of culture and who we are*
>
> *… and what we're finding … is that there is this healing process … this healing process is happening and healing in a sense of individual healing … that healing [in] a sense of 'now I understand who I am and what I'm here for' (P7, July 2018)*

But it all starts at that:

> *Localised and regionalised decision-making governance and leadership. That's where it all happens (policy actor representative, 12 December 2019).*

Despite the impacts of colonisation on the lives of Indigenous Australians not being fully understood, one participant was optimistic:

> *You know, so it's not bleak into the future – I think it's positive (P15, September 2018).*

Another participant said:

> *We have to decide to learn … we actually have to – hear, if you'd like – really listen (P8, July 2018).*

This participant went on to refer to the Truth and Reconciliation Commission that happened in Canada by challenging Australians:

> *We cannot wake up to the same Australia the next day … we actually have to decide that we are going to be a different Australia (P8, July 2018).*

This participant argued that:

> *There has to be this line in the sand … a Truth and Reconciliation commission would be awesome … or a Royal Commission into Racism (P8, July 2018).*

Going onto say:

> *Once we have those recommendations, we have to truly commit and resource that (P8, July 2018).*

And even adding:

> *And, it's a bit like this Plan. So, maybe this Plan can never really be fertilised in this health system. Maybe it actually needs to be planted in something else … because the ground is not fertile at the moment for us to do it (P8, July 2019).*

And, when asked, “Where would you plant it though?” P8 responded by saying:

> *I have this big grandiose idea you know. For Aboriginal people if we were to be trusted, we could have an Aboriginal Health Authority … an actual statutory body made up by non-Indigenous people and Aboriginal people … and the set of skills that actually worked with Council of Australian Government and AHMAC – Australian Health Ministers Advisory Council – they fund us and we actually talked to community about what their needs were and actually funded it … (July 2018).*

P8 went on to say:

> *But then alongside of that, actually have data sovereignty in driving whatever people say that they need … that we have the evidence, because we have data sovereignty … I know it sounds simple but in my head I don’t think it’s that hard (July 2018).*

And then asked:

> *You know? ... with the structures that we have – where are Indigenous people’s voices privileged? … our amazing Aboriginal politicians are there to serve the constituents. Not Aboriginal people. So, we actually need, you know some alternative arrangement to what we currently have (P8, July 2018).*

P8 argued that to move forward as a nation, Australia needs:

> *something like a Truth and Reconciliation Commission to acknowledge the history … the true history of this country and the intergenerational impact that it’s had. And make recommendations out of that, like that’s been done in Canada,*

like it's been done in South Africa, and those nations had a very similar history to ours (P8, July 2018).

In Australia, this history is not commonly known amongst public health policy makers who have the responsibility of making policy for Indigenous Australians. Hence, calls for a Truth and Reconciliation Commission. If non-Indigenous policy makers continue to be involved in making policy for Indigenous people then an open heart, with an open mind and open ears to listen and learn is mandatory. Although, in addition, there is a need to reframe culture so that it is understood by policy makers.

As expressed by an Indigenous policy maker:

Non-Indigenous Australians often struggle with the construct … that reflects, in part … kind of the ways in which culture, as a concept, can be a little bit slippery … and its representation is sometimes unclear (P13, September 2018).

Another non-Indigenous policy maker reaffirmed:

uh, you know, [I] don't find it easy to understand the concept of culture in a very tangible way (P2, June 2018).

While another non-Indigenous participant who worked in government said in relation to understanding culture:

That's a limitation to just their [policy maker's] imagination to be able to understand. Because we don't – we may never actually fully understand … (P12, September 2018).

And another participant asked:

How do you explain [culture] to them [government]? (P2, June 2018).

P2 went to say:

It's about taking them on the story, on the journey, to say, a healthy Aboriginal person most likely lives on country, has the ability to practice culture, they have a say in their own life, they speak language, and they live in the construct of traditional cultural ways … so their interactions with the other community members are as per their cultural obligations and their interactions to the greater community but also to the land. So, you know try and draw them the picture of saying, this is what a healthy functional Aboriginal person looks like and these are the important things, or these are the things that are important to Aboriginal people in that construct of being healthy (June 2018).

And then explained:

From a non-Aboriginal viewpoint, what's important to individuals? And they'll say, "Having a good life". "Having an income, having a home, having all these sort of material things. Whereas, if you ask Aboriginal people, what's important to them, healthy family, being able to practice culture, talk language, all those things …. The values of those are very different … it's quite confronting for non-Aboriginal people to understand because it's not the same value set that they work off (P2, June 2018).

Another cautioned that:

It's not actually up to [governments] to define culture or cultural identity or cultural prides and what that actually looks like. That is actually the role for Aboriginal

and Torres Strait Islander people and Aboriginal and Torres Strait Islander leadership (P4, June 2018).

With a government official also confirming:

It's a real interesting challenge … We actually want your ideas … it's your culture … I'm not writing your culture (P5, June 2018).

Defining culture has its own set of challenges with another saying *culture is not homogenous for everyone (P8, July 2018)* and others questioning the existence and relevance of an Australian culture (P3, P6 & P8).

Another participant said in relation to Aboriginal and Torres Strait Islander culture:

There is no single culture in Australia … there's no single language, there is no single tribal group we have here in Australia … where we have multiple cultures and traditionally, 350 plus language groups. And then you got the dialectic groups … you've also got such a divers geographic spread of people … so you're getting people that are on the coast, versus the islands, versus the desert zones and arid zones (P15, September 2018).

While there exist a diverse range of cultural beliefs and practices amongst Indigenous nations such cultural factors and knowledges must be considered in the design, delivery and provision of services (P1, P2, P7, P8, P9, P11, P14, P16, P17, P18 & P19, June – December 2018). Given the lack of understanding errors in practice is highly likely (P1 & P9).

A case example contained in Chapter 6 provides good practice examples of how to implement Indigenous knowledges and Indigenous cultures into clinical practice. Case

examples like that contained in Chapter 6 will assist the service system to implement those cultural determinants of health now embedded into the Health Plan's second Implementation Plan. As one participant said:

> *Cultural determinants [are about] actually trying to build cultural ways of working into programs that are delivered by people (P1, June 2028).*

Despite the challenges associated with policy makers not having a full understanding of culture there was a strong consensus that regardless of such situation they must be respectful knowers who are willing to take that journey with Indigenous people and communities. Importantly, to understand Indigenous Australian's worldviews and values is imperative if successful implementation of their knowledges and cultures is to occur, particularly within the service system. Although, in addition to understanding culture, it is also necessary to understand:

> *how to embed [culture] (P8, July 2018).*

With another participant confirming:

> *Cultural determinants and embedding culture, in particular, has been a struggle for [governments] (P4, June 2018).*

And another participant said culture needs to *"cascade across the life course" (P2, June 2018)* with others providing examples such as *birthing on country (P17, October 2018)*. Importantly, what underpins the implementation of the cultural determinants of health is the creation of self-determining communities that are facilitated by governments and supported by a range of policy instruments (P12, P17 & P18). Policy makers need to ensure that Indigenous people, and their cultures and knowledges,

are central to any health policy or program response (P4, P5 & P8). A model of practice which aims to support the implementation of IKs and ICs is offered in Chapter 5.

4.2.3. Theme 3: A willing readiness *but* a deep-seated resistance – process

Text Box 3: Extract from P8, July 2018

> *So, if we are true to self-determination in culture, then I don't know if it's going to fit in the paradigm of government. Because government is so blanketing … that's an issue. So, once we have that dominant culture turned upside down, Aboriginal and Torres Strait Islander people's ways of knowing, and being and doing are central.*

While the incorporation of culture, and racism in the Health Plan signals a willing readiness, the stories told by participants revealed a deep-seated resistance. Clearly, the system is just not ready for all this thinking with a participant saying:

> *I don't think government has been ready for it [culture] (P6, July 2018).*

True acceptance on the part of government requires what one participant was doing in their work:

> *Those strategic directions are around trying to improve systems … systems need to be able to better deliver on that … systems aren't gonna change overnight, but growing awareness is really important (P1, June 2018).*

With another saying:

> *I don't think like, from a system perspective we have measures that associate with those positives of culture …. well actually we haven't set up our data systems or anything to capture those cultural determinants of health … and, the system, the system's not ready for this thinking (P2).*

Several other participants highlighted several impediments, with one saying:

> *We live in interesting paradigms … we just have to change the mindset across the board (P14, September 2020).*

Another participant said:

> *It's an institutionalised thing, it's part of Australia's heritage … Australia is a pretty brutal place … those institutions … people … they inherit privilege, they inherent certain rights that other people don't … they create the system, the system that perpetuates themselves (P16, September 2018).*

Another participant agreed:

> *It's about power and control … it's about dominant culture again making us assimilate and colonise … our whole system and structural elements are dominant culture driven (policy actor representative, 12 December 2019).*

And another said:

> *White fellas aren't gonna give up, these white institutions aren't gonna give up their power willingly (P21, December 2018).*

While another said that:

> *There is a need to address, recognise that there is such a thing as, and then address, institutional systemic racism (P12, September 2018).*

And another said:

But that's just, that's system bias. People don't even have any insight into their behaviour … in the system where they actually have no insight into, sometimes, this stereotype, stereotypically attitudinal behaviour (P1, June 2018).

One participant suggested that a system-wide response is imperative:

So, a lot of the common themes around empowering individuals with their own health, but empowering the sector … so, this is part of a whole system, it's not just that's one bit over here is the hospital … the wholistic view of the health system is the other thing that we're trying to really look at in that health plan (P11, September 2018).

And another said:

Where government is sort of structured is that we focus on treatment for an individual and, we prescribe on the basis of an individual. We don't actually think about the broader impact on families and communities … my uncle who is a psychiatrist said he actually thinks the Department of Health should be called the Department of Illness. It's the way we focus on end-stage deficit (P5, June 2018).

P17 said some in government would argue that:

We can't do that because that's just not the way we do it … people are starting to realise … moving from now … moving away from that, but having the backup of policy … and strategy and even legislation (P17, October 2018).

Another said:

Most people you talk to across the public sector who have seen you in the leadership space would wish to actually lead good policy, strangely, tend not …

and look that way reflect whole range effectors including competing priorities, but when you probe beneath that, there is an anxiety that emotionality …. Creates what you could call it policy paralysis … a kind of paralysis of good intention …. Which could have a number of dimensions …' I don't wanna do the wrong thing. I'm scared that someone will call out as racist or I just don't know what to do' (P13, September 2018).

P13 went on to exclaim:

And they're kind of phyco-emotive responses. But what they do is tend to induce an unintended conservatism in institutions … not conservative in the sense of reactionality or negative towards Indigenous Australians but actually … they can't move because people can't lead (September 2018).

Another participant said:

The other system change is an acknowledgement of racism within that system, and a zero tolerance towards that (P8, July 2018).

P3, who had been instrumental in the development of the Health Plan, confirmed that:

By the time you've heard it [racism] in 17 consultations, plus a number of other people are saying racism is impacting on our health and wellbeing … governments need to be advised (June 2018).

Another excited participant confirmed that:

This was one of the first times as well, a national policy document explicitly named racism … we had to have a lens that looked at racism (P3, June 2018).

Although, a concerned policy actor said:

> *Unless you address culture, and unless you address racism, then there's no point (P18, October 2018).*

P12 added that actually, there is a need to:

> *[find] new ways to talk sort of talk about racism (P12, September 2018)*
>
> *… because … they've got some really good allies, but it's actually about saying, 'Racism is an issue, so how do we work through it?' (P2, June 2018) and,*
>
> *… it's incumbent on us to be able to roll up our sleeves and open up that conversation (P21, December 2018)*

As one participant argued:

> *If we want to eliminate racism we have to do it in a multi-pronged approach (P7, July 2018)*

because,

> *the more challenging issue in that cultural safety framework is institutional racism (P14, September 2018).*

However, this participant also asked:

> *What is it [institutionalised racism]? What does it look like? And what are the aspects to institutionalised racism or institutional biases against individuals – Aboriginal people … [what] do we have to overcome? (P14, September 2018).*

P14 asked this because:

The classic [manifestation] of this [institutional racism] is very few Indigenous people who are on dialysis go on the kidney transplant list (P14, September 2018).

Another participant, when lecturing, challenges their students by saying:

'Well, who is delivering health in racist-free healthcare delivery systems?' …. So, they all know that it's racist … 'Well, are you complicit in that or not? (P19, October 2018).

Being unknowingly complicit is also built into often racist and blaming policy narrative that was demonstrated by a participant as:

Get off your F#@KING BLACK arses and get a job … and get your mongrel black kids to school … get into work, get your kids to school and men, stop basing your women (P21, December 2018).

This is a mindset that pervades the rules, behaviours and norms of systems and organisations. Although on a positive note one participant said:

If someone does something on television or like, in the public, which is you know, racist or ignorant, people are starting to call it out now (P17, October 2018).

Another participant said that to combat such racist and deficit policy language we should be saying:

Culture is the strength … Aboriginal people are the strengths, culture and identities are the strengths. So, then let's use that as the strength … (P7, July 2018).

While another said:

> *Because they always seem to be racist … don't wanna be racist … it's still a difficult conversation to have (P13, September 2018).*

And another said:

> *When they're talking about unconscious bias and you come up with these terms that sort of make it seem less confronting than it actually is. Whereas the reality is that it's … [racism] kills people – it's a major health impact and we need to call it out for what it was (P12, September 2018).*

While another said:

> *Yes, as a national system, we don't have a policy position on racism, and we have no way of chewing through that to get to that (P2, June 2018).*

P2 exclaimed:

> *So, and I think it's – it's one of those things that as we mature as a system, we've got to work through (P2, June 2018).*

And added that:

> *I think it was hugely ambitious to put it in there, to have a health system, um, free of racism ... um, was hugely ambitious, because you think that was put in, what? Seven years ago, and we still can't talk about racism now and it's 2018 (P2, June 2018).*

I concur with P2 about the difficulties to talk about racism. Policy makers and public health practitioners don't feel comfortable about talking about racism, and won't.

Critically, policy makers and practitioners must start to talk about racism for the reasons highlighted in the following manuscript that is under review by the Public Health Research and Practice Journal.

4.3. Talking about the R word – racism

Reference

Parter, C., Murray, D., Mohamed, J., Rambaldini, B., Calma, T., Wilson, S., Hartz, D., Gwynn, J. and Skinner, J. C., Talking about the R word: a health system that is free of racism – under review for publication.

Authors Contribution Statement

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We confirm that Carmen Dorothy Ruby Parter made the following contributions:

The candidate planned and prepared the manuscript that involved several drafts in readiness for publication. Donna Murray, Janine Mohamed, Boe Rambaldini, Dr Shawn Wilson, A/Prof Donna L. Hartz, Dr Jo Gwynn, Prof. Tom Calma and Dr John Skinner contributed to subsequent drafts by reviewing and editing the content, and providing advice. The final draft was reviewed and approved by all co-authors.

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Signed [REDACTION] Date 09/09/2020
Dr John C Skinner

This statement aligns with the requirements of the University of Sydney regarding policy as described in the policy documents:

*Thesis and Examination of Higher Degrees by Research Policy 2015
*Thesis and Examination of Higher Degree by Research Procedures 2015

https://www.sydney.edu.au/students/prepare-thesis.html

Key Points

- Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing must be front and centre to any public health response
- A deep-seated resistance to addressing institutional and systemic racism, and racist attitudes prevents the implementation of Indigenous knowledges and Indigenous cultures
- Public health policy makers and practitioners must start talking about racism
- Working at the cultural interface where knowledge systems and cultures can co-exist is imperative
- Understanding institutional and systemic racism is warranted.

Abstract

By 2031, all governments have agreed that the ten-year life expectancy gap between Indigenous and non-Indigenous Australians will have closed. However, consistent annual Closing the Gap reports tabled by the various Prime Ministers in the Australian Parliament (for the last 12-years) have consistently indicated that the life expectancy gap continues to widen. Australia has seen just over three-decades (31-years) of government policy intervention since the landmark 1989 National Aboriginal Health Strategy. What has been missing from these policy commitments is the genuine enactment of the knowledges and cultures that are held by Indigenous Australians of ways of being, knowing and doing. Importantly, the sharing of power, provision of resources, and culturally informed policy making and program design is critical. Privileging Indigenous knowledges, cultures and voices must be front and centre in developing, designing and implementing policy and programs. A conceptual model of practice, working at the cultural interface where

knowledges are valued and innovations can occur is provided. This model of practice is where knowledges and cultures can co-exist, and could be the answer to Closing the Gap in life expectancy by 2031. Despite a growing willingness to consider these models, there remains a deep-seated resistance to identifying and addressing institutional and systemic racism, and racist attitudes including unconscious biases held by individuals. Further, western non-Indigenous worldviews of ways of being, knowing and doing continue to dominate the decisions and actions of governments - known as public health policies. An unacceptable standard approach, for and about Indigenous health instead of with Indigenous peoples, at the expense of neglectfully dismissing Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing occurs.

Introduction

The elevation and implementation of Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing are the principal factors required to close the ten-year life expectancy gap between Indigenous and non-Indigenous peoples. If real transformational change in the health status of Indigenous Australians is to be achieved, then the knowledges as well as the cultures of Indigenous people must be front and centre in all public health policy and programming responses. Unfortunately, the knowledges and cultures held by Indigenous Australians are not fully acknowledged or recognised, and is often dismissed as irrelevant.[1] For far too long, non-Indigenous and western scientific and biomedical knowledges of ways of being, knowing and doing have dominated and informed public health policies and programs. The public health sector must provide the means for Indigenous Australians to self-determine and rightfully practice their knowledges and cultures of ways of being, knowing and doing.[2]

Thirty-one (31) years have passed since the 1989 National Aboriginal Health Strategy (NAHS) declared an Indigenous health crisis.[3] Consistent government efforts to address this health crisis have been futile.[4] Nonetheless, emphasising the centrality of culture for Indigenous Australians and acknowledging the reality of racism in a public policy instrument like the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013 - 2023, has created an opportunity to position Indigenous peoples and their knowledges at the forefront of public health responses and policy.[5] Unfortunately, despite a willingness amongst some senior bureaucrats, politicians and academics, ingrained racist paradigms continue to sustain the health disparities and inequities, and social, economic and political inequalities that Indigenous Australians continue to experience.[6-8]

What do we know so far?

The efforts and investments over these 31-years, has only seen the slightest improvements to the ten year life expectancy gap between Indigenous and non-Indigenous people.[9] Further, the social determinants of health and the legacy of colonisation continues to contribute substantially to the social, economic and political inequalities experienced by Indigenous people.[9]

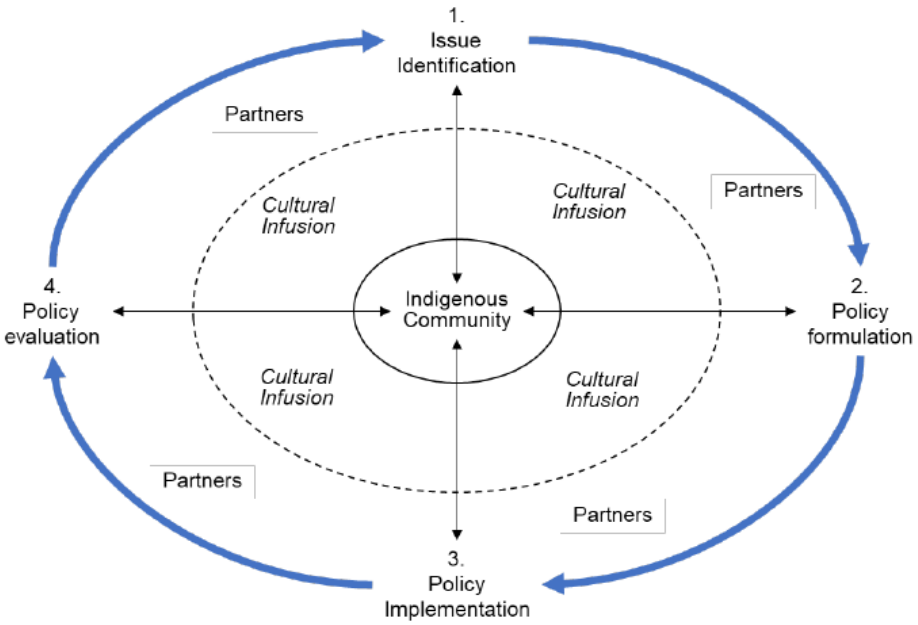
While there have been many plans and strategies, along with hundreds of millions in state, territory and Commonwealth funding since the 1989 NAHS, was introduced, there has been limited positive outcomes to improve health. Also, Indigenous wellbeing in the mainstream health system continues with avoidable negative conditions and deaths widening.[9]

What needs to happen?

The new national Closing the Gap Agreement (the Agreement), made between the Coalition of Peaks and all levels of governments, have committed to a range of reforms including "systemic and structural transformation of mainstream government organisations".(p11)[10] Astoundingly, all governments have agreed to eliminate racism with culture and truth-telling underpinning their policy responses.[10] Additionally, a national summit called "for more transparency, truth-telling, power-sharing and culture-informed decision-making practices integrated within policy productions, program implementation and evaluation strategies".(p1)[11]

Reinventing institutions and transforming their structures, systems and, practices requires an insurgency that challenges the dominance of non-Indigenous scientific western and biomedical knowledges, which have been responsible for determining policy and program decisions about the health of Indigenous Australians. That is not to say that there is no place for non-Indigenous western science. On the contrary, the knowledges and cultures held by Indigenous Australians must be recognised, valued, and be front and centre to public policy and programming, and public health practice. Importantly, they can complement and co-exist with western knowledges. However, where knowledges meet at that cultural inter-face, Indigenous knowledges and cultures are subjugated.[1, 12] Innovations are inevitable if those knowledge systems and cultures are recognised as independent entities able to complement the other through cultural infusion.[12, 13]

Figure 1: Working at the cultural interface where innovations through cultural infusion occurs – adaptation of the policy cycle [1, 13, 14]



Therefore, Indigenous Australians must be provided with the means and opportunity to rightfully self-determine and govern their affairs. Mainstream governance structures within organisations must be able to share power equally and privilege Indigenous voices, knowledges and cultural ways of being, knowing and doing in policy production and service design.

Discussion

> Racism is more than an individual issue. When systemic injustices remain, unspoken or accepted, an unethical white privilege is fostered. When individuals and groups point out systemic injustices and inequities, the dominant culture is made accountable.[15]

Recognising the reality of racism and centring the cultures of Indigenous Australians in the decisions and actions of government continue. Communities remain strong with their aspirations and positive that governments have finally started to hear their calls. But is this enough? Transformation to action is required. Based on government legacy it is obvious that their actions have not been enough,[1] as connection to culture continues to be portrayed as an Indigenous Australian problem,[16] rather than Indigenous Australians reclaiming pathways to better health.

Australia has seen consecutive national Aboriginal and Torres Strait Islander health plans that have consistently spoken about the relevance of culture and the holistic nature of health. Yet the rights of Indigenous Australians, as espoused in the Declaration of the Rights of Indigenous Peoples,[2] remain compromised. Specifically, in relation to being able to rightfully and freely self-determine, without prejudice, their cultural expressions and knowledges in how health and healthcare can be practiced.[2] Also, despite the emergence of Indigenous cultures in public policies and programs, there is no recognition of the knowledges held by Indigenous Australians and their intrinsic relationship to Indigenous cultures.[1] Further, issues of institutional and systemic racism, racist attitudes, unconscious biases and non-Indigenous western worldviews of ways of being, knowing and doing continue to prevail and prevent effective policy and programming design and implementation. Finally, research on the role of racist paradigms and their rules, norms and behaviours in shaping health systems, their organisations, and individuals' behaviour will provide greater understanding of when, where and how to act so transformative change occurs.

Conclusion

Given the fruitless COAG policy efforts of closing the life expectancy gap between Indigenous and non-Indigenous Australians, elevating and implementing Indigenous knowledges and cultures of ways of being, knowing and doing are principal factors for achieving meaningful and sustainable change. However, to enable the knowledges and cultures held by Indigenous Australians requires the sharing of power and resources to support the privileging of an Indigenous voice(s) in policy and public health program design. Critical to such a requirement is working at the cultural interface where cultural infusion occurs to create those shared and inventive solutions necessary to address the health of Indigenous Australians. Furthermore, a strong commitment and understanding from governments, policy makers and public health practitioners about their role in enabling the knowledges and cultural ways of being, knowing and doing held by Indigenous Australians is imperative. As is talking about racism. Unleashing Indigenous people's knowledges and their cultures is the answer for achieving the transformative systemic and structural reforms agreed by governments.

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4.4. Addressing Unconscious Biases

Whilst frameworks like cultural respect, cultural competency and cultural safety aim to change systems, organisations and behaviours of individuals like racist attitudes, they are not the answer when implementing Indigenous knowledges and Indigenous cultures (C. Parter, personal communication, 26 September 2018).

As one participant said:

> *We can't rely on cultural safety and cultural awareness training to support the implementation of culture (P6, July 2018).*

What is required is an urgent need to address the deep-seated issues of institutional and systemic racism to be discussed further in Chapter 5. Although, as another participant attested:

> *The other big topic of recent times is about unconscious bias and how people restrict their thinking because of how they have been influenced in their thinking (P15, September 2018).*

Issues of unconscious bias must be understood, particularly as to how the biases held by policy makers plays out in the making of policy. One policy maker insightfully observed:

> *So, I started realising, oh, hang on, why did I just tell myself to be safe around that person? That person's actually not making … they're not even looking at me, but I've just made this assumption that they're a dangerous person (P6, July 2018).*

And P6 went on to say:

So, it's … it really started to force me to think about your … what are we-what are our internal biases and how do we unconsciously play those out, then, during the course of the day, the week, the year? And what impact does that have on the way we carve out how we do our work? (July 2018).

And added:

That's actually quite scary, when I think about that a little bit more … there are things that I'm not even conscious that I'm doing that are sending signal … and that's, yeah actually quite scary (P6, July 2018).

P15 said that quite often:

Too many policy makers make decisions based on their understanding of what culture is, and what constitutes an Aboriginal person, an Aboriginal person's relationship with country and cultural practice … often it's because they have been influenced by the mass media, what they see on television, what they might read in some of the conservative newspapers … you know, some of what the shock jocks might say that are often very simplistic very sensational, very inaccurate when it comes to trying to understand Aboriginal people (P15, September 2018).

An example of such behaviour was demonstrated in the following incident:

I had two individuals tell me, "Oh, this particular researcher, who was describing this research project as an Indigenous led research project … um, so we've taken that out" … I asked them … I said, "Why?" … And, they said, "Well, they're not Indigenous." I said, "Who?" … "Oh, the people, they're not Indigenous, we know" … "How do you know?" … "Well we looked at their photo on the website, they're

not Indigenous." … And, so … we than had a very lengthy discussion of why that possibly wasn't appropriate … it's not our claim to make (P6, July 2018).

Despite these challenges, many positive stories arising from yarning sessions provided comprehensive examples of a range of policy tools and instruments to enact culture when implementing Indigenous knowledges and Indigenous cultures throughout programs and services. Some of these examples have been woven through the above yarns. Others have been omitted deliberately due to ethical and cultural obligations. Re-telling stories containing examples of integrating Indigenous people's knowledges and cultural knowledges of ways of being, knowing and doing require the explicit consent of Indigenous people and communities who are the holders of such knowledges. Nonetheless, other examples have been summarised and de-identified in the next chapter. They are used respectfully and with caution.

4.5. Chapter 4 Discussion

To effectively implement Indigenous knowledges and Indigenous cultures, policy makers must concede that there is an innate relationship between culture and the knowledges held by Indigenous Australians. Further, they must concede that the diverse and unique knowledges held by communities and individuals are just as valid as western science and its knowledges.

So, when referring to culture in a public policy instrument like the Health Plan, reference should always be made to the knowledges held by Indigenous Australians. A reframing in the policy dialogue is therefore a necessity. The aim of this reframing is to remind policy makers that culture is about the knowledges that are owned and held by Indigenous Australians. Reframing culture in this way will complement the six

cultural domains that are already embedded into the next iteration of the Health Plan's Implementation Plan.

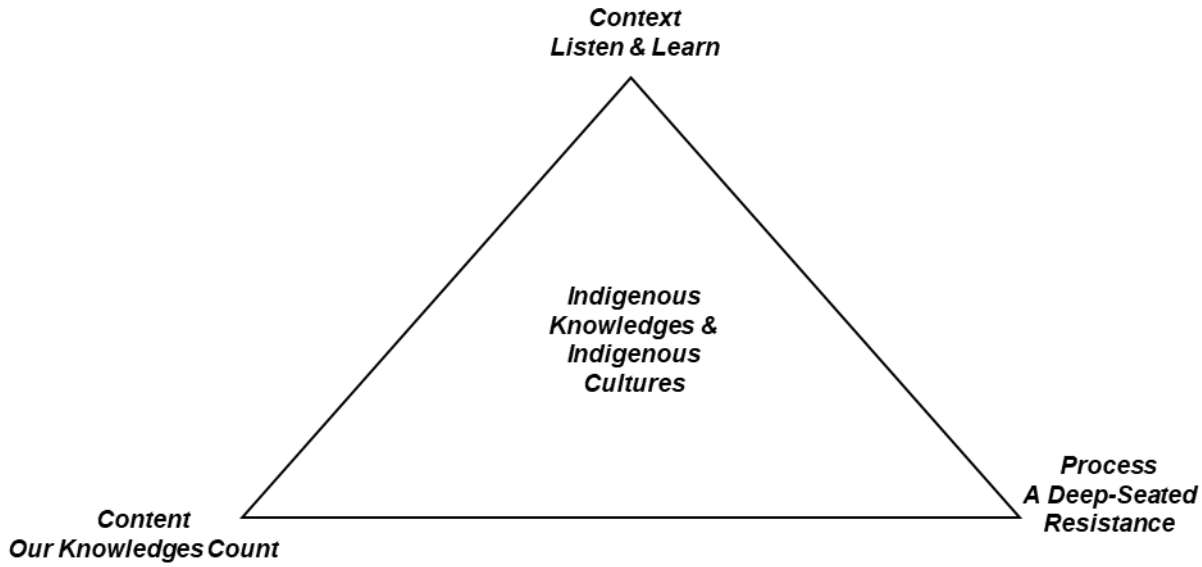
In addition, further investment and research is required to genuinely centre Indigenous knowledges alongside Indigenous cultures when it comes to implementation. The nexus between the knowledge systems that interact and play out in the cultural interface mentioned in Chapter 1 must be understood. Given that such a space is a highly contested one that is dominated by western scientific and biomedical knowledges and cultures of healthcare, the next issue is the question of how these knowledges can begin to complement each other in public health policy and practice.

Policy makers must be prepared to be open and sensitive to community stories, and they must be able to listen and learn from Indigenous peoples as they walk on a journey of respectful knowingness. It is imperative that policy makers acknowledge an Indigenous worldview that is not consistent with non-Indigenous western worldviews. In addition, understanding the impacts of colonisation through truth telling is essential.

For the knowledges and cultures of Indigenous people to take their place in the policy production process, policy makers must be cognisant of the deep-seated, racialized and often invisible resistance of dominant cultures and western ways of being, knowing and doing. These dominant paradigms must be challenged for Indigenous public health policies to succeed in closing the health gap between Indigenous and non-Indigenous Australians. The model of practice provided in the next chapter offers a tool to challenge and reform such dominant paradigms that aims to change the value system that is conducive to those values held by Indigenous Australians.

Below, the policy triangle is re-introduced in a form that provides a visual summary of the yarning session stories.

Figure 13: 3 Themes of policy triangle



4.6. Chapter 4 Conclusion

Chapter 4 re-told policy actors' stories and identified three main themes in these stories.

Firstly, there remains a necessity to reframe culture, given policy makers' difficulties in fully understanding Indigenous Australian's worldviews of ways of being, knowing and doing. Hence, theme one establishes clearly that our cultures are our knowledges, and that our knowledges count.

Secondly, it is essential for policy makers to be attentive listeners who are willing to learn. This is necessary because they need to be aware of the nuances of the knowledges and cultures of ways of being, knowing and doing held by Indigenous communities. This is why calls for policy makers to possess an open heart, an open mind, and open ears to listen and learn is imperative. A set of soft attributes required of policy maker (P3, June 2018).

Finally, the third theme highlights barriers that will prevent the full realisation and operation of the knowledges and cultures that Indigenous Australians possess. Clearly, there remains a deep-seated resistance - of institutional and systemic racism - to giving effect to Indigenous knowledges and Indigenous cultures. To effectively implement Indigenous knowledges and Indigenous cultures, this deep-seated resistance must be understood. This resistance manifests itself in how systems, organisations and individuals behave.

Chapter 5 will now offer a systemwide translational model of practice that aids in bringing understanding of this deep-seated resistance in relation to institutional and systemic racism. The model also relates to the implementation of Indigenous knowledges and Indigenous cultures.

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CHAPTER 5. A SYSTEMWIDE TRANSLATIONAL MODEL OF PRACTICE TO ADDRESS RACISM

5.1. Introduction

This chapter contains an accepted peer reviewed paper in section 5.2 that has been presented as an abstract to the 16th World Congress on Public Health Virtual Conference to be held from 12 – 17 October 2020. The (283 word) abstract summarises the findings from the policy actors' stories (from Chapter 4) and relates them to the challenges of implementing culture, and indeed the knowledges held by Indigenous people and communities. The challenges of institutional and systemic racism represent a significant public policy dilemma requiring redress.

My personal stories, woven throughout this chapter, provide accounts of real-life experiences of racism. I use accounts of such lived experiences to describe how racism, white privilege and whiteness; pervade the way that racist systems, organisations and individuals behave.

A systemwide translational model of practice, which I call the model of practice throughout this chapter, is described and has been informed by the knowledges contained in the stories from policy actors.

When developing the model of practice, I draw from the Intervention Level Framework (ILF) developed by Malhi et al (2009) and, initially introduced back in Chapter 3, section 3.4.4. The five leverage points of the ILF are paradigms, goals, system elements, feedback and delay loops, and structural elements. These leverage points will be discussed further below when describing the model of practice – at a glance.

As previously mentioned, the ILF applies concepts of system thinking that considers opportunities in leverage points of systems aimed to address hard to address complex issues (Malhi et al, 2009). Malhi et al (2009) applied the ILF to identify places to intervene aimed at making complex food systems more healthy, green, fair, and affordable. I am applying the ILF to identify places to intervene aimed at making health systems free of racism.

The 3Es of implementation about enabling, embedding and enacting Indigenous knowledges and Indigenous cultures, also described back in Chapter 3, section 3.4.4, is integral to the model of practice. As previously clarified, enable is about providing the means and opportunities for Indigneous Australians to practice their knowledges and cultures. Embed is to permanently integrate into place the knowledges and cultures held by Indigenous Australians into the practice of public health policy and design of programs. Enact are the policy tools and instruments to persuade systems and organisations to perform in a way that gives effect to Indigenous knowledges and Indigenous cultures. I will similarly discuss the 3Es further when describing the model of practice – at a glance.

The model of practice provides a way to understand the challenges of implementing Indigenous Australian's cultures and knowledges in what is already known as a racist health system (Arabena, 2013; Australian Government, 2013; Awofeso, 2013). It also assists in being able to address institutional and systemic racism that is sustained by the behaviours of individuals like policy makers. As highlighted in the following conference abstract, giving effect to realise Indigenous cultures, and indeed Indigenous knowledges in public health responses could be beneficial when addressing complex global issues of climate change. Making health systems free of

racism, requires the knowledges and cultures of Indigenous Australians. Unless policy makers address issues of institutional and systemic racism, implementing Indigneous cultures and knowledges will be futile and a serious public policy dilemma is apparent.

5.2. The public policy challenge of implementing Indigenous cultures and Indigenous knowledges

Reference

Parter, C. and Skinner, J. C., (2020), Implementing Indigenous cultures and knowledges: A public policy dilemma, *European Journal of Public Health* – in press

Authors Contribution Statement

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University of Sydney

Publication Statement

As co-authors of the published work:

Parter, C. and Skinner, J.C, (2020). Implementing Indigneous cultures and Indigenous knowledges: A public policy dilemma, European Journal of Public Health – accepted and in print.

I confirm that Carmen Dorothy Ruby Parter made the following contributions:

The candidate planned and prepared the manuscript that involved several drafts in readiness for submission and publication. Dr John C. Skinner contributed to subsequent drafts by reviewing and editing the content, and providing advice. The final draft was reviewed and approved by all co-authors.

Signed [REDACTION] Date 7th August 2020
Dr John C. Skinner

This statement aligns with the requirements of the University of Sydney regarding policy as described in the policy documents:

*Thesis and Examination of Higher Degrees by Research Policy 2015
*Thesis and Examination of Higher Degree by Research Procedures 2015

https://www.sydney.edu.au/students/prepare-thesis.html

In Australia, governments are committed to integrating the cultures of Indigenous peoples into the decisions and actions of governments – known as public policies. The National Aboriginal and Torres Strait Islander Health Plan 2013–2023 has culture central to its policy framework making it permissible for Indigenous peoples to practice their cultures and knowledges.

While there is a readiness to implement Indigenous cultures, regrettably there still remains deep-seated resistance due to institutional and systemic racism, and racist attitudes. These factors along with unconscious biases prevent the realisation of Indigenous people's cultures and their knowledges.

A system-wide translational model of practice (the model) has been developed that aims to support the implementation of Indigenous cultures and knowledges. The model adopts a system thinking approach that considers complex social phenomenon's involving paradigms, structures and actors within and across systems and sub-systems. Similarly, the model targets system leverage points aimed to embed Indigneous cultures and knowledges into policy practice.

Indigenous people's cultures and knowledges could be the answer to the global challenges facing the public health community. However, as is the case in Australia, Indigenous people's cultures and knowledges are devalued and often dismissed as irrelevant. The model of practice offers a framework to enable, embed and enact the cultures and, in deed the knowledges held by Indigenous peoples. The model could be beneficial for other countries who are searching for solutions to address complex problems like global warming.

Critically, a key requirement of the model is to listen and learn from Indigenous peoples along with acknowledgement that Indigenous cultures is innately related to the knowledges held by Indigenous people. Finally, using leverage points in systems to embed Indigenous people's cultures and knowledges into global solutions is a necessity.

5.3. Addressing racism is paramount

I begin with story:

> On the weekend, I was invited to a friend's birthday party that was attended mostly by non-Indigenous (white) people. It was a very white space!
>
> My visible 'blackness' got a stupefaction gaze when I entered the room of this beautiful mansion! Such a reaction is a sign that I was about to have some very interesting conversations.

> Anyway, I was approached by a tall, lanky, Australian, and obviously a very privileged white person and white male, who clearly was really interested in my heritage.
>
> On approaching he asked, 'are you a … native?' … on hearing this question, I was stunned and shivered with silent disgust … stuttering as I proceeded to tell him of my Aboriginal and South Sea Islander heritage. So, shocked that I couldn't even educate him about the inappropriateness of the term he just used.
>
> When reference was being made to a snake that was co-habiting on the grounds of the property where the party was being held, the conversation got worse and diminished into … do you eat snakes? I remained paralysed from the earlier question and I stated abruptly 'No, I personally don't eat snake!' with a smiling assassin's expression on my face (personal journal entry, 2 June 2020).

So, what just happened?

This is racism, white privilege and whiteness in action. As Moreton-Robinson (2015) writes:

> Race matters in the lives of all peoples; for some people it confers unearned privileges, and for others it is the mark of inferiority (p. iii).

Whiteness does not relate to the colour of one's skin, and rather is about power, conquest and authority over another including structural dominance (Moreton-Robinson, 2015). Bargallie (2020), who reveals racism in the Australian public sector, explains her use of the term 'white':

> [When I use] the term ‘white’, I am not referring to white people per se, but whiteness as a system of power relations that privileges non-Indigenous peoples over Indigenous Australian peoples. Whiteness is socially constructed through identity and constantly reinforces the power of white identifications and interests disguised as the natural, normal and better way of being in the world (p. 19).

So, I entered the room, dominated by whiteness, and immediately was labelled a native (Moreton-Robinson, 2015). The space in which I stood was possessed by the encroachment of patriarchal white privilege (Moreton-Robinson, 2015). When referred to as a native, I was placed in the position of being the inferior ‘other’ (Moreton-Robinson, 2015). The nativeness was further confirmed when reference was made as to whether I ate snake.

A set of deficit assumptions came with the ‘native’ imagination (Moreton-Robinson, 2015). These assumptions insinuated that I am primitive, uncivilised, and on the lowest rung of the human’s race ladder (Moreton-Robinson, 2015). In fact, I am not even human. I am also filthy, a drunk and a lazy bugger who is uneducated, and unemployed (Moreton-Robinson, 2015). Obviously, I am poor and probably live mostly on social security benefits with many other untoward ‘blacks’ (Moreton-Robinson, 2015). These racialized stereotypical assumptions I call the native assumptions.

The native assumptions underpinned the overt racist experiences that I grew up with as a child going to school. I recall in the 1970s being told in a history class how Aborigines were primitive nomads who continued to live in humpy bark huts (personal journal entry, 16 August 2016). As a young adolescent trying to find a job, I was constantly reminded that people like me didn’t like working and were lazy (personal journal entry, 16 August 2016). I continue to be confronted with the native assumptions

today, even as a professional adult. They play out in the subtlety of the public sector workplace (to be described below). These experiences confirm what P16 said earlier in Chapter 4, that *we're the only ones who can really inform [policy makers] … we're the only ones who can tell people what our experiences of racism is (P16 September 2018)*.

In my encounter at my friend's birthday party, the white patriarchal knower asserted his white possessiveness and racialized superior knowledge over another (Moreton-Robinson, 2015). The above stereotypical native assumptions are based on colonialist and imperialist paradigms (Moreton-Robinson, 2015; Smith, 1999). They are the ontological realities that Moreton-Robinson (2015) says are the effects of white possession "underpinned by an excessive desire to invest in reproducing and reaffirming the nation-state's ownership, control, and domination" (p xii-xiii) of the other that is manifested in encounters like the one I describe above.

As I gathered myself from the onslaught of such racism, the conversation proceeded, and I was asked, what do you do? My response was:

> I am a professor, a FIFO [fly in and fly out] academic … working at the University of Sydney doing a Doctor of Philosophy (personal journal entry, 2 June 2020).

What reaction did I get? An absolute stance of stunned astonishment and bewilderment! A 'that can't be right!' gaze. Why? Because there was no connection between my response and what the patriarchal white knower imagined to be my reality. So, what just happened? I was no longer a native!

The white privileged patriarchal racialized knower's knowledge had been challenged. Being a visibly black Aboriginal and South Sea Islander had diminished me to the status of a 'native', but that classification was no longer applicable.

Nonetheless, the racial signifiers constantly remind me of my nativeness and of such inferiority because as Moreton-Robinson (2015) writes:

> The cities signify with every building and every street that this land is now possessed by others; signs of white possession are embedded everywhere in the landscape. The omnipresence of Indigenous sovereignties exists here too, but it is disavowed through the materiality of these significations, which are perceived as evidence of ownership by those who have taken possession (p. iii).

One research participant said:

> *I argue that Indigenous knowledges and cultures of ways of being, knowing and doing exist (P8, July 2018).*

However, Indigenous knowledges and Indigenous cultures have been dominated and denied by the possessive whiteness of western non-Indigenous ways of being, knowing and doing. Durey and Thompson (2012) also express the same sentiments.

The racial signifiers of white possessiveness are consistent reminders of the coloniser marking their territory, their ownership of the lives, knowledges, and lands previously owned by Indigenous peoples. These signifiers of domination, possession and control continue to play out in the way that systems, organisations and individuals behave (Moreton-Robinson, 2000 and 2015).

My experience of racism is a demonstration of the possessiveness of whiteness, as espoused by Moreton-Robertson (2015). I argue that these possessive white native assumptions of the inferior other play out in the making of policy. These assumptions are inherent in the rules, norms and behaviours of systems, organisations and individuals. Moreton-Robinson (2000 & 2015) similarly shares such a position. The nativeness of the native assumptions have their undertones due to the legacy of colonisation that sustains inequity and inequality (Durey & Thompson, 2012; Kirmayer & Brass, 2016; Moreton-Robinson, 2015; Rix, 2014; Smith, 1999). These are the ingrained mindsets and beliefs (referred to below in the ILF) that play out in systems and their sub-systems like health, including health's structures of operation (Malhi et al., 2009). The native mindset is manifested in a way that excludes and marginalises minority cultures (Rix, 2014) like the knowledges and cultures held by Indigenous Australians.

The same attitudes embodied in the native assumptions were further revealed by Bargallie's (2020) study that uncovers racism in the Australian public sector (APS). In Bargallie's (2020) study the story is told through the voices of Indigenous public servants. She writes in relation to their experiences:

> Indigenous employees experience racial microaggressions in every aspect of the APS workplace. Racial microaggressions, in the form of hostile, derogatory and insulting behaviours, processes and practices, are often invisible to non-Indigenous people because racism seems normal in a racist environment (2020, p. 103).

As a public servant, I consistently experienced the kinds of microaggressions described by Bargallie's (2020) research participants. In my work as a policy maker,

native assumptions were evident when recommendations I made were not heard and were often dismissed as irrelevant and of no worth. My native racialized visible blackness disadvantaged my authority as an expert in Indigenous health. Consequently, I learnt to use others of authority, usually a white privileged person, perhaps with the title of Professor or Doctor, to make the very same recommendations, which were then heard and actioned (personal journal entry, 12 December 2020).

My knowledge and culture of ways of being, knowing and doing were dismissed as irrelevant and diminished. A policy actor also confirmed a similar experience by saying:

> *as a public servant, I have to represent a certain value or code … So, in that practical application, how do you fully enact culture in that culture in that way when technically your culture may not matter in the decision … so, it's the tension … I'm automatically excluded from the voice process, even though I'm an Indigenous person (de-identified personal communication).*

This is racism. As Bargallie (2020) says:

> This 'invisibility' allows a culture of denial to flourish, leaving racial microaggressions overlooked, ignored and unchallenged – this makes racism an 'absent presence'(p 103).

Bargallie (2020) then says:

> This is the 'absent presence' of racism that I argue is prevalent in the APS. The role of historical stereotyping, processes and practice in the context of Indigenous labour allows the phenomena of exploitation, misrepresentation and exclusion to manifest and flourish contemporarily (p 103).

I argue that the experiences and organisational behaviours described by Bargallie (2020), and experienced by me in my racist encounters, are endemic in policy making in Australia. It is therefore critical that organisational and systemic racialized behaviours at these institutional and system levels must be challenged. Participant P8 called for *a zero tolerance towards that [behaviour] (July 2018)*.

As a participant pointed out in Chapter 4, those who *inherit privilege, they inherit certain rights that other people don't … they create the system, the system that perpetuates themselves (P16, September 2018)*. Those with such rights view others as inferior and tend to exploit them to accumulate a range of resources such as wealth that ranks them as being superior (Came and Griffith, 2018). As Lea (2020) writes these sinister forces have their origins in colonial rules of dispossession and oppression. She (2020) argues in her book – Wild Policy: Indigeneity and the unruly logic of intervention relating to Indigenous social policy - that

> … policy is not trying to eradicate foundational inequalities … policy's first-order job is aiding and abetting the interests of extractive capital, pushing profit upward in the name of economic development, financial debt, and corporate wealth. Ameliorating or softening the harsher collateral effects of inequality, rather than overturning the socio-economic system that relies on serial exploitations to thrive, is the actual (albeit disavowed) task of social policy within most democratic nation-sates (p. 19).

Lea (2020) went on to say

> In settler colonial nations, this hidden relation between profiteering and impoverishment is becoming more apparent. Evidence of continuing

> dispossession insistently leaks past nationalist attempts to cauterize dispossessive acts as part of a done-and-dusted invasion episode (p. 19)

These broader settler-colonial factors of modernity are often not taken into consideration says Paradies (2020) who also writes that

> For Indigenous peoples from around the world, the 'slow violence' of colonisation exists alongside violent assaults and fatal neglect. There is also a growing realisation of the impossibility of justice through the law, or reconciliation, or of any answers at all from within settler-colonial states (p. 438).

Settler-colonial states such as Australia. These racialised and dehumanising policy forces are often not fully understood in the Indigenous public health policy sub-domain argues Lea (2020).

Wolf contends (and as cited by Lea, 2020) 'settler colonialism [i]s a "structure and not an event" referring to the ongoing domestication of seized territories via shifting technologies of dispossession' (p. 19). Lea (2020) reaffirms that the shape shifting wildness of Indigenous social policy is unavoidably messy with the unruly racialized demonic forces continuing to sustain Indigenous inequalities. Given these forces, she asks; Can there be good policy? And responds by saying it is a yes and no answer (Lea, 2020).

As mentioned in the preceding chapter, these unruly forces are *part of Australia's heritage … Australia is a brutal place … those institutions … people* (P16, September 2018). Another yarning participant argued that *it's about power and control … it's about dominant culture again making us assimilate and colonise ... our whole system and*

structural elements are dominant culture driven (yarning workshop participant, 12 December 2019). I argue that these are the forces of racism at play.

Racism 'is a violent system of power that can be active and explicit, passive and implicit, or between binary' (Came and Griffith, 2018, p. 19). Paradies adds that

> Settler-colonial societies, interest in colonisation is often focused on relatively distant colonial pasts where Indigenous peoples were 'displaced' (and other euphemisms for slavery, rape, torture, murder and genocide), with relatively scant attention paid to ongoing colonial presence/presents in which systemic, structural, physical, epistemic and ontological violence continue to oppress, assimilate and eradicate Indigenous peoples (2020, p. 438)

These are 'deeply ingrained aspect of life that reflects norms and practices that are often perceived as ordinary, constant and chronic' (Came and Griffith, 2018, p. 181). 'Racism pervades national cultures via institutional structures, as well as the ideological beliefs and everyday actions of people' (Came and Griffith, 2018, p. 181-182). In this situation there is a need *to address, recognise that there is such a thing as, and then address institutional systemic racism (P12, September 2018)*. However:

> *What is it? what does it look like? And, what are the aspects to institutionalised racism or institutional biases against individuals – Aboriginal people … [what] do we have to overcome? (P14, September 2018).*

I concur with P14's questions highlighting the need to fully understand the dynamics of institutional and systemic racism and how Indigenous health inequity continues to be sustained in a health system that is racist. Additionally, I agree with Awofeso (2011) who argues that "racism is a structural determinant of Indigenous health inequity in

Australia" (p. 10). Similarly, Came and Griffith (2018) share a similar sentiment saying that

> Racism also may be considered a fundamental determinant of health because it is a dynamic process that endures and adapts over time, and because it influences multiple mechanisms, policies, practices and pathways that ultimately affect health (p. 181).

Due to a lack of agreement, racism as a "wicked" problem is extremely difficult to address because there is no consistent clarity about the nature and causes of racism (Came and Griffith, 2018). This is despite there being a plethora of scholarly knowledge about racism, colonisation including white supremacy, and the intergenerational impact on health and socio-economic wellbeing (Came and Griffith, 2018).

Awofeso (2011) argues nonetheless that addressing racism requires:

> Multifaceted anti-racism interventions [that] demand active participation by Indigenous people, governments, a culturally competent health workforce, all Australians, and the international human rights community (p. 1).

We do need a national policy position on the details of how to eliminate racism. However, the destructive forces described above are not for the fainthearted (Lea, 2020). The policy actors who participated in this research, work consistently hard in attempting to secure positive result from what often can be considered bad policy (Lea, 2020). Lea (2020) call such individuals as institutional killjoys who

> insist that contracts be honored, promises be kept, accounts be held, corruptions be resisted, projects have fidelity, and people be respectfully

> supported. Thus insisting, they call into question the compromised, belittling, or discriminatory ways that things are ordinarily done … they can reach a point where, worn down by butting into institutional walls, they find their jobs untenable (Lea, 2020, p. 14-15)

Calls for a national inquiry into racism (P8, July 2018) is falling on deaf ears with killjoys like P12 pointing out that *finding new ways to talk … about racism … [is] actually about saying 'Racism is an issue, so how do we work through it?' (September 2018). P2 shared a similar sentiment as P12 while*P21 also argued that *it is incumbent on us to be able to roll up our sleeves and open up that conversation (P21, December 2018).* These are the people who persistently endure 'to extract benefits from policy openings and who risk becoming killjoys in the process are essential to the "yes" of possible good from policy' (Lea, 2020, p. 15). Although, at what costs given the wild nature of Indigenous social policy that Lea (2020) has described. Nonetheless, as P7 said, *if we want to eliminate racism, we have to do it in a multi-pronged approach (July 2018)*.

Came and Griffith (2018) offer an anti-racism praxis framework believing that racism must be addressed at an institutional level. Critical to responses of addressing racism involves critical reflective praxis, education concerning the socio-political environment, and an analyse of structural power with intent to achieve system changes (Came and Griffith, 2018). Importantly, such anti-racism praxis must be monitored and evaluated (Came and Griffith, 2018, p. 182 -186).

Frameworks like Came and Griffith are useful tools that offer opportunities in tackling a "wicked" problem like racism. The elements described by Came and Griffith (2018) would complement the systemwide translational model of practice. However, such

frameworks will require further development and is out of scope for this present research study. Although, any future research could draw from such a framework when implementing the cultural determinants of health whilst simultaneously addressing racism.

I concur with Arabena (2013), and conclude that if Indigenous knowledges and Indigenous cultures, represented through the cultural determinants of health, are to be effectively implemented, then there is a need to genuinely address issues of institutional and systemic racism with targeted effort designed to change institutional behaviours rather than the beliefs, values and attitudes held by individuals (Came and Griffith, 2018). The stories of policy actors have informed such a conclusion, and they have informed the development of a systemwide translational model of practice (the model of practice). As will be described shortly, a model of practice is a way of practice to apply concepts of system thinking. Strategies to address racism and decolonise public health policy are also contained in the model of practice that follows (Fredericks, Adams, & Edwards, 2011).

5.4. The systemwide translational model of practice

5.4.1. Translation of Indigenous knowledges and Indigenous cultures

The translation of Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing is the cornerstone of the model of practice. The application of the model is conditional on privileging the voices of Indigenous people in the policy production process. When a policy actor was asked about the challenges associated with translating Indigenous knowledge and cultures of ways of being, knowing and

doing they responded by saying that the knowledge should not *get lost in translation or colonised* (P8, July 2018).

When this policy actor was asked what they meant by 'colonised', they provided an example relating to a piece of work being undertaken with non-Indigenous policy makers. The Indigenous leaders provided their knowledge to define cultural safety, but they discovered that their knowledge was being re-interpreted. The policy actor (P8) went on to say:

> *So, when I talk about knowledge translation, I don't mean that we put a non-Indigenous lens over Indigenous knowledges … No, no, no, no. 'Cause that's what they were actually doing … culturally unsafe … by colonising it and making it palatable for non-Indigenous Australians (July 2018).*

P8 added that:

> *Colonising and making it palatable for non-Indigenous Australia … that is always a risk, that we are colonising Indigenous knowledges (July 2018).*

P8 asserted:

> *No, no, no, no, no, no. Actually, Aboriginal people will do this work and we'll come up with our definition as a collective group (July 2018).*

An experienced policy maker working in government indicated that having Indigenous staff in their branch and the bureaucracy meant that they relied on them *to provide an interpreter service (P3, June 2020).* This policy maker was concerned that *it is hard … because they have to very much walk those two worlds … they themselves have to be self-aware enough, and have analysed enough what culture means to them as an*

Indigenous person in order for them to then be able to translate it into the language of the bureaucrat (P3, June 2020), which is a skill in and of itself.

Another policy maker said:

> *You know there has been strong Aboriginal leadership in the bureaucracy as well, and I don't think that is sometimes always acknowledged. But, from where I sit given a lot of those people have been my bosses for a very long period of time and over the time you do see that passion and that intimate knowledge translate into work and, also bring your colleagues and your peers along with you. And that allows for some really deadly robust policy debates (P4, June 2018).*

So, when translating IKs and ICs into public health policy, a level of caution must be exercised to manage the risk of losing in translation the knowledges provided by Indigenous Australians. Further, the risky practice involving the subjugation of Indigenous knowledges must be managed ethically at that cultural interface (Nakata. 2007, Ermine 2004 & Durie, 2007). It will be essential to draw on the expertise of senior Indigenous leaders, or the Indigenous health leadership group, to prevent such colonisation of Indigenous knowledges from occurring. As expressed by one participant:

> *if you put Aboriginal leaders in charge of it … they [policy makers] would get a better outcome (P2, June 2018).*

Finally, the systemwide translational model of practice is conditional on privileging Indigenous voices in the production of public health policy.

5.4.2. System thinking to address institutional and systemic racism

Drawing on system thinking concepts, the Intervention Level Framework (ILF) introduced in Chapter 3 examines leverage points in systems to address complex problems (Malhi et al., 2009). It is necessary to adopt a systems perspective to overcome the native assumptions ingrained in the mindsets of systems and organisations. Building the capability of the health system to enable it to challenge and reform those native assumptions is required. As one participant confirmed:

> *A lot of the common themes [are] around empowering individuals with their own health, but [this neglects] empowering the sector … so, this is part of a whole system, it's not just that's one bit over here is the hospital … the wholistic view of the health system is the other thing that we're trying to really look at in that health plan (P11, September 2018).*

Empowering the whole system also involves ensuring Indigenous people are adequately employed in the health system in various positions, particularly in leadership decision-making roles (personal communication, June – December 2018). Similarly, a range of policy instruments are required to support empowering and building the capability of systems. Examples of such policy instruments include initiatives to promote cultural respect, cultural competency, cultural awareness and cultural safety (P1, P2, P4, P6, P8 & P9, June, July & August 2018).

Another participant affirmed that:

> *The [new Health Plan's] Implementation Plan could actually change the mindset of and embedded systems and structures … and the same is like … constitutional recognition and the voice to parliament … 'oh, that's so brave', but*

let's face it, we're changing something that is so ingrained in this country at the moment (policy actor representative, 12 December 2019).

The following model of practice is a tool to explain the challenges associated with implementing Indigenous knowledges and Indigenous cultures. Examples of implementation structured around the three processes of enacting, embedding and enabling are also provided. However, there are several attributes that a model of practice should consider that were highlighted by policy actors at the 12 December 2019 yarning workshop.

5.4.3. The December 2019 yarning workshop

On 12 December 2019, selected policy actors, including the researcher's PhD academic team, agreed to participate in a yarning workshop hosted by the research study's reference group – the NHLF.

A modification to the original ethics application was approved by the two ethics committees – the Aboriginal Health and Medical Research Council HREC and the University of Sydney HREC. Copies of these HREC requests and outcomes are included in Appendix 6, along with a participant invitation letter, participant information statement and consent forms. A discussion paper was developed to assist in facilitating the discussions and it is enclosed as an appendix to the feedback report concerning the workshop outcomes at Appendix 7. The Workshop feedback report was also considered by the study's reference group – the NHLF. Their comments have been included accordingly into this chapter.

Workshop participants considered a proposed model of practice including a range of challenges and solutions. The challenges then informed a set of attributes required of a model of practice.

5.4.4. The attributes of a Systemwide Translational Model of Practice

The attributes arising from the workshop indicated that a model of practice needed to address the following challenges:

(a) dealing with issues of power and control inherent in systems and organisations

(b) disrupting the dominant culture so the knowledges and cultures of Indigenous Australians are front and centre to policy initiatives

(c) a requirement to change the value systems and mindsets of governments to deliver a systemwide cultural shift that aligns with Aboriginal and Torres Strait Islander ways of being, knowing and doing

(d) changing goals for greater impact that is informed by culture in a cultural context, although value systems must align for this to occur

(e) decolonising white paradigms of practice that are so ingrained in the behaviour of systems and organisations

(f) reaffirming that the values and contributions of the cultural knowledges held by Indigenous people are paramount

(g) catering for the diverse cultural needs of Aboriginal and Torres Strait Islander communities in being able to practise their cultures outside institutional and policy frameworks but within their unique cultural frames of reference of ways of being, knowing and doing

(h) ensuring governance structures protect the knowledges and cultures that are held by knowledge keepers, including maintaining data sovereignty

(i) decentralising power and decision-making – people power

(j) achieving health, healing and economic impact for community and people – nation building – revitalising, reclaiming and embedding language and lore into our nations (D. Murray, 10 June 2020).

Importantly, there must be:

(a) system performance targets and indicators aimed at making systems accountable, instead of the standard targets placed on Aboriginal and Torres Strait Islander people which imply that improving their health is their problem

(b) system accountability to community as an imperative

(c) constitutional accountability as a requirement (D. Murray, personal communication, 10 June 2020).

In addition to the above, addressing racism remains a priority because *not only does racism make people sick, it also stops the system from making people get better (NHLF representative, 31 August 2020)*.

As a consequence of these attributes, the revised model summarised below offers a framework for addressing the challenges that have been raised above and in the preceding chapter. However, additional investment in research is required to develop these attributes further such as exploring what *community accountability would entail in practice (NHLF representative, 31 August 2020).*

Prior to presenting the summary of the model of practice, I list the principles which underpin it.

5.4.5. Principles for a Systemwide Translational Model of Practice

A set of principles to further the holism of Indigenous health through a human rights approach is required. The following principles therefore underpin the application of a Systemwide Translational Model of Practice:

(a) Community knowledges and lived experiences of cultural ways of being, knowing and doing told through stories are valid forms of knowledges.

(b) The centrality of self-determining communities is paramount for culturally informed innovations to be created and policy makers need to become the facilitators.

(c) Where worldviews interact at the cultural interface, Indigenous knowledges and cultures of ways of being, knowing and doing are paramount.

(d) A learning culture, and building on the lessons learnt, are vital.

(e) The diversity and uniqueness of the knowledges and cultures held by Indigenous people and communities must be acknowledged (personal journal entry, 14 October 2019 and 4 August 2020).

5.4.6. The Systemwide Translational Model of Practice – at a glance

The model of practice takes account of the fact that there are many systems and sub-systems at play, as had been reiterated by a participant who said:

> *There's local government, there's state systems, there's federal systems and even universities or hospitals or some of the big institutions that are out there,*

the police and local police station … institutions, the big systems affect so much (P17, October 2018).

These systems and sub-systems contain numerous actors with their knowledges interacting with each other at the cultural interface (Nakata, 2007).

By applying the Intervention Level Framework (ILF), leverage points in systems and their subsystems can be identified (Malhi et al., 2009; Meadows, 1997, 1999). The identification of such leverage points has a deliberate intent to disrupt, deconstruct and decolonise what are inherently institutional and systemic racialized systems and structures of practice – the native assumptions – of the dominant culture (Arabena, 2013; Durey & Thompson, 2012; Durey, Thompson, & Wood, 2012; Henry, Houston, & Mooney, 2004).

These inherently institutionalised and systemic racialized systems and structures unobtrusively operate in a way that perpetuates the health inequities and social inequalities experienced by Indigenous Australians (Markwick, Ansari, Clinch, & McNeil, 2019). Furthermore, as Paradies has established, racism has a causal connection with the poor health and wellbeing of marginalised groups such as Indigenous Australians (Paradies, 2006; Paradies & Cunningham, 2009; Paradies, Harris, & Andersen, 2008; Paradies, 2006, Paradies, 2018).

The model of practice therefore aims to rightfully strive for a health system that is free of racism, which has been the Health Plan's vision since its inception (Australian Government, 2013). Additionally, the model of practice also strives for a health system that is rightfully equipped to recognise, value and implement Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing. This is shown below in the first row of the table contained in Figures 14, 15 and 16.

The word ‘rightfully’ is used deliberately to reinforce a human rights approach that is informed by the Declaration of the Rights of Indigenous People (United Nations, 2007). ‘Equip’ was a word used by a policy actor and is described by the Collins English Dictionary as meaning “to provide with abilities, understanding etc.” (“equip”, 2009). So, equip in the model of practice is about providing the health system, and its sub-systems with the abilities and understanding to be able to address institutional and systemic racism.

Transforming systems and organisations, including individuals that operate within them, means that they will become aligned with the values and knowledges and cultures of ways of being, knowing and doing held by Indigenous people and communities. This is represented as actions in the second row of the at-a-glance table of the figures. These actions involve disrupting, deconstructing and decolonising western non-Indigenous ways of being, knowing and doing – the dominant culture.

The 3Es of implementation namely enact, embed and enable, are contained in the third and fourth rows of the at-a-glance table in the figures. The 3Es of implementation and their meanings are included in row four. The 3Es overarch the ILF’s leverage points in column two and the examples for transforming systems and organisations are provided in column three of the at-a-glance figure in the model of practice.

The five system leverage points of the ILF relating to paradigms, goals, system structure, feedback and delays, and structural elements (Malhi et al., 2009) have been integrated into the model of practice in column two, together with the 3Es of implementation: enacting, embedding and enabling IKs and ICs.

Enacting is about the policy tools and instruments that aim to assist with transforming systems and organisations to give effect to Indigenous people's ways of being, knowing and doing. Some examples drawn from stories of policy actors are included.

Embedding is about permanently integrating IKs and ICs into system and organisational practices with examples provided in column three.

Enabling is about providing the means, authority and opportunities for privileging Indigenous voices into the design and delivery of policy, and the Coalition of Peaks is an example of governments doing this. Another example is the Health Plan. Governments and policy makers enabling and privileging an Indigenous voice – the NHLF – in co-designing a national strategy for addressing the health of Indigenous Australians.

The first column of the model of practice summarises the process challenges of implementation arising from the stories for Theme 3 (outlined in Chapter 4 above). Essentially, the dominant non-Indigenous racialized cultural worldviews override, dismiss and devalue Indigenous worldviews. These are the racialized paradigms of the health system – the native assumptions – whose goals are based on dominant cultural and racist ways of thinking and working that undermine efforts to close the health gap. In some cases, policy actors' stories have been provided to demonstrate the challenges in the first column. These are then aligned to the five leverage points of the ILF contained in the second column of the at-a-glance figure, with one of the 3Es of implementation. So, the 'enact' element of implementation overhangs the paradigms and goals of the ILF, while 'embed' is related to system structure and feedback and delay loops of the ILF. 'Enable' is aligned with structural elements of the ILF leverage points. As an example, the dominant cultural and racialized

discriminatory paradigms – the native assumptions – relate to the ILF paradigms and goals (Malhi et al., 2009). The paradigms and goals of the ILF are the most deeply held beliefs of a system and its goals, rules and structures arise out of these ingrained and often invisible 'mindsets' (Malhi et al., 2009). 'Enact' relates to paradigms and goals of the ILF. 'Enact' is described as those policy tools and instruments that, when used, will compel systems and organisations to conform to Indigenous people's ways of being, knowing and doing. Some of these policy tools and instruments are mentioned in the published research protocol contained in Chapter 2. 'Enact' assists with transforming those hard-to-deal-with norms and rules of systems and organisations – the native assumptions. These norms and rules provide the leverage points that have the greatest impact, but they are the hardest to exploit (Malhi et al., 2009).

The Uluru Statement of the Heart and the Makarrata Commission of Truth Telling are 'enact' examples of policy tools that have the potential to change the paradigm and goals of a dominant racialized white system of operation. It must be noted that the present government has not agreed to the concept of an Indigenous voice embedded into the Australian constitution, with national consultation presently underway to consider another mechanism. Similarly, the federal government has not agreed to a Truth Telling Commission that would give voice to communities by enabling them to talk about the intergenerational trauma of colonisation described in Chapter 4 above. These two enactment tools, recommended by a participant, provide an opportunity to challenge the deep-seated beliefs and mindsets of paradigms and goals. The ideas of a Health Authority and a royal commission into racism could play a similar role. However, resources must be forthcoming if such policy tools are to be used (P8, July 2018).

In contrast, changing structural elements of the ILF, at the bottom of the at-a-glance figure, is the easiest to achieve leverage point, but it has a much lower impact. The structural elements involve the many subsystems of a system like the health system. The health system, for example, has many actors and physical elements, which connect back through feedback loops and information flows (Malhi et al., 2009). It is at this point that 'enable' is positioned with the structural elements of the ILF. As mentioned previously, 'enable' is about providing the means and opportunities for Indigenous Australians to have input into the design and delivery of policy and programs. For example, Indigenous Australians must be enabled to lead, direct and create changes within their own communities through national building. As one participant said:

> *So we [Indigenous people] create our own policy in our own ways of doing based on our ways of being and doing … that has a much higher impact than any government policy or practice … embedding language and revitalising and reclaiming that language and, therefore, our lore, has had a health and wellbeing and healing impact on our communities and with each other …So, we [Indigenous communities] reset from a deficit about who we are, what we want, and what our challenges are, to a positive based to this is what we have. And, this is what we should be focusing on. And, these are our instructions for the nation as a collective. So, some of that work is getting a much bigger impact than any service delivery program … from social and cultural revitalisation development, then your see economic development as an impact … so that's the sum of those key lessons that came from that nation building way of working rather than the standard approach, which is why nation building, we slipped into the [Health Plan's] Implementation Plan. Because that's localised and*

regionalised decision-making governance and leadership. That's where it all happens (policy actor representative, December 2019).

The system structure of the ILF relates to the structures and elements that make up the whole system, containing subsystems, actors and the interconnections in between (Malhi et al., 2009). The feedback and delay elements of the ILF are about how the system regulates itself (Malhi et al., 2009). Specifically, the monitoring, reporting and measuring of a sub-system's achievements against a broader system goal or target (Malhi et at, 2009) such as the Closing the Gap targets mentioned in the published article contained in Chapter 1. 'Embed' is aligned with the structures and elements of the ILF, including its feedback and delay loop, and it involves health systems and their sub-systems permanently integrating IKs and ICs. One policy actor highlighted a challenge associated with this process:

It's one thing to have culture in a conceptual way but how do you actually then cascade culture as a core component and a key deliverable through a health policy initiative but implement it in a way which allowed and made permissible cultural activities and where those cultural activities would occur? (P19, October 2019).

P19 went on to argue:

I think to this point it's probably to do with the funding arrangements and the COAG agreements and the state-Commonwealth distribution of money policy, programmatic responses and the responsibilities of those things that we're still seeing health being delivered through a healthcare system, which is inept, unable and ill-health-focussed rather than actually thinking about health and wellbeing outside of those things (P19, October 2018).

In relation to the feedback and delay loop of the health system regarding monitoring and measuring system performance another participant said:

> *Talking about racism and systemic racism through the system … we're starting to look at metrics around it. We've got take own leave and elective surgery, looking at things around elective surgery and waiting times … [there is] general acceptance that it [racism] is an issue through the system (P5, June 2018).*

P5 concluded by saying:

> *I don't think we're there yet (June 2018).*

Another participant said:

> *We have proxy indicators for racism. We don't actually ask the question of have you experienced racism and have you experienced racism in the last twelve months or has it had an impact on you … because [inaudible] found out that 97% of the people that he surveyed had experienced racism (P4, June 2018).*

Measuring culture has its own challenges, as one participant pointed out:

> *Like how do we measure culture and set the clock … um, 'cause it's not the easiest thing to measure is it? No, hmm (P11, September 2018).*

Another participant said:

> *We don't actually collect data about us, that is valid for us, or to us … I mean the Australian Bureau of Statistics is currently consulting with people about what sort of data should be collected. And, we're saying this kind of data is important to us (P4, June 2018).*

And another participant commented:

> *There's data custodianship and data sovereignty. So, that goes to trust. So, how do we trust the system? (P2, June 2018).*

Tackling system levers of change at the highest impact points of a system and at the lowest impact leverage points is a necessity. This was confirmed by one participant, who worked in a senior leadership and decision-making position in government:

> *The combination [of] the big picture ticket items, as people would see, have to continue to be developed and progressed together with on the ground, the smaller ones (P17, October 2018).*

I argue that to disrupt, deconstruct and decolonise native assumptions, policy actors need to put more attention and investment into changing invisible and detrimental paradigms and goals. I strongly encourage them to do so by using the policy tools required to achieve highly impactful results that aim to put the knowledges and cultures of Indigenous Australian's at the centre of the production of policy. Some of these policy tools, such as a Bill of Rights, are named in the model of practice alongside 'enact'.

Below is the at-a-glance systemwide translational model of practice represented in a series of Figures (14-16).

Figure 14: Enact at a glance - A Systemwide Translational Model of Practice - addressing racism

<table>
<tr><td colspan="3">AIM: A right to a health system that is free of racism, and a health system that is rightfully equipped to recognise, value and implement Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing.</td></tr>
<tr><td rowspan="4">Summarised stories from yarning sessions & workshop</td><td colspan="2">ACTION: To ensure that Indigenous Knowledges and Indigenous Cultures are front and centre to policy responses, the action involves transforming systems and organisations by disrupting, deconstructing & decolonising – 3Ds – western knowledges and cultures of ways of being knowing and doing.</td></tr>
<tr><td colspan="2">3Es of IMPLEMENTING IKs and ICs</td></tr>
<tr><td colspan="2">ENACT
‘Enact’ refers to the policy tools and instruments to persuasively sanction and coercively compel systems, organisations and individuals to behave in a manner conducive to providing for the needs, values and goals of Indigenous Australians</td></tr>
<tr><td>Intervention Level Framework</td><td>Examples from stories to transform systems & organisations & the individuals within them</td></tr>
<tr><td rowspan="2">Dominant culture and racialized discriminatory paradigms – the native assumptions – with their goals built into systems and organisations, dominate, dismiss and devalue Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing.</td><td>PARADIGM (a)
Systems ‘mindset’ e.g. the native assumptions
Deepest held beliefs, often unspoken beliefs about the way the system works
Goals, rules and structures arise out of the paradigm
Actions and ideas at this level propose to either shift or reinforce the current paradigm
It is very difficult to intervene at this level but can be very effective</td><td rowspan="2">i. A Bill of Human Rights (Dec 2019)
ii. The Uluru Statement of the Heart and the Makarrata Commission on Truth Telling
iii. A Royal Commission into Racism
iv. An Aboriginal and Torres Strait Islander Health Authority – a statutory authority
v. Aboriginal and Torres Strait Islander health professionals employed in the system</td></tr>
<tr><td>GOALS (b)
Conform to system’s paradigm e.g. the native assumptions
Are targets that need to be achieved for the paradigm to shift
Actions at this level focus or change the aim of the system
The levels below conform to and enable the system’s goals e.g. the native assumptions</td></tr>
</table>

Figure 15: Embed at a glance - A Systemwide Translational Model of Practice - addressing racism

<table>
<tr><td colspan="3">AIM: A right to a health system that is free of racism, and a health system that is rightfully equipped to recognise, value and implement Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing.</td></tr>
<tr><td rowspan="4">Summarised stories from yarning sessions & workshop</td><td colspan="2">ACTION: To ensure that Indigenous Knowledges and Indigenous Cultures are front and centre to policy responses, the action involves transforming systems and organisations by disrupting, deconstructing & decolonising – 3Ds – western knowledges and cultures of ways of being knowing and doing.</td></tr>
<tr><td colspan="2">3ES of IMPLEMENTING IKs and ICs</td></tr>
<tr><td colspan="2">EMBED
‘Embed’ is about how to integrate permanently into place the operations of IKs and ICs of ways of being, knowing and doing held by Indigenous Australians</td></tr>
<tr><td>Intervention Level Framework</td><td>Examples from stories to transform systems and organisations including individuals</td></tr>
<tr><td>System structures and goals based on dominant culture and racialized discriminatory paradigms – the native assumptions - with power imbalances that prevents the holism of Indigenous health and inappropriateness of data including lack of data that is inconsistent with the value systems held by Indigenous Australians</td><td>SYSTEM STRUCTURE (c)
All of the elements that make up the system as a whole, including the subsystems, actors, and interconnections between these elements
Conforms to the system goals and paradigms
Actions at this level will change the entire system structure by changing the linkages within systems or incorporating novel types of structural elements or incorporating novel elements
System structures give rise to the dynamic behaviour of the system over time
FEEDBACK & DELAYS (d)
Feedback allows the system to regulate itself by providing information about the outcomes of different actions back to the source of the actions
Feedback occurs when actions by one element of the system affect the flows into or out of that same element
Can be simple and direct or involve multiple variables</td><td>Ministerial Council on CTG partnership with the Coalition of Peaks and National CTG Agreement looking at:
institutional and systemic racism
16 new targets and
co-designing regionalisation mechanisms such as a reiteration of ATSIC
Cultural safety – eliminating racism

Cultural respect, cultural competency and cultural awareness.

Measuring racism through metrics such as taking own leave, elective surgery and waiting times.

Developing proxy racism indicators like asking patients about experiences with racism

Health Equity work – Queensland Health

Although,</td></tr>
</table>

<table>
<tr><td colspan="3">AIM: A right to a health system that is free of racism, and a health system that is rightfully equipped to recognise, value and implement Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing.</td></tr>
<tr><td rowspan="4">Summarised stories from yarning sessions & workshop</td><td colspan="2">ACTION: To ensure that Indigenous Knowledges and Indigenous Cultures are front and centre to policy responses, the action involves transforming systems and organisations by disrupting, deconstructing & decolonising – 3Ds – western knowledges and cultures of ways of being knowing and doing.</td></tr>
<tr><td colspan="2">3ES of IMPLEMENTING IKs and ICs</td></tr>
<tr><td colspan="2">EMBED
‘Embed’ is about how to integrate permanently into place the operations of IKs and ICs of ways of being, knowing and doing held by Indigenous Australians</td></tr>
<tr><td>Intervention Level Framework</td><td>Examples from stories to transform systems and organisations including individuals</td></tr>
<tr><td></td><td>Can be self-regulating/balancing or self-reinforcing
Actions at this level attempt to create new, or increase the gain around existing, feedback loops
Adding new feedback loops or changing feedback delays has the potential to restructure the system</td><td>you’ve got to be careful not to try and measure everything and it can be too distracting to have you know everything … sometimes that’s not that useful. But pick out the things that are really key … the key indicators of you know progress and success and stick to that (P11).</td></tr>
</table>

Figure 16: Enable at a glance - A Systemwide Translational Model of Practice - addressing racism

<table>
<tr><td colspan="3">AIM: A right to a health system that is free of racism, and a health system that is rightfully equipped to recognise, value and implement Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing.</td></tr>
<tr><td rowspan="3">Summarised stories from yarning sessions & workshop</td><td colspan="2">ACTION: To ensure that Indigenous Knowledges and Indigenous Cultures are front and centre to policy responses, the action involves transforming systems and organisations by disrupting, deconstructing & decolonising – 3Ds – western knowledges and cultures of ways of being knowing and doing.</td></tr>
<tr><td colspan="2">3Es of IMPLEMENTATION
ENABLE
‘Enable’ is about providing the means and opportunities for Indigenous people and communities to have a voice in being able to practice their knowledges and cultures of ways of being, knowing and doing</td></tr>
<tr><td>Intervention Level Framework</td><td>Examples from stories to transform systems and organisations including individuals</td></tr>
<tr><td>… it’s a structural element of the system that has expectations of us to do what’s normal, but the governance structure is actually doing the opposite of what’s important to Aboriginal and Torres Strait Islander people and communities (policy actor representative, Dec 2019)

… one size fits all, which is mainstream population, and the standard approach, to service delivery. So, if we can’t change it to a community development for our nation building perspective, from our cultural lens, it’s never really gonna, policies, are never gonna work (policy actor representative, Dec 2019)

… go back to the PM’s Closing the Gap speech … we all work with Aboriginal and Torres Strait Islander people, and ‘not’ to Aboriginal and Torres … we do things ‘with’, not ‘to’ (P6)</td><td>STRUCTURAL ELEMENTS (e)
Subsystems, actors, and the physical elements of the system
Connected through feedback loops and information flows
Actions at this level affect specific subsystems, actors, or elements of the system
At this level many actions are usually required to create system-wide change</td><td>Service systems such as mainstream hospitals and primary health care providers (but not limited to these)
collaborating and co-designing their local health care responses with local communities that take into consideration the unique and diverse cultural factors of those communities
incorporating traditional healers and traditional medicine practices into care that draws from cultural knowledges
… the Coalition of Peaks or the arrangement around joint counsel around this co-design, joint decision-making is possibly something that you can develop and change structural elements. So that’s definitely change structural elements about the dialogue and the priorities. And, this co-design partnership approach and then there’s feedback delays and structures still need to be transformed …. Because again it’s that standard approach the dominant culture views of structures. But we’re trying to change the goals … (policy actor representative, Dec 2019)</td></tr>
</table>

So, what is effectively happening with the systemwide translational model of practice is that:

> *It's going against the grain … which again will influence policy change in the future, and that's again changing a value set (policy actor representative, 12 December 2019).*

Although at the Sydney 2018 National Aboriginal and Torres Strait Islander Summit, one participant reiterated that:

> *We talked about resetting the operating system … we have to decide to learn … to listen (P8, July 2018).*

But critically, it is also about privileging Indigenous voices (P8, July 2018).

Although, as one participant said:

> *In terms of system enablers and enablers across organisation, it really does require strong leadership from the top (P6, July 2018).*

While another said:

> *My thinking on system change: It's a slow burner, concerted effort that might not just start with appointing people to boards or employing Aboriginal person, but everyone taking responsibility ... for their own professional development and cultural safety, and everyone taking responsibility for Aboriginal and Torres Strait Islander health outcomes (P8, July 2018).*

Other examples relating to the 3Es of implementation are provided in column three in the at-a-glance model of practice contained in Figures (14, 15 & 16). Other examples

were also provided in policy actors' stories. However, cultural obligations and relational accountabilities described in Chapter 3 led me to decide not to include them. To reiterate, some case examples are community owned knowledges and would have required additional permission to use in this thesis (policy actor representative, 3 August 2020).

Nonetheless, given the evidence gap concerning the implementation of Indigenous people's knowledges and cultures, consideration should be given to the development of a monograph containing examples of enacting, embedding and enabling the knowledges and cultures owned by Indigenous communities for integration into the design and delivery of public policies, public health responses and healthcare delivery. Chapter 6 provides a case example of implementing IKs and ICs in a clinical practice setting involving the Katherine Hospital.

The above Systemwide Translational Model of Practice at-a-glance Figures 14 - 16 begins to establish a new way to think about addressing the complexities of institutional and systemic racism facing Indigenous health. The model of practice is calling for a new way of working that adopts a systems perspective that pursues leverage points in the health system and their sub-systems. The ILF, together with the 3Es of implementation, offers opportunities to think and work differently in order to implement IKs and ICs. Having a health system that is free of racism and a health system that is equipped to recognise, value and implement the knowledges and cultures own and held by Indigenous communities is paramount.

5.5. Chapter 5 Discussion

Clearly, a multi-faceted response is a necessity to reform the racialized and prejudicial systems and sub-systems, detrimental institutional wide rules and behaviours, and structural norms – the native assumptions – that pervade the way that governments and policy makers think, behave and act.

These colonialist and imperialist rules, norms and behaviours of systems, organisations and individuals (Moreton-Robinson, 2015) are directly related to the impacts and legacy of colonisation (Kirmayer & Brass, 2016). They manifest themselves through the current social, political, economic and health inequalities experienced by Indigenous Australians (Markwick et al., 2019). Colonisation's continuation in the public policy and public health policy environment is furthering, what we term as 'policy trauma' (A. Mahoney and C. Parter, personal communication, June 2018). The inappropriateness and continuation of public health policies perpetuates the colonialist's paternalistic process of colonisation and the ingrained mindset of the native assumptions described earlier.

If real sustainable transformational systemic, organisational and individual change is to occur, then the development and maintenance of strategic collaborative alliances and partnerships is a necessity (P8 & P14). The aid of Indigenous-led scholarly Indigenous knowledge, translatable into evidence-based practice, is pivotal (P8 and P21).

Critically, a prerequisite for being an effective Indigenous leader, whether that leader is an individual or a community-led organisation, is having a sound grounding in one's Indigenous ways of being, knowing and doing (P7 & P21). Without such grounding,

Indigenous leaders or Indigenous organisations become ineffectual (P7 & P21). The nation building task of revitalising, reclaiming and reinvigorating Indigenous people's culture and cultural knowledges is imperative, and government funding to support this project is warranted (P8 & workshop participants, June 2018 and December 2019 respectively).

The 3Es of implementation – enabling, embedding and enacting Indigenous knowledges and Indigenous cultures – were common terms used by the policy actors who participated in this study. The participants offered many stories about the ways that policy makers, governments, healthcare providers and individuals can introduce strategies to provide Indigenous Australians with the means and opportunities to enable their cultures and knowledges within the public policy and public health policy domains. Similarly, examples of how to permanently integrate Indigenous people's cultures and knowledges of ways of being, knowing and doing into the public policy health domain were also provided. Specifically, these examples referred to policy instruments such as legislation, statutory bodies and government commitments required to enact the cultures and knowledges that Australian Indigenous peoples hold. These instruments include the Treaty processes occurring in Victoria, Queensland and Australian Capital Territory (P17 & P18, October 2018 and 12 December 2019 Yarning Workshop participants).

A system-wide translational model of practice has been developed that aims to provide a tool to understand the challenges presented, and to assist in implementing Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing. This model of practice requires a new way of thinking, and a new way of working. Specifically, it requires examining leverage points in systems, as demonstrated in the

above at-a-glance Figures 14 - 16. However, further investment and research is required to progress a new way of thinking and working, particularly in relation to dealing with institutional and systemic racism.

Despite the challenges presented, there remains a level of excitement and optimism with a ‘can do attitude’ evident in the stories told by participants.

A system thinking approach is critical, to changing ingrained racialized native assumptions, discriminatory paradigms, and culturally biased rules and norms of systems, organisations and individuals.

As mentioned in Chapter 2, system thinking is a form of practice that examines the inter-connectedness of complex social phenomena related to often invisible factors involving paradigms, structures and actors within and across systems and sub-systems like those briefly mentioned above in the model of practice (Peters, 2014; Taghreed, 2016). The examination of leverage points in the system to effect such change is a necessity and this was expressed by one policy actor who said:

> ’Cause it won’t, it won’t work. But what are some of the systems and levers (P5, June 2018).

5.6. Chapter 5 Conclusion

Chapter 5 calls for a health system that is rightfully free of racism, and a health system that is rightfully equipped to recognise, value and implement Indigenous people’s knowledges and cultures of ways of being, knowing, and doing. A systemwide translational model of practice aims to ensure that the knowledges held by Indigenous Australians is exchangeable and translatable through the model of practice into public health policies. Importantly, the model of practice challenges the dominant ways of

being, knowing and doing and offers examples of enacting, embedding and enabling IKs and ICs. The required actions involve disrupting, deconstructing and decolonising the racialized native assumptions and discriminatory paradigms that are grounded in the processes of colonisation. In short, the model of practice is decolonising public health policies.

Chapter 6 will provide a case example of implementing IKs and ICs in healthcare practice.

5.7. References

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CHAPTER 6. PUTTING INDIGENOUS KNOWLEDGES AND INDIGENOUS CULTURES FRONT AND CENTRE OF PRACTICE – RE STORYING

6.1. Introduction

> *I think policy making is a bit of a mystery … we get these wonderful policy documents, and policies are well designed … they fall down in implementation (P16, September 2018).*

Chapter 6 contains a manuscript that has been submitted for publication to the *Rural and Remote Health Journal*.

During yarning sessions, two policy actors mentioned the Katherine Hospital as an exemplary case. Using the ABC radio national background briefing about Katherine Hospital, and including stories from policy actors, the article shows how culture as a determinant of health can be implemented when providing services to local Aboriginal people and communities.

6.2. Putting culture front and centre to clinical practice

Reference

Parter, C., Gwynn, J., Wilson, S., Hartz. D. L., and Skinner, J. C. (2020), Putting Indigenous cultural beliefs and knowledges front and centre to clinical practice: A rural and remote case example - the Katherine Hospital. *Rural and Remote Health Journal* – submitted for publication

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As co-authors of the published work:

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We confirm that Carmen Dorothy Ruby Parter made the following contributions:

The candidate planned and prepared the manuscript that involved several drafts in readiness for publication. Dr Josephine Gwynn, Dr Shawn Wilson, Dr Donna L. Hartz, and Dr John Skinner contributed to subsequent drafts by reviewing and editing the content, and providing advice. The final draft was reviewed and approved by all co-authors.

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This statement aligns with the requirements of the University of Sydney regarding policy as described in the policy documents:

*Thesis and Examination of Higher Degrees by Research Policy 2015
*Thesis and Examination of Higher Degree by Research Procedures 2015

https://www.sydney.edu.au/students/prepare-thesis.html

Abstract

In Australia, policies that aim to improve the health of Indigenous people have started to incorporate culture with recent examples being the National Aboriginal and Torres Strait Islander Health and Implementation Plans. However, conceptualising culture into healthcare practice has its contextual challenges with an evidence gap in implementation apparent. To address such an evidence gap case studies are useful educational tools to assist with implementing Indigenous people's culture within health services.

The Katherine Hospital, which provides services to rural and remote communities in Northern Territory of Australia, is such an example. This case study arose out of a broader research project that explored how policy makers implement culture. The lessons that can be drawn from such case studies like the Katherine Hospital are useful for other services particularly where the Indigenous population is proportionally higher to that of the general population, predominantly in rural and remote areas of Australia. Additionally, the six Aboriginal and Torres Strait Islander Health actions contained in the second edition of the National Safety and Quality Health Service Standards provide governance and accountability examples to assist with giving effect to Indigenous people's cultures and their knowledges in the provision of services. Culture is now a determinant of health and is well integrated into Australia's Indigenous health policies. Policy makers, practitioners and services are now required to implement them. Therefore, further investment in research to create evidence drawn from other case studies is required.

Introduction

In Australia, Indigenous culture as a determinant of health is now prominently integrated into the decisions and actions of governments aimed to improve the health of Indigenous peoples. Cultural determinants of health involve the cultural beliefs and knowledges held by Indigenous Australians concerning connection to Country, their language, and family, kinship and community relationships. (3) Cultural expressions of identity through art, music and sports, and other traditional and self-determining community practices are also applicable. (3)

However, a gap in evident to implement culture in the delivery of healthcare services and their processes is apparent. (1, 2) The Katherine Hospital, which provides services to rural and remote communities in Northern Territory of Australia, is a case study in the implementation of culture.

As described by [De-Identified], a study exploring how culture can be implemented by policy makers, (4) heard stories from nineteen policy actors about the challenges of implementing culture with several examples provided. Some of their stories follow.

Two policy actors mentioned the Katherine Hospital (the hospital) as an exemplary case with one highlighting that

> *There was a wonderful 40-minute program on radio national … I make all my guys listen to that 40 minutes … cause it's really important thing, because it touches on so many issues … it's definitely … a good case study (P6, June 2018).*

To be demonstrated below, the Katherine Hospital has proven how the cultural determinants of health can be considered in healthcare and clinical practice. Critical though is being able to draw from Indigenous peoples' knowledges to give effect to these cultural determinants of health. The six new Aboriginal and Torres Strait Islander health actions contained in the second edition of the National Safety and Quality Health Service Standards (the Health Service Standards), offer governance and accountability examples of good practice when drawing from those cultural knowledges Indigenous people hold. (5,6)

Cultural determinants of health an enabler for good health

The inclusion of cultural determinants of health in policies is consistent with calls for culture to be at the centre of change as *an enabler of health and wellbeing*. (7)

Connection to culture has a strong relationship to good health and wellbeing (8) because, as a policy actor said

> *If we've got a good connection to language, we've got good connection to your culture, ability to practice culture, access to land, and all those sorts of things, they're strengths that add to wellbeing, and are important to Aboriginal health (P2, June 2018).*

However, *culture, as a concept, can be a little bit slippery to understand* (P13, September 2018) and *then how to embed [culture] … remains the critical issue (P8, July 2018).* Further, *how do we build on the cultural sort of side of it? Is a really, important question. So, what does that mean for our service system? (P11, September 2018).* Because *we can't rely on cultural safety or cultural awareness training to support the implementation of culture (P6, June 2018).*

The Health Service Standards are requiring hospitals to understand and embed those cultural determinants of health into organisational practice. Specifically, they are expected to know and understand Indigenous Australian's cultural beliefs and practices particularly when making environments welcoming and friendly and providing cultural awareness and cultural competency programs for their workforce. (5,6) Working in partnership with Indigenous communities will further enhance such understanding when designing culturally responsive strategies aimed to meet their local community's needs. (5,6)

The case example – Katherine Hospital

Background

The Katherine Hospital is approximately 320 kilometres southwest of its capital city, Darwin in the Australian Northern Territory – NT. (9) A predominantly rural and remote population of 20,000 people live in its catchment area of 340,000 square kilometres. (9) The Aboriginal population regionally is proportionately higher where they continue to practice their cultural beliefs and knowledges, ceremonies and traditional medicines, and healing practices. (9, 10, 11).

Box 1: Description of the Aboriginal population within the Katherine Hospital catchment area. (9)

> **Aboriginal people** make up 52% of the region's population. Larger Aboriginal communities include Ngukurr, Barunga, Bulman, Lajamanu and Kalkarindji. There are three main Aboriginal groups that intersect in the town of Katherine. These are the Dagoman, Jawoyn and Wardaman peoples. The region covers over 16 different tribal groups, the most prominent of which are Jaowyn, Wardaman, Dagaman, Nguliwuru, Walpiri, Gurindji, Waramungu and Myali. Many still live close to traditional ways. Over 30 languages are spoken. Kriol is the most widely used language in the Katherine regions, with different variants spoken.

A 40-minute ABC radio national program – Background Briefing – examined a hospital in crisis that soon *bec[a]me rank[ed] as among Australia's best for its relationship with its Indigenous patients*. (10) In addressing the crisis, the hospital demonstrates how the cultural determinants of health are implemented.

The Katherine Hospital's Story

Katherine Hospital's medical model of care was untenable representing the very antithesis of Aboriginal culture and the holism of health. (12) Aboriginal patients were taking their own leave at alarming rates. In 2011, one in four Aboriginal patients were taking their own leave *because they didn't feel the hospital cared for them and they didn't trust the doctors ...or their treatment was inadequate*. (10, 13)

Taking their own leave is complex, and explanatory factors include racism, cultural safety and mistrust of the health system. (14) Communication and language barriers are also significant factors along with not understanding treatment and care, conflicting social obligations, and isolation and loneliness. (14)

What turned Katherine Hospital's crisis around?

Katherine Hospital implemented a range of strategies to address the high rates of Aboriginal people taking their own leave. (10, 13).

Specifically, cultural factors were considered in treatment plans, as occurred for a Jaowyn Elder with acute kidney failure. Without treatment at a tertiary institution, she was unlikely to survive the weekend with a clinician saying *going to Darwin might save her life ... [but it] is too far from her Country and family*. (13) Spiritual connection to Country and family became paramount and limited immediate transfer to a tertiary institution like Darwin hospital. Understanding the importance of connection to Country and family is

> *A real battle and a fight ... just getting the system to understand the importance of being on Country, if you're gonna pass away. The importance of being treated closer to home and all those sorts of things. How can we improve that for people? So, it basically means they have to leave Country, and I guess the outcomes aren't good because people quite often just stop half way, they don't want to be removed from Country, they don't wanna not have their family around them. That whole patient journey is really critical because of the vast distance between regional centres and [a tertiary] hospital (P1, June 2018).*

The hospital clinician went on to say

> *So, the doctors are about to negotiate with her ... it will be complex and requiring great knowledge in understanding about her culture and wishes ... she needs a big boss doctor to have that conversation with her and her family and the family will know who the boss doctors are.* (13)

Understanding the broader family structures and relationships in Indigenous societies is a necessity. Talking to family and not an individual, as expected in western non-Indigenous nucleus families, is culturally appropriate. The complexities and sensitivities of Aboriginal kinship relationships particularly taboos must be understood. (10) As expressed by a policy actor

> *When you go to practice ... you might not be aware [of] kinship relationships, of all these relationships ... brother sister ... young men can't talk to their sisters ... so avoidance relationships ... unless you understand that they're operating ... you're going to end up doing something very silly (P9, August 2018).*

Who went on to say that working in a cultural context is critical because

> *If you don't have any cultural background or an education in what sort of cultural imperatives might be ... when you go to practice, those things will be a challenge because you might be aware of them necessarily, you might not be aware (P9, August 2018),*

Concluding that

> *If you understand that that's how the community sees itself, then it becomes easier to develop policy around how you practice healthcare (P9, August 2018).*

Additionally, understanding cultural practices is also warranted. (10) As a hospital clinician said about bush medicine, *I'm always happy to do whatever and sort of incorporate that in our treatment plan*. (13) Further saying,

> *We try to be relatively respectful in terms of bush medicine, and black magic and witch doctors ... if they'd like to have that as part of their treatment, then certainly facilitate it.* (13)

A policy actor described how her mother uses a bush medicine and said

> *Its properties are more sort of antiseptic but you can also like drink it, and it will clear up any wounds really quickly, and if you've got a cough ... a really, powerful bush medicine* (P11, September 2018).

This policy actor exclaimed, *we should be tapping into that and actually, revitalising that whole area of knowledge* (P11, September 2019).

The inclusion of bush medicines and cultural practices into a patient's treatment is an example of implementing the cultural determinants of health. Such examples are critical if policy makers, practitioners and services are to give effect to those cultural determinants of health.

The hospital also understood that *English isn't their first language. It may not even be their second or third either. If there's any doubt, we get interpreters in, or even on the phone*. (13)

Metaphors were often used too, to explain certain conditions with a fungal infection described by a hospital clinician as *you know like mushrooms growing*. (10) While, diabetes was described as *sticky red blood that clogs up the pipes and causes blockage ... how a medication will help pull the sugar out of the blood*. (10)

Critical though is that *the responsibility to understand Aboriginal culture and worldviews became the business of everyone and not simply left to Aboriginal staff such as the Aboriginal Hospital Liaison Officer*. (10)

Discussion

Katherine Hospital became one of the best in Australia in terms of its relationship with Aboriginal people. Indigenous cultural beliefs and practices were taken into consideration when addressing the rates of Aboriginal patients taking their own leave. Governing bodies of services like hospitals must take full responsibility for building the cultural determinants of health into an organisation's planning, resource allocation, and data monitoring and accountability systems. Furthermore, that their workplace is culturally competent and workforce culturally safe.

Importantly, Indigenous consumers, patients and carers, including Indigenous staff must be involved in assessing whether services are culturally competent and culturally safe. Finally, working in equal partnership with Indigenous Australians is an imperative particularly as culture is now a determinant of health and integrated firmly into Indigenous policies. (2)

To assist services to implement the cultural determinants of health, good practice examples are contained in the Health Service Standards. (7,8) Finally, further research to document other case studies that give effect to cultural determinants of health is a necessity.

Conclusion

Indigenous cultures, as a determinant of health, are well integrated into national Indigenous health policies requiring policy makers, practitioners and services to implement these cultural beliefs and practices. However, conceptual and contextual difficulties remain. Nevertheless, lessons from examples like the Katherine Hospital will go a long way to address an evidence gap. More case studies are therefore warranted. Similarly, the Health Service Standards provide governance and accountability examples of good practice when drawing from Indigenous peoples' their cultural beliefs, knowledges and practices. Lessons that can be learnt when integrating these cultural factors into service delivery.

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Case examples, such as the above, will be critical for creating the evidence about implementing and giving effect to the cultural determinants of health.

The Health Plan is another exemplary case example to be shortly documented in a book chapter. The centrality of culture and striving for a health system that is free of racism is a demonstration of the achievements when Aboriginal and Torres Strait Islander people control, direct, and co-design a public policy instrument. It is their knowledges and cultures of ways of being, knowing and doing that has been integrated into the Health Plan's policy framework. The accepted book chapter abstract is at Appendix 9.

Pivotal to addressing an implementation evidence gap are case examples like these with additional investment and research warranted.

6.3. Chapter 6 Conclusion

Katherine Hospital is an exemplary case example that has demonstrated how the cultural determinants of health can be implemented. The impending book chapter about the Health Plan is another exemplary case example. It is case examples like these that will address an evidence gap concerning how Indigenous peoples' knowledges and cultures can be implemented in the design, implementation and delivery of programs and services. Importantly, the governance and accountability mechanisms of having Indigenous Australians front and centre to initiatives is critical if their knowledges and cultures are to be implemented. Case examples provide lessons that policy makers working in governments on Indigenous health policy could learn from.

Chapter 7, which follows, will further this discussion. Chapter 7 makes some recommendations followed by some concluding remarks.

CHAPTER 7. FINAL DISCUSSION, RECOMMENDATIONS AND CONCLUDING REMARKS

7.1. Introduction

Chapter 7 is the final chapter of this thesis. It provides an overview of the study's response to the research question. Specifically, it responds to the question of how policy makers implement culture once it has been incorporated into a public policy instrument like the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013–2023. The chapter also includes a further discussion containing recommendations, and the thesis finishes with some concluding remarks. First though, a quick commentary regarding the recently agreed new national Closing the Gap Agreement (Australian Government, 2020) is provided with a new era forthcoming as governments commit to addressing racism with culture and truth telling central to their policy responses..

7.1.1. A commentary on the new Closing the Gap (CTG) national agreement

I write this final chapter a day after (30 July 2020) all levels of government agreed to a new historic national partnership on closing the socio-economic gaps between Indigenous and non-Indigenous Australians (Australian Government, 2020). The new national CTG agreement is the first public policy decision to have been done in genuine partnership with Indigenous Australians - represented by the Coalition of Peaks. The agreement sets out a comprehensive agenda of significant transformational reforms in genuine and equal partnership with Indigenous Australians with an achievement year of 2031 (Australian Government, 2020).

This national agreement is the first of its kind to name institutional and systemic racism and individual racist attitudes, including unconscious biases requiring redress. Furthermore, the cultures of Indigenous Australians are central to policy and place-based responses aimed at addressing the socio-economic vulnerabilities experienced by Indigenous Australians that contribute to the 10-year life expectancy gap between Indigenous and non-Indigenous people. It is a remarkable achievement that is closely related to the results of this research study.

So, nationally, Australian governments are entering into new terrain as they commit themselves to genuinely addressing those system and organisational impediments grounded in racialized dominant western cultural paradigms – the native assumptions – that are sustaining the social, political and economic inequalities faced by Indigenous people and communities.

While these are exciting times for Indigenous Australians as they work in partnership with Australian governments, a level of pessimism remains because the possessiveness of whiteness, as described by Moreton-Robinson remains (Moreton-Robinson, 2015) and is that deep-seated resistance identified in Chapter 4. This possessiveness must be fully understood, as must institutional and systemic racism. Governments must commit resources to fully understanding such phenomena, with further research warranted.

It is vital that the knowledges and cultures of ways of being, knowing, and doing that are owned and held by Indigenous Australians are embedded in this new national CTG agreement.

The new agreement appears to have all the hallmarks of providing Indigenous peoples with the means, power and authority to inform policy and programs – in other words,

it appears to enable. Similarly, it appears to ensure that the knowledges and cultures of Indigenous people are integrated permanently into the operations of government programs and services – in other words, it appears to embed. The transformational reforms being recommended in the new agreement require intensive research into what policy tools are needed to compel the relevant white institutions to replace their current, hard-to-change mindsets and beliefs with Indigenous worldviews and frames of reference of ways of being, knowing and doing. Unless such research is undertaken, the aspirational vision and goals of the new national CTG agreement will not be met by 2031. If it continues with the status quo, Australia will have had another wasted decade of policy commitment.

7.1.2. Health is leading the way

In health, the findings of this current research study have the potential to lead the way for other governments and agencies as they embark on a new era of CTG.

This is because several conceptual frameworks have been developed to assist with bringing meaning and understanding to the ways Indigenous culture is understood by policy makers. Importantly, culture is about the knowledges that Indigenous Australians possess.

As reaffirmed in Chapter 4, Indigenous Australian's knowledges can be found in community and ancestral stories and grey literature. These knowledges include the lived experiences of communities. Figure 12 captures the essence of such knowledges in Chapter 4. The knowledges are held by Indigenous Elders and communities, Indigenous organisations such as those in the community-controlled sector, and Indigenous leaders. Policy makers must draw on such Indigenous

knowledges and put aside their unconscious biases or racist attitudes when making Indigenous public health policy.

Further, the adapted ‘Our Way Model’, Figure 1 contained in Chapter 1, conceptually positions Indigenous people as central to the policy development cycle, and allows for that cultural dimension, and knowledges to be bought to the policy production process (Parter, 2005). Critical to the ‘Our Way Model’ is a recognition of the need to work at the cultural interface where knowledge systems meet (Nakata, 2007), and where innovations can occur through cultural infusion (Parter, 2005).

For the knowledges held by Indigenous people to be recognised and valued, the dominant western non-Indigenous culture must accept that Indigenous people’s cultural knowledges of ways of being, knowing and doing are relevant to policy production. I demonstrate such ways of being, knowing and doing in Chapter 3. As contained in the “My research is my story” manuscript as Figure 1, the Indigenist paradigm, standpoint, methodological and methods approach that informs my framework of inquiry, is how I represent such an Indigenous worldview of ways of being, knowing and doing. This conceptual approach and framework of inquiry are useful tools for policy makers when understanding Indigenous peoples’ worldviews of ways of being, knowing and doing. More importantly, for policy makers to appreciate how their own worldviews of ways of being, knowing and doing influence’s their interpretation while making policy in relation to Indigenous health. No longer should the knowledges and cultures held by Indigenous Australians be dismissed or diminished.

A model of practice, known as the systemwide translational model of practice discussed in Chapter 5, section 5.4, has been developed to address the deep-seated

ingrained racialized discriminatory native assumptions that will prevent the implementation of Indigenous knowledges and Indigenous cultures.

The model also provides a tool to understand the challenges that health faces in ensuring that Indigenous knowledges and Indigenous cultures is well embedded into public health policies and responses. Identifying the leverage points where the greatest gains can be achieved is the potential that the model of practice offers for addressing institutional and systemic racism. A model of practice is a way of practice to apply concepts of system thinking.

The systemwide translational model of practice fulfils the original intent of the aim of the study with a number of conceptual frameworks such as Figures 1 and 12 (mentioned above) brings meaning and understanding to Indigenous culture that is understood by policy makers. Importantly, that our culture is our knowledges and that our knowledges count, as determined in Chapter 4. Policy makers must understand Indigenous ways of being, knowing and doing in order to implement culture particularly once incorporated into a public policy instrument like the Health Plan.

7.1.3. Thesis overview reaffirmed

In Chapter 1, I started by telling my story about why I chose to work in policy after a career as a nurse. Essentially, I did so because the policies designed for Indigenous Australians in relation to their health were not appropriate. My experiences working as a policy maker in government and the challenges encountered when implementing culture indicated that policy makers and governments just ‘did not get’ Indigenous Australian cultures. The published Closing the Gap (CTG) article included in Chapter 1 further highlights such challenges and possible solutions to address an evidence gap.

I developed the ‘Our Way Model’ (Parter, 2005) to conceptualise for governments what was required to enable the cultures of Indigenous Australians when developing policy. This 2005 research signalled the inception of my PhD.

Chapter 2 sets the scene for my PhD research study. It describes the policy environment, the actors, and the rise of culture as a determinant of health. A published research protocol (Parter, et al, 2020) with amendments and the study’s governance and ethics applications are included in this chapter. Chapter 2 concludes by identifying where this research study fits within the present Indigenous public health policy environment. Specifically, it relates to implementation of culture, which is now a determinant of health built into the Health Plan’s second Implementation Plan (Department of Health, 2019).

Chapter 3 tells my story of the theories and underpinning concepts that are integral to my research study. The manuscript under second review titled “My research is my story” authenticates and validates my Indigeneity. The collective theoretical frameworks and concepts contained in this chapter are known as Carmen’s Theory. Carmen’s Theory contributed to the findings of the research study in meeting the research study’s aims.

Chapter 4 contains the three themes arising from stories told by policy actors. The findings reiterate that policy makers must concede that Indigenous culture is about Indigenous knowledges and cultural knowledges of ways of being, knowing and doing. If policy makers are to facilitate the implementation of Indigenous knowledges and cultures of ways of being, knowing and doing, they must be respectful knowers of Indigenous peoples and Indigenous communities’ worldviews. The ways of being, knowing and doing in these worldviews are in stark contrast to those of western

science and knowledges. Additionally, the Truth Telling of the impact of colonisation must be told so that the past is understood by policy makers when making policies in relation to Indigenous health and wellbeing. While there is a willingness to accept the relevance and importance of Indigenous culture, a deep-seated resistance of institutional and systemic racism has also been revealed. Despite the evidence that racism makes marginalised groups like Indigenous Australians sick (Paradies, 2006; Paradies & Cunningham, 2009; Paradies, Harris, & Andersen, 2008; Paradies, 2006), and that institutional and systemic racism maintains the health inequities and social inequalities experienced by Indigenous Australians (Arabena, 2013; Australian Government, 2013; Awofeso, 2012; Bargallie, 2020; Durie & Thompson, 2012; Durie, Thompson and Wood, 2012) , talking about racism with mainstream non-Indigenous policy makers is difficult. Nonetheless, taking policy makers on a journey to co-design a multi-pronged anti-racism response throughout the health system and its sub-systems is imperative. More importantly, we must have a health system that is equipped to recognise, value and implement the knowledges and cultures of ways of being, knowing and doing that Indigenous people and communities hold.

The systemwide translational model of practice contained in Chapter 5 offers a tool to understand the challenges of addressing institutional and systemic racism. It also considers opportunities for leverage points in the system which can be used to transform those racialized rules and norms – the native assumptions – of systems and organisations including individual behaviours. Presently, the dominant western cultures and scientific knowledges are not conducive to the value systems, and cultural knowledges that Indigenous Australians own.

Given that a generational change period of 31 years of Indigenous health policy intervention has already occurred, it is timely for policy makers and governments to relinquish their power, control and possessive whiteness by enacting policy tools to support the implementation of Indigenous Australian cultures and knowledges. Further, a multi-pronged approach that embeds IKs and ICs into practice is warranted. Providing Indigenous leaders, their organisations and communities with the authority, power and means to co-design policies and programs that support the implementation of anti-racist interventions that privileges IKs and ICs is a necessity.

The nation building task of revitalising, reclaiming and reinvigorating IKs and ICs of ways of being, knowing and doing is essential, and brings healing to communities. Governments must be willing to provide the structural elements such as funding to support culturally informed healing initiatives. However, policy makers must accept that to align with the value set of Indigenous communities, the paradigms, goals, system elements, feedback and delay loops, and structural elements of the current system must be transformed. Indigenous leadership and their knowledges and cultures of ways of being, knowing and doing are central to the systemwide translational model of practice, and they will play an essential role in the co-designing of transformational change.

Chapter 6 explores how to implement Indigenous knowledges and Indigenous cultures, as determinants of health, into healthcare practice by drawing from a case example – the Katherine Hospital. The hospital was mentioned by two participants of yarning sessions. It is one of many examples of how cultural factors are embedded into healthcare practice when meeting the unique needs of their local Aboriginal population. Policy makers can learn from such case examples like the Katherine

Hospital, but they must be prepared to listen with an open heart and an open mind, and they must be willing to work alongside Indigenous leaders and communities. But more investment and research are required to document other case examples that demonstrate how the cultural determinants of health can be implemented.

A set of recommendations follows in the final concluding remarks of this thesis.

7.1.4. Future opportunities to disseminate research findings

Recently, the findings of my research study were presented at the Lowitja Institute Cultural Determinants of Health Policy Roundtable on 14 September 2020 (the Roundtable). The Roundtable consisted of senior departmental officials, non-government experts, and members of the Department of Health's Indigenous Policy Advisory Group (IPAG). It is anticipated that a set of recommendations will be forthcoming to inform future work about implementing culture as a determinant of health. As an expert public policy person, policy makers will be able to use the findings to assist with implementing culture particularly as culture is firmly embedded into the Health Plan's next Implementation Plan as a determinant of health. Although, to implement Indigenous knowledges and Indigneous cultures will mean racism needs to be addressed.

Also, policy actors who requested a copy of the study's findings will receive a report shortly. They have indicated their keenness to draw from the lessons learnt from the research to apply in their own work practices.

Additionally, the study's reference group - the NHLF - will be presented with the research findings. It is envisaged that the study's findings will inform the next iteration of the Health Plan's Implementation Plan concerning striving for a health system that

is free of racism. The NATSIHSC of AHMAC will also receive the study's finding whose future work involves addressing institutional and systemic racism.

Finally, I will be presenting on my research study's findings at the Poche Indigenous Health Network's 9th Annual Research Showcase on 18 - 19 November 2020 via Zoom.

The study essentially has a national research and impact that is vital as my cultural responsibilities do require that this research must inform policy conversations and debates.

7.2. Final concluding remarks

As policy makers and all levels of government embark on a new National Closing the Gap Agreement (Australian Government, 2020), a continued and trusting co-design approach that is a genuine partnership with Aboriginal and Torres Strait Islander people and communities is paramount. A systems perspective is warranted to address the ingrained and invisible colonialist, imperialist and racialized paradigms – the native assumptions – that have dominated the Indigenous affairs and Indigenous public health policy environment for the last 31 years.

Policy makers and governments must relinquish their power and control over the affairs of Indigenous Australians because Indigenous Australians do have the solutions, and it is their sophisticated knowledges and cultures of ways of being, knowing and doing that must be front and centre of any public policy health response. The new national agreement appears to do this.

Unfortunately, the whiteness described by Moreton-Robinson (2015, 2000) must be challenged because unproductive systemic behaviours, if left unchecked and

unchallenged, will continue to exacerbate the impoverishment that Indigenous Australians experience. Policy makers and all governments must invest in addressing racialized, dominant and discriminatory paradigms – the native assumptions - that maintain and privilege whiteness.

The future that I want to see for my grandchildren and future generations is an Indigenous population that has the same quality of life in health, education and employment that is currently enjoyed by most Australians. Also, I want to see a society that is mature enough to call out racism, a society that finally understands that Australia does have a 'black' history. A not so pleasant history, but a story that needs to be told if its 'white' systems are to be transformed.

I remain hopeful that in my lifetime, I will get to see Indigenous Australians experiencing the quality of life that our non-Indigenous counterparts enjoy, a life that is indeed free of all forms of racism.

When we finally have an Aboriginal or Torres Strait Islander Prime Minister or a Governor General in this country, that to me will be an indication that we have finally matured into a nation that accepts and has dealt with our racist past, a nation that has agreed to the Uluru Statement of the Heart, and that embraces Makaratta Commission involving truth telling, and a health authority led by Indigenous Australians (P8, July 2018). Unless Australian governments and their policy makers come to terms with their racist past, and acknowledge the racialisation of the public policy environment, the health gap between Indigenous and non-Indigenous Australians will never close, and the cultural determinants of health will never be implemented.

I remain hopeful that governments will now re-think the ways that they do business, and that they will provide the power and control to Indigenous peoples to rightfully

determine their own affairs. Integral to such a transformation is having the national, state and territory public policy infrastructure that takes policy development, production and implementation to local communities. Place-based approaches to implementing Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing are a necessity. As one participant said, you need the macro policy infrastructure as well as the local approaches to achieve health equity and social, economic equality for all Indigenous Australians (P17, October 2018).

Sustainable change can only be achieved through a rights-based approach that values, recognises and implements Indigenous knowledges and Indigenous cultures within a public health policy environment. When communities are rightfully resourced to contribute to those high-level macro policy commitments, we will see changes in value systems that are conducive to Indigenous Australians' ways of being, knowing and doing.

Due to its holistic nature, health is not just about our physical wellbeing – it is about the social, cultural and emotional wellbeing of the entire community, and that is what we aspire to. Perhaps the policy environment is ready to challenge those western and often contradictory worldviews that are the very anthesis of Indigenous people's worldviews of relatedness, connectivity, respect, reciprocity, reverence and responsibility. These values are held and owned by Indigenous Australians, and it is these values that will drive the transformational changes of systems and organisations that are needed to ensure they behave in a manner that honours Indigenous people's knowledges and cultures, including their expressions of connection to country, language, lore and cultural practices. It is essential that the systems of governments and their institutions begin to change their underpinning philosophies of ways of being,

knowing and doing. These changes manifest in the way that funding is provided and programs like birthing on country become normalised praxis in mainstream health.

7.2.1. Recommendations

For IKs and ICs to be effectively implemented, strategies must be designed with the intent of disrupting, deconstructing and decolonising those racialized paradigms of power, control and dominance – the native assumptions – that act out in the inappropriate behaviour of systems, organisations and individuals. Importantly, value systems must be consistent with the values, knowledges and cultures of ways of being, knowing and doing of Indigenous Australians.

As highlighted by the Intervention Level Framework (Malhi et al,2012), examining leverage points in systems and identifying appropriate policy tools to enact the necessary transformational changes in such systems is a necessity if culture – as a determinant of health, and indeed our knowledges – is to be implemented.

Central to any response are the following requirements:

1. The voices, knowledges, cultures and worldviews of Indigenous communities must be privileged in a way that makes it permissible to work within that cultural context – a cultural match.
2. Community-led, community-owned and community-determined solutions and priorities that adopt a place-based approach to co-designing initiatives in equal partnership with governments is paramount.
3. Community-directed inclusive decision-making coalitions that are elected by community and are held accountable to community are imperative.

4. Re-building nations by means of revitalising, reclaiming and embedding language and lore throughout communities in Australia is warranted.
5. Governance structures that are conducive to embedding Indigenous Australian's voices, knowledges, cultures and worldviews of ways of being, knowing and doing into policy and program production, implementation and evaluation are mandatory.
6. Accountability mechanisms that hold governments accountable to communities are a necessity (D. Murray, personal communication, 10 June 2020).

In Australia such principles are already in operation, as demonstrated by the new national CTG agreement (Australian Government, 2020) developed in equal partnership with governments and the Coalition of Peaks, who are represented on the Indigenous affairs taskforce. Furthermore, Indigenous public health policy has been led and continues to be directed by community through the national Aboriginal and Torres Strait Islander health leadership – the NHLF – as they progress the next iteration of the Implementation and Health Plans.

Further investment is now necessary to establish what the cultural determinants of health are in practice, including in service delivery practice? Therefore, additional case examples, such as the Katherine Hospital contained in Chapter 6, will provide the necessary educational tools for policy makers to learn from when implementing the cultural determinants of health.

More importantly, in terms of institutional and system racism

What is it? What does it look like? And what are the aspects to institutionalised racism or institutional biases against individuals – Aboriginal people … [what] do we have to overcome? (P14)

How is institutional and systemic racism to be addressed to make those system lever changes? (D. Murray, personal communication, 10 June 2020).

7.3. Chapter 7 Conclusion

Chapter 7 concludes by reaffirming that the aims of the research study have been met. It also provides a summation of the research study and its relationship to the new CTG national agreement. Some final concluding remarks are made with a set of recommendations. It is important to note that further work and additional investment is a necessity. This is required to give expression to Indigenous Australians' knowledges and cultures, in the form now of cultural determinants of health, within a public health policy and public health service system environment. Critically though, is the central positioning of Indigenous Australians in the policy production processes in a way that privileges their voices of ways of being, knowing and doing. However, Australia must be prepared to call out racism and develop strategies to minimise the health and wellbeing implications that racism has for Indigenous Australians.

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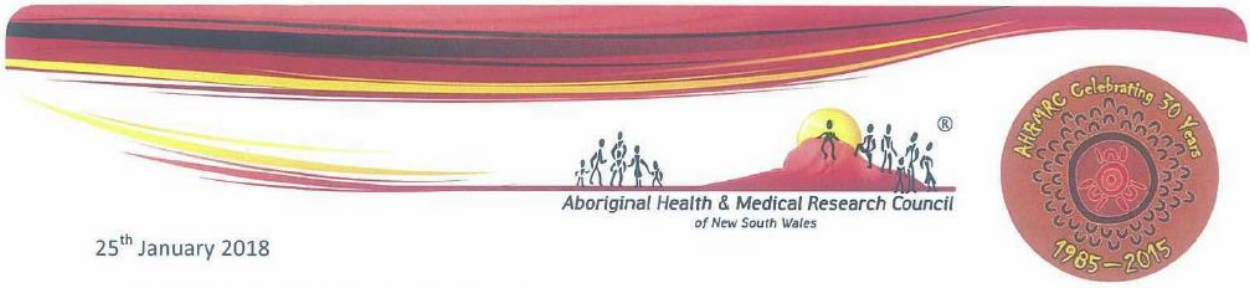
APPENDICES

Appendix 1: 2016 Conference Poster

Appendix 2: AH&MRC of NSW Letter of Support



25th January 2018

Adjunct Associate Professor Carmen Parter
Poche Centre for Indigenous Health
University of Sydney
Camperdown
NSW 2006
T: 0427972511
E: carmen.parter@sydney.edu.au

Dear Adjunct Associate Professor Parter

Re: Indigenous Culture and Indigenous Knowledges in Public Health Policies

I am writing regarding your letter requesting AH&MRC support for the *Indigenous Culture and Indigenous Knowledges in Public Health Policies.* AH&MRC has reviewed your project and is satisfied that this proposal in principle is aligned with the Values and Ethics Guidelines.

Aboriginal community governance is an important principle of ethical and effective Aboriginal health research and reporting. It is a condition of AH&MRC support that there is an appropriate level of Aboriginal community governance. I understand that this project has a Research Advisory Board made up of Aboriginal and non-Aboriginal representatives drawn from across the University of Sydney and an Aboriginal Community representative. I also understand that this project has an Indigenous Reference Group (National Health Leadership Forum), a collective partnership of national Indigenous organisations who represent a united voice on Aboriginal and Torres Strait Islander health and wellbeing with expertise across service delivery, workforce, research, healing and mental and social and emotional wellbeing.

I note that the lead researcher of this project, Adjunct Associate Professor Carmen Parter, is an Indigenous researcher from the Poche Centre for Indigenous Health. In addition, all members of the research team for this project are Indigenous researchers. I also note that the project proposal has been presented to the Gnibi (Bundalung) Elders Council at Southern Cross University in Lismore, where Adjunct Associate Professor Carmen Parter lives, works and studies. The Gnibi (Bundalung) Elders Council was supportive of this project.

Additionally, I note that you will be seeking approval from the AH&MRC Ethics. AH&MRC support does not guarantee Ethics approval and we request a copy of the Committee's approval letter once it is obtained; it can be emailed to: researchsupport@ahmrc.org.au.

Funded by NSW Health Department

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Appendix 3: NHLF and Member Letters of support

National Health Leadership Forum

A/Professor Carmen Parter
Poche Centre for Indigenous Health
Vice President (Aboriginal & Torres Strait Islander), Public Health Association of Australia
The University of Sydney
PO Box 768
Tweed Heads NSW 2485

28 June 2017

Dear Carmen,

I am writing to you in my capacity as Chair of the National Health Leadership Forum (NHLF), and want to thank you for your time at our last NHLF meeting on 30 May 2017.

The NHLF was interested to hear about your important work in 'Making sense of Indigenous Culture and its relationship to Indigenous Knowledge in national public health policies'. This is important work and the NHLF notes your efforts and we offer our support for your PHD research.

Furthermore, and as discussed at the NHLF meeting, the NHLF members are willing to act as a reference group for your research and will look forward to hearing updates on your work periodically. I suggest that coordination of any material for consideration of the NHLF be managed through the NHLF Executive Officer.

I extend an invitation to you to provide an update on this work to the NHLF at our next meeting.

I can be reached on 0487 770 039, or alternatively details for the next NHLF meeting can be sought through Paul Wright, NHLF Executive Officer on 02 9284 9625, 0412 415 556 or paul.wright@humanrights.gov.au

Yours sincerely

[REDACTION]

Richard Weston

Chair, National Health Leadership Forum
CEO, The Healing Foundation

AIDA
The Australian Indigenous Doctors' Association
ABN: 84 131 668 936

A/Prof Carmen Parter
Wingara Mura Leadership Academy Fellow
Poche Centre for Indigenous Health
Vice President (Aboriginal and Torres Strait Islander) Public Health Association of Australia
University of Sydney
PO Box 768
Tweed Heads NSW 2485

Dear Carmen

Re: "Bringing meaning and understanding to Indigenous Culture through its relationship to Indigenous Knowledge/s in public health policies" - Doctorate of Philosophy Research Study (PhD)

I am writing regarding the above mentioned impending PhD research study and your summary thesis proposal that was tabled at the 14 August 2017 meeting of the National Health Leadership (NHLF).

I note that your PhD will respond to your research question about what does Culture mean in Australia's National Aboriginal and Torres Strait Islander Health Plan (NATSIHPlan) from an Indigenous standpoint? It will also establish if Indigenous Culture is linked to Indigenous Knowledge/s and determine the policy implications for such understanding in public health policy. Similarly, I have noted your sub-research questions and that you're using an Indigenous research methodology and methods that could involve engaging with and interviewing Aboriginal and Torres Strait Islander people and/or policy makers.

We acknowledge that this research study is well overdue and fulfills a gap in current scholarly knowledge. More importantly, that this study has the potential to bring new knowledge to understanding Culture's relationship with Indigenous Knowledge/s that can influence the future of public policy relating to improving the health of Aboriginal and Torres Strait Islander communities.

I also note that as this study proceeds it may change its direction, and if it does we ask that you let us know accordingly by emailing myself at craig.dukes@aida.org.au.

Finally, the Australian Indigenous Doctors' Association is pleased to support this PhD research study and look forward to up-dates, receipt of reports or other related documents for our information.

I thank you very much for allowing us to consider your PhD research study and the best of luck as you proceed.

Yours sincerely

[REDACTION]

Mr Craig Dukes
Chief Executive Officer

04 October 2017

PO Box 3497 Manuka ACT 2603 | Old Parliament House, 18 King George Terrace Parkes ACT 2600
P: (02) 6273 5013 or 1800 190 498 | F: (02) 6273 5014 | E: aida@aida.org.au | W: aida.org.au

CATSINaM

Janine Mohamed
CEO
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINAM)
15 Lancaster Place
Majua Park ACT 2609

A/Prof Carmen Parter
Wingara Mura Leadership Academy Fellow
Poche Centre for Indigenous Health
Vice President (Aboriginal & Torres Strait Islander) Public Health Association of Australia
University of Sydney
PO Box 768
Tweed Heads, NSW, 2485

Dear Carmen

"Bringing meaning and understanding to Indigenous Culture through its relationship to Indigenous Knowledge/s in public health policies" - Doctorate of Philosophy Research Study (PhD)

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CATSINaM

I also note that as this study proceeds it may change its direction, and if it does we ask that you let us know accordingly by emailing myself via ceo@catsinam.org.au.

Finally, the CATSINaM is pleased to support this PhD research study and look forward to up-dates, receipt of reports or other related documents for our information.

I thank you very much for allowing us to consider your PhD research study and the best of luck as you proceed.

If you require any further information regarding this matter please contact Chloe Peters via admin@catsinam.org.au

Your faithfully

[REDACTION]

Janine Mohamed
CEO of CATSINaM
24 August 2017

Unity and Strength through Caring

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25 August 2017

A/Prof Carmen Parter
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Poche Centre for Indigenous Health
Vice President (Aboriginal & Torres Strait Islander) Public Health Association of Australia
University of Sydney
PO Box 768
Tweed Heads, NSW, 2485

Dear Carmen

"Bringing meaning and understanding to Indigenous Culture through its relationship to Indigenous Knowledge/s in public health policies" - Doctorate of Philosophy Research Study (PhD)

I am writing regarding the above mentioned impending PhD research study and your summary thesis proposal that was tabled at the 14 August 2017 meeting of the National Health Leadership (NHLF).

Indigenous Allied Health Australia (IAHA) is a member of the NHLF. IAHA is a national not for profit, member-based Aboriginal and Torres Strait Islander allied health organisation with the aim of Aboriginal and Torres Strait Islander peoples achieving health equity through improved access to culturally responsive allied health care that is recognised as an essential part of a holistic approach to achieving optimal health and wellbeing.

IAHA's brings together and collectively supports Aboriginal and Torres Strait Islander cohorts within 26 allied health professions and is the only organisation that:

- provides targeted networking, development and support opportunities to Aboriginal and Torres Strait Islander allied health professionals and students and the wider allied health workforce;
- focuses specifically on building and sustaining a strong Aboriginal and Torres Strait Islander allied health workforce;
- provides national leadership, expert advice and policy direction on allied health issues within an Aboriginal and Torres Strait Islander context;
- supports Aboriginal and Torres Strait Islander Australians through promoting allied health careers and facilitating further education and leadership development of Indigenous allied health professionals; and

- advocates for Aboriginal and Torres Strait Islander peoples to have health equality through a health system that is free from racism and enables equitable access to culturally responsive allied healthcare.

I note your PhD will respond to your research question about what Culture means in Australia's National Aboriginal and Torres Strait Islander Health Plan (NATSIHPlan) from an Indigenous standpoint? It seeks to identify if and how Indigenous Culture is linked to Indigenous Knowledge/s and identify implications associated with this understanding for public health policy. Similarly, I have noted your sub-research questions and you plan to use an Indigenous research methodology which may involve engaging with and interviewing Aboriginal and Torres Strait Islander people and/or policy makers. Importantly, this study has the potential to bring new knowledge to understanding Culture's relationship with Indigenous Knowledge/s that can influence the future of public policy relating to improving the health of Aboriginal and Torres Strait Islander communities. These are important elements of the research which, we believe, will increase the value of the research findings, the potential for it to be translated to practice successfully and, as a result contribute to policy and systems that are more effective in addressing Aboriginal and Torres Strait Islander health needs and outcomes.

We agree that the importance of these issues have been overlooked in policy and that Indigenous-led research into this area is well overdue. It is needed to meet a significant gap in current scholarly knowledge.

I also note that as this study proceeds it may change its direction, and if it does we ask that you let us know accordingly by emailing myself, at CEO@iaha.com.au.

Finally, Indigenous Allied Health Australia is pleased to support this PhD research study and look forward receiving updates and reports as they become available.

If you require any further information from IAHA please contact me directly, or Allan Groth, our Chief Operating Officer on 02 6285 1010.

.

Yours Sincerely

[REDACTION]

Donna Murray
CEO, Indigenous Allied Health Australia

the Lowitja Institute

Australia's National Institute for Aboriginal and Torres Strait Islander Health Research

25 September 2017

A/Professor Carmen Parter
Wingara Mura Leadership Academy Fellow
Poche Centre for Indigenous Health
Vice President (Aboriginal & Torres Strait Islander) Public Health Association of Australia
University of Sydney
PO Box 768
Tweed Heads NSW 2485

Dear Carmen

"Bringing meaning and understanding to Indigenous Culture through its relationship to Indigenous Knowledge/s in public health policies" - Doctorate of Philosophy Research Study (PhD)

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I note that your PhD will respond to your research question about what does culture mean in Australia's National Aboriginal and Torres Strait Islander Health Plan (NATSIH Plan) from an Indigenous standpoint? It will also establish if Indigenous culture is linked to Indigenous knowledge/s and determine the policy implications for such understanding in public health policy. Similarly, I have noted your sub-research questions and that you're using an Indigenous research methodology and methods that could involve engaging with and interviewing Aboriginal and Torres Strait Islander people and/or policy makers.

We acknowledge that this research study is well overdue and fulfils a gap in current scholarly knowledge. More importantly, that this study has the potential to bring new knowledge to understanding culture's relationship with Indigenous knowledge/s that can influence the future of public policy relating to improving the health of Aboriginal and Torres Strait Islander communities.

I also note that as this study proceeds it may change its direction, and if it does we ask that you let us know accordingly by emailing myself via romlie.mokak@lowitja.org.au.

Finally, the Lowitja Institute is pleased to support this PhD research study and look forward to updates, receipt of reports or other related documents for our information.

I thank you very much for allowing us to consider your PhD research study and the best of luck as you proceed.

If you require any further information regarding this matter please contact Perina Drummond, Executive Assistant via ea@lowitja.org.au.

Yours faithfully

[REDACTION]

Romlie Mokak
Chief Executive Officer

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NATSIHWA
National Aboriginal and Torres Strait Islander Health Worker Association

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Vice President (Aboriginal & Torres Strait Islander) Public Health Association of Australia
University of Sydney
PO Box 768
Tweed Heads, NSW, 2485

Dear Carmen

"Bringing meaning and understanding to Indigenous Culture through its relationship to Indigenous Knowledge/s in public health policies" - Doctorate of Philosophy Research Study (PhD)

I am writing in support of your thesis proposal as tabled at the 14 August 2017 meeting of the National Health Leadership Forum (NHLF). I apologies for the delay in responding to you.

Your research on the relationship of Aboriginal and Torres Strait Islander culture and Aboriginal and Torres Strait Islander knowledges to health policy is very pertinent to the interests of our members, Aboriginal and/or Torres Strait Islander Health Workers and Health Practitioners. Our members take a special place in the health system. They are often the only source of understanding of local culture and thus have an important role in providing effective health care to Aboriginal and Torres Strait Islander peoples. Our members also have a role in improving the overall cultural competency of health services, imparting their knowledge about the world views of their people and the nature of culturally appropriate health care.

NATSIHWA welcomes your research which has the potential to influence policies which acknowledge the importance of Aboriginal and/or Torres Strait Islander Health Workers and Health Practitioners and provide for empowerment of these workers to make best use of their knowledge and skills. I am interested in your aim to use Indigenous research methodology involving refining the research problem from Aboriginal and Torres Strait Islander perspectives and investing in benefits for participants.

I note that as this study proceeds it may change its direction, and if it does we ask that you let us know accordingly by emailing Helen Cameron, policy@natsihwa.org.au, telephone 02 6221 9224.

NATSIHWA is pleased to support this PhD research study and looks forward to up-dates and receipt of reports or other related documents for our information.

Yours sincerely

[REDACTION]

Karl Briscoe

CEO, NATSIHWA

11 October 2017

Appendix 4: AH&MRC and UoS HERC Approval

THE UNIVERSITY OF SYDNEY

Research Integrity & Ethics Administration
Human Research Ethics Committee

Friday, 20 April 2018

Mrs Donna Louise Hartz
Office of the DVC (Indigenous Strategy and Services); DVC Indigenous Strategy and Services
Email: donna.hartz@sydney.edu.au

Dear Donna Louise

The University of Sydney Human Research Ethics Committee (HREC) has considered your application.

After consideration of your response to the comments raised your project has been approved.

Approval is granted for a period of four years from **20 April 2018** to **20 April 2022**

Project title: **Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledge (IC&IK) in public health policies: A Case Study - The National Aboriginal and Torres Strait Islander Health Plan (NATSIHPlan) 2013 - 2023.**

Project no.: **2018/069**

First Annual Report due: **20 April 2019**

Authorised Personnel: **Hartz Donna Louise; Hartz Donna Louise; Parter Carmen; Wilson Shawn;**

Documents Approved:

Date Uploaded	Version number	Document Name
10/04/2018	Version 2	Attachment F-Individual Participant Consent Form-CLEAN
10/04/2018	Version 1	AH&MRC Ethic Committee Approval
10/04/2018	Version 2	Attachment D-Participant Invitation Letter-CLEAN
10/04/2018	Version 2	Attachment E-Participant Information Statement-CLEAN
07/12/2017	Version 1	Attachment I-AHMRC Ethic Committee HREC Application
07/12/2017	Version 1	Attachment G-Prompt Questions for Yarning Sessions
07/12/2017	Version 1	Attachment H-AHMRC Ethic Committee corro
04/12/2017	Version 1	Attachment A-Thesis Protocol-IC&IK in Public Health Policy
04/12/2017	Version 1	Attachment C-Statement Addressing the five AHMRC Criteria

Condition/s of Approval

- Research must be conducted according to the approved proposal.
- An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.
- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
  - Serious or unexpected adverse events (which should be reported within 72 hours).
  - Unforeseen events that might affect continued ethical acceptability of the project.

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Level 2, Margaret Telfer Building (K07)
The University of Sydney
NSW 2006 Australia

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E human.ethics@sydney.edu.au
W sydney.edu.au/ethics

ABN 15 211 513 464
CRICOS 00026A

- Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate *immediate* risk to participants).
- Personnel working on this project must be sufficiently qualified by education, training and experience for their role, or adequately supervised. Changes to personnel must be reported and approved.
- Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, as relevant to this project.
- Data and primary materials must be retained and stored in accordance with the relevant legislation and University guidelines.
- Ethics approval is dependent upon ongoing compliance of the research with the *National Statement on Ethical Conduct in Human Research*, the *Australian Code for the Responsible Conduct of Research*, applicable legal requirements, and with University policies, procedures and governance requirements.
- The Ethics Office may conduct audits on approved projects.
- The Chief Investigator has ultimate responsibility for the conduct of the research and is responsible for ensuring all others involved will conduct the research in accordance with the above.

This letter constitutes ethical approval only.

Please contact the Ethics Office should you require further information or clarification.

Sincerely

[REDACTION]

Associate Professor Stephen Assinder
Chair
Human Research Ethics Committee (HREC 1)

The University of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2007) and the NHMRC's Australian Code for the Responsible Conduct of Research (2007).

THE UNIVERSITY OF SYDNEY

[DATE TO BE INSERTED]

[NAME, ADDRESS ETC]

Dear [INSERT TITLE & NAME]

Letter of invitation to participate in a yarning session for a research study

This letter of invitation is inviting you to be a participant in a research project that I am conducting as part of a Doctorate of Philosophy (PhD) study. It is a research study that aims to bring meaning and understanding to Indigenous Culture and Indigenous Knowledges (IC&IKs) in public health policies. Specifically, I am seeking your support to participate in an hour long yarning session.

If you would like to know more about this research study I have enclosed with this letter a Participant Information Sheet (PIS). This Sheet will tell you about the research study. Knowing what is involved will help you decide if you want to take part in the research. Please read the sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary. Before you decide whether you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the attached PIS carefully and discuss it with others if you wish.

By giving your consent to take part in this study you are telling me that you

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined in the attached PIS.
- ✓ Agree to the use of your personal information as described.

You can keep a copy of this Participant Information Sheet for your records.

Thank you for taking the time to read this letter and the attached PIS. If you wish to participate please fill in the attached Participant Consent Form (PCF) and email it back to me at the email address mentioned below. Alternatively, I can grab a copy of this PCF when we next meet.

THE UNIVERSITY OF SYDNEY

If required, I can be contacted on my mobile at [REDACTION] or via my email at carmen.parter@sydney.edu.au to discuss any concerns or issues you might have.

Thanks for taking the time to read this letter and I look forward to discussing this research study with you shortly.

[REDACTION]

Carmen Parter
Poche & Wingara Mura Leadership Academy Fellow
Poche Centre for Indigenous Health
University of Sydney
c/- PO Box 768
TWEED HEADS NSW 2485

THE UNIVERSITY OF SYDNEY

Poche Centre for Indigenous Health
School of Public Health
Faculty of Health and Medicine

ABN 15 211 513 464

Dr Donna Hartz (for Carmen Parter)
A/Academic Director
National Centre for Cultural Competency

Room A27
Edward Ford Building
The University of Sydney
NSW 2006 AUSTRALIA
Telephone: +61 2 91140829
Facsimile: +61 2 93513196
Email: donna.hartz@sydney.edu.au
Email cc. carmen.parter@sydney.edu.au
Web: http://www.sydney.edu.au/

Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledge (IC&IK) in public health policies – A Case Study: The National Aboriginal and Torres Strait Islander Health Plan (the Health Plan) 2013-2023

Participant Information Sheet

Purpose of study

You are invited to take part in a research study that Carmen Parter, a Doctorate of Philosophy (PhD) student from the Poche Centre for Indigenous Health, University of Sydney, is conducting. It will take place under the supervision of my research team involving Dr Donna Hartz (my PhD primary supervisor) and Dr Shawn Wilson and Dr Josephine Gwynn (my PhD auxiliary supervisors).

The purpose of the research study is to explore what it means to have culture central to a national policy like Australia's National Aboriginal and Torres Strait Islander Health Plan (the Health Plan) and investigate how culture can be enacted (or put into practice) in this context. It is anticipated that a theoretical and/or conceptual framework(s) maybe developed that will fill a knowledge gap about culture and its practical application in a public health policy context.

You have been invited to participate in this study because you are a key participant, known as policy elites in this study, who has or continues to be actively involved in the Indigenous health public policy space that influences Indigenous health policies nationally. This core group of policy elites have been chosen because you are best placed to assist in bringing meaning and understanding to culture in the Health Plan.

What does the study involve?

If you choose to take part in this study you will be asked to take part in a one hour audio recorded semi-structured interview known as a yarning session, which is completely confidential. Yarning is a way that you can tell your story about your understanding and/or experiences concerning

i. Why culture was placed in the Health Plan
ii. Whether there was any meaning bought to culture when it was placed in the Health Plan, and
iii. How culture would be put into practice given its central positioning in the Health Plan.

A prompt question will help you start telling your story. On the odd occasion, I may seek further clarification or insight from you about a point that you make whilst telling your story. The yarning session will be held at a location convenient to you. Unfortunately, there is no financial support for your participation. However, refreshments will be provided.

How much of my time will the study take?

As mentioned above, the yarning session will involve an hour of your time. In addition, if you choose, you can request a summary report containing themes from yarning sessions and provide feedback. You can request this report at carmen.parter@sydney.edu.au.

Do I have to participate in this study and is it voluntary?

Your involvement in the study is completely voluntary and you are not under any obligation to consent and – if you do consent – you can withdraw at any time without affecting your current or future relationship with the University of Sydney and the Poche Centre for Indigenous Health or with any other associated organisations involved in this study.

What happens to my information?

All aspects of this study, including results, will be strictly confidential and only the researchers will have access to information on participants. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

When will the yarning sessions be conducted?

The yarning sessions are likely to start in June and completed by end of December 2018.

How will the study benefit you?

By telling your story in this study will help fill the knowledge gap about what it means to have culture in a public health policy likes Australia's National Aboriginal and Torres Strait Islander Health Plan. More importantly, how to put into practice culture in a public policy context. This

new knowledge could change our understanding and practices about culture in public health policies. It could also contribute to improvements in the health and wellbeing of Australia's Indigenous communities.

Can I tell other people about the study?

You are welcome to tell other people about this study, if you wish.

What if I require further information about the study?

If you would like further information about this study feel free to contact me on my mobile number at 0427 972 511 or my email at carmen.parter@sydney.edu.au.

Will I be told the results of the study?

If you would like to be told the results of this study then please email me at carmen.parter@sydney.edu.au and I will ensure that you receive the information accordingly.

What if I have a complaint or any concerns about the study?

As this study has been reviewed by the University of Sydney's (UoS) Human Research Ethic Committee (HREC) and the Aboriginal Health and Medical Research Council's Ethic Committee any complaints or concerns that you have about the study can be made to someone independent of the study as follows. You will need to quote the study title and protocol numbers as indicated below.

The Chairperson AH&MRC Ethics Committee PO Box 1575 Strawberry Hills NSW 2012 Phone: (02) 9212 4777 Email: ethics@ahmrc.org.au Fax: (02) 9212 7211 Project Title: Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledges in public health policies like Australia's National Aboriginal and Torres Strait Islander Health Plan AH&MRC HREC Ref. No.: [1354/17]	The Manager Ethic Administration University of Sydney NSW 2006 Phone: (02) 86278176 Email: ro.humanethics@sydney.edu.au Fax: (02) 86278177 Project Title: Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledges in public health policies like Australia's National Aboriginal and Torres Strait Islander Health Plan UoS HREC Project No.: [2018/069]

This information sheet is for you to keep

THE UNIVERSITY OF SYDNEY

Poche Centre
School of Public Health
Faculty of Health & Medicine

ABN 15 211 513 464

Dr Donna Hartz (for Carmen Parter)
A/Academic Director
National Centre for Cultural Competency

Room A27, Edward Ford Building
The University of Sydney
NSW 2006 AUSTRALIA
Telephone: +61 2 911 40829
Facsimile: +61 2 935 13196
Email:
donna.hartz@sydney.edu.au &
carmen.parter@sydney.edu.au

Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledge in public health policies – A Case Study: The National Aboriginal and Torres Strait Islander Health Plan (the Health Plan) 2013 - 2023

PARTICIPANT CONSENT FORM

I, …… ……
have consented to participate in the above research project on the following basis:

1. I have received the Participant Information Statement and have had the opportunity to ask questions. I understand the purpose of the research and my involvement in it.

2. I have the right to withdraw my consent and cease any further involvement in the research project at any time without giving reasons and without any penalty. This will not affect any services that I receive.

3. Any information I provide during this research will remain confidential. Where the results of the research are published, my involvement and my personal results will not be identified

4. I understand that interviews may be digitally audio recorded, but the digital recording file will be secured and then destroyed at the completion of the project.

I consent to:

- **Audio-recording** YES ☐ NO ☐

I would like to review my interview transcripts YES ☐ NO ☐

I would like to receive feedback about the yarning sessions YES ☐ NO ☐

I would like to receive feedback about the overall results of this study YES ☐ NO ☐

If you answered **YES**, please indicate your preferred form of feedback and address:

☐ Postal: _____

_____

☐ Email: _____

.....
Signature

.....
PRINT name

.....
Date

From: **Human Ethics** human.ethics@sydney.edu.au
Subject: [2018/069] Human Ethics: Modification outcome
Date: 20 June 2018 at 8:17 am
To: Donna Hartz donna.hartz@sydney.edu.au, Carmen Parter carmen.parter@sydney.edu.au, shawn.wilson@scu.edu.au

HE

Dear Mrs Hartz

Project Title: Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledge (IC&IK) in public health policies: A Case Study - The National Aboriginal and Torres Strait Islander Health Plan (NATSIHPlan) 2013 - 2023.
Project number: 2018/069

Modification outcome

Your request to modify the above project was reviewed on **15 June 2018.**

Please find attached a letter regarding the outcome of your recent modification request.

Questions?
If you have any queries you can contact us on the details below.

Regards,
The Ethics Office

Research Integrity & Ethics Administration | Research Portfolio
THE UNIVERSITY OF SYDNEY
Level 2 Margaret Telfer Building (K07) | The University of Sydney | NSW | 2006
T +61 2 9036 9161 | **E** human.ethics@sydney.edu.au | **W** http://sydney.edu.au/ethics

THE UNIVERSITY OF SYDNEY

Research Integrity & Ethics Administration
Human Research Ethics Committee

Wednesday, 20 June 2018

Mrs Donna Louise Hartz
Office of the DVC (Indigenous Strategy and Services); DVC Indigenous Strategy and Services
Email: donna.hartz@sydney.edu.au

Dear Donna Louise

Your request to modify this project, which was submitted on 07 June 2018, has been considered.

The project has been approved to proceed with the proposed amendments.

Details of the approval are as follows:

Project Title: **Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledge (IC&IK) in public health policies: A Case Study - The National Aboriginal and Torres Strait Islander Health Plan (NATSIHPlan) 2013 - 2023.**

Project No.: **2018/069**

Next Annual Report due: 20 April 2019

New Approved Documents:

Date Uploaded	Type	Document Name
07/06/2018	Version 3	V3 Individual Participant Consent Form-CLEAN

Please contact the Ethics Office should you require further information or clarification.

Sincerely

[REDACTION]

Dr Helen Mitchell
Chair
Modification Review Committee (MRC 1)

The University of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2007) and the NHMRC's Australian Code for the Responsible Conduct of Research (2007).

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ABN 15 211 513 464
CRICOS 00026A

12th March 2018

Adjunct Associate Prof Carmen Parter
Poche Centre for Indigenous Health
University of Sydney
c/- PO Box 768

AH&MRC Ethics Committee
02 9212 4777
ethics@ahmrc.org.au

Dear ADJAP Carmen Parter,

HREC Reference number: 1354/17
Project title: Bringing meaning and undertstanding to Indigenous Culture and Indigenous Knowledge (IC&IK) in public health policies – A Case Study: The National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (NATSIHPlan)

Thank you for submitting the above research project for single ethical review. This project was considered by the AH&MRC Ethics Committee at its meeting held on 4th December 2017 and 5th February 2018.

I am pleased to advise you that the above research project meets the requirements of the *National Statement on Ethical Conduct in Human Research (2007)* and ethical approval for this research project has been granted by AH&MRC Ethics Committee.

The nominated NSW participating site/s in this project is/are approved.

[Note: If additional sites are engaged prior to the commencement of, or during the research project, the Coordinating Principal Investigator is required to notify the AH&MRC HREC. Notification of withdrawn sites should also be provided to the AH&MRC HREC in a timely fashion.

The approved documents include:

Document	Version	Date
AHMRC Ethic Appl-C Parter		17/11/2017

Approval of this project from AH&MRC Ethics Committee is valid from 12th March 2018 to 11th March 2019 subject to the following conditions being met:

- The Coordinating Principal Investigator will immediately report anything that might warrant review of ethical approval of the project.
- The Coordinating Principal Investigator will notify the AH&MRC Ethics Committee of any event that requires a modification to the protocol or other project documents and submit any required amendments in accordance with the instructions provided by the HREC. These instructions can be found at www.ahmrc.org.au/ethics .

- The Coordinating Principal Investigator will submit any necessary reports related to the safety of research participants in accordance with AH&MRC Ethics Committee policy and procedures. These instructions can be found at www.ahmrc.org.au/ethics .

- The Coordinating Principal Investigator will report to the AH&MRC Ethics Committee annually in the specified format and notify the HREC when the project is completed at all sites.

- The Coordinating Principal Investigator will notify the AH&MRC Ethics Committee if the project is discontinued at a participating site before the expected completion date, with reasons provided.

- The Coordinating Principal Investigator will notify the AH&MRC Ethics Committee of any plan to extend the duration of the project past the approval period listed above and will submit any associated required documentation. Instructions for obtaining an extension of approval can be found at www.ahmrc.org.au/ethics .

- The Coordinating Principal Investigator will notify the AH&MRC Ethics Committee of his or her inability to continue as Coordinating Principal Investigator including the name of and contact information for a replacement.

This letter constitutes ethical approval only. This project cannot proceed at any site until separate research governance authorisation has been obtained from the CEO or Delegate of the institution under whose auspices the research will be conducted at that site.

Should you have any queries about the AH&MRC Ethics Committee's consideration of your project please contact Mr Sonny Green. The AH&MRC Ethics Committee Terms of Reference, Standard Operating Procedures, membership and standard forms are available from www.ahmrc.org.au or from the Ethics Coordinator.

The AH&MRC Ethics Committee wishes you every success in your research.

Yours faithfully,

[REDACTION]

Ms Val Keed
Chairperson
AH&MRC Ethics Committee

11th May 2018

Adjunct Associate Prof Carmen Parter
Poche Centre for Indigenous Health
University of Sydney
c/- PO Box 768

AH&MRC Ethics Committee
02 9212 4777
ethics@ahmrc.org.au

Dear Carmen Parter,

HREC Reference number: 1354/17
Project title: Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledge (IC&IK) in public health policies – A Case Study: The National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (NATSIHPlan)

The amendment to this project submitted on 7th May 2018 was approved/ratified by the AH&MRC Ethics Committee on 11th May 2018.

The documents listed below are approved:

Document	Version	Date
2018069 Human Ethics Application outcome.pdf		2018
Coverletter responding to UoS HREC.pdf		2018
Attachment D – Participant Invitation letter V270318 –CLEAN.docx	Version 270318	2018
Attachment E – Participant Information Statement V270318 @ 1900-CLEAN.docx	Version 270318	2018
Attachment F – Individual Participant Consent Form V270318-CLEAN.doc	Version 270318	2018
Prompt Question for Yarning Session.pdf		2018
HEAppCatA2018-069.pdf		2018

The Committee notes that these amendments are in response to requests arising from the review of University of Sydney Human Research Ethics Committee.

You must forward a copy of this letter to all Principal Investigators and to your institution.

Please note that all requirements of the original ethical approval for this project still apply.

Should you wish to discuss this matter, please contact either Mr Sonny Green, Ethics Coordinator on 02 9212 4777 or ethics@ahmrc.org.au .

The AH&MRC Ethics Committee wishes you every continued success in your research.

Yours faithfully,

[REDACTION]

Ms Val Keed
Chair AH&MRC Ethics Committee

Appendix 5: Yarning sessions script

Script for Yarning Sessions as @ 0530 on 22 June 2018

Hello [NAME OF PERSON]

Can I just thank you for giving me an hour of your time today and I am so excited that you agreed to contribute towards my research project about 'Bringing meaning and understanding to Indigenous culture and Indigenous knowledge in public health policy. As you know, I am using the National Aboriginal and Torres Strait Islander Health Plan as a case study.

But, I just need to check as to whether you have any questions about those documents I sent you [PAUSE] or anything else in relation to this research project.

And, thanks, I have got your signed consent form.

I must however point out a recent change in my PhD academic team and, that is, Dr Mark Lock has recently withdrawn from this team.

Ok, let's begin our yarning **ALTHOUGH I JUST NEED TO MAKE SURE THAT THE RECORDER IS WORKING**

So, I really want to hear your story concerning

- The role you play in the national Indigenous health policy space as a policy person
- What your experience and involvement has been regarding the National Plan and obviously with a focus on culture
- And, your own experiences about working with Indigenous culture and/or Indigenous knowledge in the work that you do

Yarning Sessions

Preliminary Findings Report

Storying: Policy Actor's Stories

Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledge in public health policies: A Case Study – The National Aboriginal and Torres Strait Islander Health Plan (the Health Plan) 2013 – 2023.

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By Carmen Parter
March 2020

© Carmen Parter

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Introduction

This report is provided to those participants who requested feedback about yarning sessions held with policy actors (formerly referred to as policy elites) for a research study that attempts to bring meaning and understanding to Indigenous culture when included in a public policy instrument. As culture is visibly central to the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013-2020 (the Health Plan), it is being used as a case study [1].

Policy makers who work in government struggle with implementation challenges once culture has been incorporated in a policy instrument like the Health Plan. The study's research question therefore is

> When the culture of Indigenous Australians is incorporated in a public policy instrument like the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023, how do policy makers implement - enable, embed and enact - culture, and indeed Indigenous knowledges?

The research aims to develop a conceptual understanding to assist in bringing meaning to Indigenous culture that is understood by policy makers working in governments. This will complement the cultural determinants of health activities[1] that is currently underway in collaboration with the National Health Leadership Forum. Additionally, a systemwide translational model of practice is under development with an intent to contextualise how the public health sector can translate the knowledges and cultures of ways of being, knowing and doing held by Indigneous Australians throughout their practices.

An evidence gap is apparent [2] and the work being undertaken by this research study will contribute towards creating scholarly information that has the potential to influence future policy work.

This study has received ethics approval from the NSW Aboriginal Health and Medical Research Council (Ref No.: 1354/17) and the University of Sydney (Project No.: 2018/069) Human Research Ethic Committees. Policy actors gave informed consent to participate in this study and consent forms signed accordingly.

This report contains preliminary findings, and fulfils an ethical requirement to provide feedback to participants who request such a report. Similarly, my cultural obligations to respectfully reciprocate my gratitude for the knowledges freely provided during the stories told, is a prerequisite. I remain appreciative of the support and time that participants offered. **The report's content are provided in confidence and <u>not for further distribution</u>** particularly as the research study is still underway with a final comprehensive paper being available later this year.

I would however **welcome your comments** in relation to these preliminary findings that can be sent to carmen.parter@sydney.edu.au .

---

[1] *Note: Since the commencement of this research study a significant amount of work has been undertaken to conceptualise culture, notably the work of the Mayi Kuwayi Study and Lowitja Institute six cultural domains, with the impending 2nd iteration of the Health Plan's Implementation Plan positioning cultural determinants of health as foundational to and alongside social determinants of health.*

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The policy actors (formerly known as policy elites)

Following ethical approval in May 2018, nineteen (19) yarning sessions were conducted with policy actors from June to December.

Policy actors were initially identified by the National Health Leadership Forum[2], which is the research study's reference group, with others suggested by participants during the course of yarning sessions. In this report policy actors will be represented by a P and will also be referred to as participants. Participants were purposively selected based on their involvement with the development and/or implementation of the Health Plan. Similarly, they were also drawn from the Indigenous public health policy sub-system of Australia's very large and complex public health policy system.

In total, twenty-six (26) participants had been identified as eligible to participate in yarning sessions. Of the 26, twenty-one (21) participants were willing to participate in a yarning session with consent forms signed accordingly. Two (2) of the 21 were not able to participate in a yarning session due to the difficulties of finding a convenient time, and nineteen (19) yarning sessions with participants were held. Of the 19, seventeen (17) were face-to-face yarning sessions with 2 conducted over the telephone. Sixty percent of the 19 were of Aboriginal or Torres Strait Islander descent drawn from across government and non-government sectors.

All yarning sessions were audio recorded and transcribed. An inductive coding and thematic analysis process continues with the assistance of NVivo, a software data management tool.

The yarning sessions

The yarning sessions were designed to allow participants to tell their story. They were asked why culture was incorporated into the Health Plan, whether any meaning was bought to culture, what challenges had been encountered to put culture in the Plan and during its implementation, and what they considered were the enablers to implement culture. Participants were also asked whether the knowledges held by Indigenous people were ever considered when bringing meaning to culture.

Storying – Policy Actor's Stories

Interrogating and Understanding Culture

The need to further interrogate culture was recognised as a necessity to assist in bringing meaning and understanding to culture. As pointed out by one participant who was instrumental in the Health Plan's development

[2] *The National Health Leadership Forum is an alliance of Australia's national Aboriginal and Torres Strait Islander peak national health bodies including the Healing Foundation, the Doctors, Dentists, Health Workers, Physiotherapists and Psychologists Associations, the Nurses and Midwives Congress, Allied Health Incorporation, Health Research-Lowitja, Community Controlled Health Organisation, the Mental Health Leadership forum, and the Torres Strait Islander Authority.*

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> *... did that Plan really, interrogate culture and provide guidance on culture? ... there's a whole lot of work around that in a rigorous, intellectual way ... it's a fairly superficial treatment of culture, in the sense it's very descriptive ... it talks about our connection to culture, culture being protective ... those sorts of things, identity in culture .... But the Plan, itself doesn't interrogate that in any great detail and it signals the need for further work to be done ... (P21)*

The Themes

Three preliminary themes have been identified and are drawn from the stories that policy actors told. These themes include the following

Theme 1 – Culture Is our knowledges, and our knowledges count

One thing was certain that when referring to culture it was also about knowledge as one participant said

> *... you know, Aboriginal culture at the center of a thing like that, Health Plan and having Aboriginal people there to prosecute it or to keep it on the agenda, helps us to tap into those knowledge's that are out there ...* (P16)

And, adding that

> *... our culture is to share knowledge ... (P16)*

Although another participant alluded to the inherent dismissal of Indigenous Australian's knowledges who said

> *... the impediments or the barriers to that is the continuing devaluing of Indigenous knowledges .... (P21)*

Also, the knowledges derived from lived experiences of Indigenous peoples, leaders and communities must be acknowledged (P17). As should the cultural knowledges relating to the realities of what is real to Indigenous Australians – known as ways of being (ontology) – and to how Indigenous Australians know the things that they know – known as ways of knowing (epistemology). Similarly, why it is that Indigenous Australians do the things in the way that they are done – known as ways of doing (axiology).

Several Indigenous participants expressed their cultural knowledges of ways of being, knowing and doing in the way that they lived their lives as leaders within the Indigenous public health policy environment. Inherent cultural obligations including community responsibilities and accountabilities underpinned the way that they did the work that they did in the way that is expected of them by their families and communities.

These Indigenist cultural knowledges of ways of being, knowing and doing are often in opposition to western and scientific non-Indigenous worldviews of ways of being, knowing and doing.

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Theme 2 – Open hearts, open minds to listen and learn

There was a consistent message that governments, policy makers and the broader community must understand and have a knowingness of the nuances of culture that is expressed through Indigenous people's connection to country, languages, laws and lore and traditional healing practices. This knowingness is a prerequisite when supporting the implementation of the 3Es that follow below. As mentioned by several participants, these cultural expressions are often in tension with non-Indigenous western scientific worldviews.

Work to further understand culture and cultural determinants is critical particularly within a policy context (P13). Indeed, the incorporation of culture in the Health Plan was a catalyst for conversations that differentiated the differences between social determinants and cultural determinants of health (P2 & P5). Importantly, that the work to further understand culture and cultural determinants of health must be led, directed and owned by Indigenous leaders and communities (P5).

The diversity of culture and the many knowledge systems that exist amongst Indigenous Australians must be acknowledged as should the knowledges learnt from Indigenous communities (P6 & P16).

Stories told by participants suggested that there is a need to reframe culture as it became apparent that governments, policy makers and the general public found it difficult to understand culture. An Indigenous participant said

> *... non-Indigenous Australians often struggle with the construct ... that reflects, in part ... kind of the ways in which culture, as a concept, can be a little bit slippery ... and its representation is sometimes unclear .... (P13)*

Another non-Indigenous participant saying

> *... uh, you know, don't find it easy to understand the concept of culture in a very tangible way ... (P2)*

While another non-Indigenous participant who worked in government said in relation to understanding culture

> *... that's a limitation to just their [policy maker's] imagination to be able to understand. Because we don't we – we may never actually fully understand ... (P12)*

Despite the challenges associated with policy makers having an understanding of culture there was a strong consensus that regardless of such situation they must be respectful knowers of Indigenous Australian's worldviews and knowledges of ways of being, knowing and doing. Also, there are many cultural beliefs and practices existing amongst nations and such diversity and uniqueness must be considered in the design delivery and provision of services. Given the lack of understanding errors in practice is highly likely (P1 & P9).

Importantly though is the need to ensure Indigenous people and the cultures and knowledges that they hold must be central to any health policy or program response (P4, P5 & P8).

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Theme 3 – A willing readiness BUT a deep-seated resistance

While the incorporation of culture and also racism in the Health Plan was a significant breakthrough, the resistance of systems, organisations and individuals became apparent from stories of participants. With one participant saying

> *... the system, the system's not ready for all this thinking ... (P2)*

And, another saying

> *... I don't think government has been ready for it [culture] ... (P6)*

Several participants presented a range of systemic paradigm characteristics such as racialized, deficit and discriminatory policy language used in the Indigenous public policy narrative. As a demonstration of this underlying invisible racist and often blaming narrative including negative racialized policy language one participant expressed it as

> *... get off your F#@KING BLACK arses and get a job ... and get your mongrel black kids to school ... get into work, get your kids to school and men, stop basing your women ... (P21)*

Another participant said, to combat such deficit policy language

> *... Culture is the strength ... Aboriginal people are the strengths, culture and identities are the strengths. So, then let's use that as the strength ... (P7)*

As well as organisational and workplace structural issues were a common occurrence. Funding of culture for example is not recognised as a funding priority of governments (P6) with one participant saying

> *... the colonizers worked so hard to wipe out our culture but what have they done to restore it? Have they really funded culture? ... (P8)*

Also, Indigenous Australian's representation in leadership roles and the workforce generally remains poor (P8, P6, P17 and 21). As is the culturally unsafe behaviours displayed by non-Indigenous individuals regarding their racist attitudes, cultural biases or westernised worldviews of ways of being, knowing and doing was rife (P6, P15 & P14). Not having a knowingness of Indigenous worldviews was common (P5, P9 and P12). Specifically, that a set of professional attributes such as a willingness to learn and value Indigenous cultures and knowledges of ways of being, knowing and doing is a necessity. This is a prerequisite if policy makers are to provide the means and opportunities for Indigenous people to express their cultures and knowledges of ways of being, knowing and doing (P3).

Despite these challenges, many positive stories provided comprehensive examples of a range of policy tools and instruments to enact culture when implementing Indigenous cultures and Indigenous knowledges.

A multi-faceted response is a necessity to reform those racialized and prejudicial systems and sub-systems, detrimental institutional wide rules and behaviours, and structural norms that pervade the way that governments and policy makers think, behave and act. These colonialist

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and imperialist rules, norms and behaviours of systems, organisations and individuals [(P16) [6] that manifest themselves through the current social, political, economic, and health inequalities experienced by Indigenous Australians are directly related to the impacts and legacy of colonisation [(P8, P15 &P16) [7].

If real sustainable transformational system, organisational and individual change is to occur then the development and maintenance of strategic collaborative alliances and partnerships is a necessity (P8 & P14). Also, the aid of Indigenous led scholarly knowledge translatable into evidence-based practice is pivotal (P8 and P21). As is a prerequisite for being an effective Indigenous leader, either as an individual or as a community led organisation. This is about having a sound grounding in one's cultures and knowledges of Indigenous ways of being, knowing and doing (P7 & P21) particularly when supporting the 3Es of implementation (discussed below). Without such grounding, Indigenous leaders or Indigenous organisations become ineffectual (P7 & P21).

Additionally, while frameworks like cultural respect, cultural competency and cultural safety aim to change systems, organisations and behaviours of individuals, they are not the answer when implementing cultures and knowledges held by Indigenous Australians. As one participant said

> *... we can't rely on cultural safety and cultural awareness training to support the implementation of culture ...(P6)*

What is required is the urgent need to address the deep-seated issues of institutional and systemic racism and those racalised attitudes held by individuals. As one participant said

> *... but the other system change I think we really do need is ... an acknowledgement of ... racism within that system, and a zero tolerance towards that ... (P8)*

Furthermore, issues of unconscious biases must be understood as one participant said

> *... So, I started realising, oh, hang on, why did I just tell myself to be safe around that person? That person's actually not making ... they're not even looking at me, but I've just made this assumption that they're a dangerous person. And so, it's ... it really started to force me to think about ... what are our internal biases and how do we unconsciously play those out, then, during the course of the day, the week, the year? And what impact does that have on the way we carve out how we do our work? (P6)*

With another saying

> *... the other big topic of recent times is about unconscious bias and how people restrict their thinking because how they have been influenced in their thinking ... (P15)*

Finally, the impacts of non-Indigenous western worldviews of ways of being, knowing and doing on policy and program design, implementation and evaluation must be understood by policy makers and governments (P15). Importantly, genuine, respectful and reverent relational collaborations is imperative for cultures and knowledges to be maintained.

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Summary

As expressed by participant stories there is a need to interrogate culture given current difficulties of conceptualising culture. An opportunity to move beyond the superficial description and treatment of culture is inevitable and culture's expression had been articulated accordingly by participants. Intellectual rigour to reframe culture that moves the policy conversations beyond the superficial descriptors is warranted and missing from the Health Plan. Although, as confirmed by some participants the work underway to distinguish the differences between cultural determinants to those of social determinants will be of significance to future Indigenous health policy and programs (P2 & P5).

Culture is about the knowledge or knowledges held by Indigenous Australians gained from lived experiences and learnt from communities. These knowledges gives recognition to an Indigenous worldview that recognises the inherent relevance of those unique cultural ways of being, knowing and doing. The recognition of the diversity, importance, relevance and value of Indigenous culture and Indigenous knowledge systems is also a prerequisite if reframing culture is to occur. Crucially, that such reframing must be understood by policy makers and governments. Hence the mantra, *culture is our knowledges and our knowledges count*.

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A Model of Practice – The 3Es of Implementation – Enable, Embed and Enact

Many participants spoke of enabling, embedding and enacting Indigenous cultures. They offered many stories about ways that policy makers, governments, healthcare providers and individuals can introduce strategies to provide Indigenous Australians with the means and opportunities to enable their cultures and knowledges within a public policy and public sector space. Similarly, examples of how to permanently integrate Indigenous people's cultures and knowledges of ways of being, knowing and doing into the public policy health domain was also offered. Particularly, the policy instruments such as legislation, statutory bodies and government commitments required to enact the cultures and knowledges that Australian Indigenous peoples hold. One participant calling on the need for the Uluru Statement and Truth Telling including the need for an Aboriginal and Torres Strait Islander Health Authority (P8).

A system-wide model of practice is in development that aims to provide a tool to assist in translating Indigenous cultures and knowledges of ways of being, knowing and doing for release in a paper latter this year.

Discussion: New Thinking, New Way – The Missing Link

Despite the challenges identified briefly in this report, there remains a level of excitement and optimism with a 'can do attitude' evident in the stories told by participants. Clearly, the challenges of implementing culture requires a new approach. Most participants spoke in terms of systems and how the system needs to change. All mentioned the impacts of racism.

Critically, to change ingrained racialized and discriminatory paradigms, culturally biased rules and norms of systems, organisations and individuals, a system thinking approach is therefore useful. System thinking is a form of practice that examines the inter-connectedness of complex social phenomenon relating to often invisible factors involving paradigms, structures and actors within and across systems and sub-systems [10, 11]. The examination of leverage points in the system to effect such change is a necessity and this was expressed by one policy elite as

> *... cause it won't, it won't work. But what are some of the systems and levers ... (P5)*

Conclusion

These preliminary findings of yarning session stories told by policy actors acknowledges the need to interrogate culture. A reframing of culture that moves beyond descriptors is required if policy makers working in government are to provide the means (enable) to integrate (embed) and enact Indigenous cultures and knowledges.

Importantly, to reform inherently racist, culturally biased and western ways of being, knowing and doing across systems, organisations and individuals is a necessity. These institutional system-wide and organisational systemic racist behaviours must be challenged. As does racist attitudes, unconscious biases and western non-Indigenous ways of being, knowing and doing if Indigenous cultures and Indigenous knowledges is to be implemented and translated effectively. System thinking could be useful to help identify leverage points in the system that aim to implement Indigenous cultures and knowledges of ways of being, knowing and doing.

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The 3Es of implementation of enabling, embedding and enacting Indigenous cultures and knowledges will be explored further in a system-wide translational model of practice that is under development.

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NHLF National Health Leadership Forum

Share Your Story!

Yarning Session Participants

Mentors, Family & Friends

Mayi Kuwayu
The National Study of Aboriginal & Torres Strait Islander Wellbeing

PhD Academic Team

Dr John Skinner

Dr Shawn Wilson

Dr Jo Gwynn

A/Prof Donna Hartz

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Reference

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Appendix 7: HREC Approval – 12 December 2019 Yarning Workshop

THE UNIVERSITY OF SYDNEY

Research Integrity & Ethics Administration
HUMAN RESEARCH ETHICS COMMITTEE

Wednesday, 13 November 2019

Dr John Charles Skinner
Poche Centre Indigenous Health; Faculty of Medicine and Health
Email: john.skinner@sydney.edu.au

Dear John Charles,

Your request to modify this project, which was submitted on 09/10/2019, has been considered.

This project has been approved to proceed with the proposed amendments.

Protocol Number:	**2018/069**
Protocol Title:	**Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledge (IC&IK) in public health policies: A Case Study - The National Aboriginal and Torres Strait Islander Health Plan (NATSIHPlan) 2013 - 2023.**
Annual Report Due:	**20/04/2020**

Documents Approved:

Date Uploaded	Version Number	Document Name
09/10/2019	Participant Consent Form	Participant Consent Forum (PCF)
09/10/2019	Participant Info Statement	Participant Information Statement (PIS)
09/10/2019	Recruitment Letter/Email	Participant Invitation Letter (PIL)

Please contact the ethics office should you require further information.

Sincerely,

[REDACTION]

Dr Brett Toelle
Acting Chair, Modification Review Committee Chair (MRC 3)

The University of Sydney of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2007) and the NHMRC's Australian Code for the Responsible Conduct of Research (2007)

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THE UNIVERSITY OF SYDNEY

[DATE TO BE INSERTED]

[NAME, ADDRESS ETC]

Dear [INSERT TITLE & NAME]

Letter of invitation to participate in a yarning workshop for a research study

This letter of invitation is inviting you to be a participant in a research project and a yarning workshop that I am conducting as part of a Doctorate of Philosophy (PhD) study. It is a research study that aims to bring meaning and understanding to Indigenous Culture and Indigenous Knowledges (IC&IKs) in public health policies. Specifically, I am seeking your support to participate in a half-day yarning workshop to yarn about a model of practice that arose from yarning sessions I had with policy elites last year.

If you would like to know more about this research study I have enclosed with this letter a Participant Information Sheet (PIS). This Sheet will tell you about the research study. Knowing what is involved will help you decide if you want to take part in the research and yarning workshop. Please read the sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary. Before you decide whether you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the attached Participant Information Statement (PIS) carefully and discuss it with others if you wish.

By giving your consent to take part in this study you are telling me that you

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study and yarning workshop as outlined in the attached PIS.
- ✓ Agree to the use of your personal information as described.

You can keep a copy of this Participant Information Sheet for your records.

Thank you for taking the time to read this letter and the attached PIS. If you wish to participate please fill in the attached Participant Consent Form (PCF) and email it back to me at the email address mentioned below. Alternatively, I can grab a copy of this PCF when we next meet.

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If required, I can be contacted on my mobile at [REDACTION] or via my email at carmen.parter@sydney.edu.au to discuss any concerns or issues you might have.

Thanks for taking the time to read this letter and I look forward to discussing this research study with you shortly.

[REDACTION]

Carmen Parter
Poche & Wingara Mura Leadership Academy Fellow
Poche Centre for Indigenous Health
University of Sydney
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THE UNIVERSITY OF SYDNEY

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School of Public Health
Faculty of Health and Medicine

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Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledge (IC&IK) in public health policies – A Case Study: The National Aboriginal and Torres Strait Islander Health Plan (the Health Plan) 2013-2023

Participant Information Sheet

Purpose of study

You are invited to take part in a research study that Carmen Parter, a Doctorate of Philosophy (PhD) student is conducting. The research study is taking place under the supervision of my research team involving Dr John Skinner (my PhD primary supervisor) and Dr Shawn Wilson, Dr Josephine Gwynn and Dr Donna Hartz (my PhD auxiliary supervisors). The members of this research team will be participating in a yarning workshop that is described below.

The purpose of the research study is to explore what it means to have culture central to a national policy like Australia's National Aboriginal and Torres Strait Islander Health Plan (the Health Plan) and investigate how culture can be enacted (or put into practice) in this context. It is anticipated that a theoretical and/or conceptual framework(s) may be developed that will fill a knowledge gap about culture and its practical application in a public health policy context.

Last year following ethic approval, yarning sessions with twenty policy elites were held from June to December 2018. Draft themes and a conceptual model of practice have been developed to respond to a research question that asks

When the culture of Indigneous Australians have been incorporated in a public health policy like the Australian Government's National Aboriginal and Torres Strait Islander Health Plan (the Health Plan), how do policy makers enable, embed and enact culture?

A yarning workshop will be held to explore further the draft conceptual model of practice aimed to enable, embed and enact culture once Indigneous culture has been incorporated in a public health policy like the Health Plan. You are invited to participate in this yarning workshop that will add value to the overall research study.

What does the Yarning Workshop involve in relation to this study?

If you choose to be involved in this study you will be asked to take part in a half-day audio recorded yarning workshop with other participants from the National Health Leadership Forum and two representatives from the National Aboriginal and Torres Strait Islander Standing Committee of the Australian Health Ministers Advisory Committee. Also, the research study's academic team (described above) will also be participating as will an expert advisor (yet to be confirmed). Your participation, identity and the stories told during the yarning workshop will be kept private and remain confidential.

The yarning workshop is designed to hear about the findings of the twenty policy elite yarning sessions that were held last year. These twenty policy elites told their story about their understanding and experiences concerning

i. Why culture was placed in the Health Plan
ii. Whether there was any meaning bought to culture when it was placed in the Health Plan, and
iii. How culture could be put into practice given its central positioning in the Health Plan.

The yarning workshop will be held in Canberra, ACT. Unfortunately, there is no financial support for your participation. However, refreshments will be provided.

How much of my time will the study take?

If you choose to take part in the yarning workshop, we will require a half-day of your time. Additionally, you will also need to dedicate at least 40-minutes of your time to read a summary report that will contain draft findings of themes arising from the twenty policy elite yarning sessions.

Do I have to participate in this study and is it voluntary?

Your involvement in the study and yarning workshop is completely voluntary and you are not under any obligation to consent and – if you do consent – you can withdraw at any time without affecting your current or future relationship with the University of Sydney and the Poche Centre for Indigenous Health or with any other associated organisations involved in this study.

What happens to my information?

All aspects of this study, including results from yarning workshop, will be strictly confidential and only the researchers will have access to information on participants. A report of the total study may be submitted for publication, but individual participants will not be identifiable in such a report.

When will the yarning workshop be conducted?

The yarning workshop is planned for December 2019 with dates yet to be confirmed. Once dates have been confirmed I will let you know.

How will the study benefit you?

By participating in this study and yarning workshop you will be contributing to creating new knowledge and evidence about how policy makers in governments enable, embed and enact culture once the cultures of Indigenous Australians have been incorporated in a public policy like the Health Plan. This new knowledge could change our understanding and practices about culture in public health policies. It could also contribute to improvements in the health and wellbeing of Australia's Indigenous communities.

Can I tell other people about the study?

You are welcome to tell other people about this study, if you wish.

What if I require further information about the study?

If you would like further information about this study feel free to contact me on my mobile number at 0427 972 511 or my email at carmen.parter@sydney.edu.au.

Will I be told the results of the study?

If you would like to be told the results of the full study then please email me at carmen.parter@sydney.edu.au and I will ensure that you receive the information accordingly.

What if I have a complaint or any concerns about the study?

As this study has been reviewed by the University of Sydney's (UoS) Human Research Ethic Committee (HREC) and the Aboriginal Health and Medical Research Council's Ethic Committee any complaints or concerns that you have about the study can be made to someone independent of the study as follows. You will need to quote the study title and protocol numbers as indicated below.

The Chairperson AH&MRC Ethics Committee PO Box 1575 Strawberry Hills NSW 2012 Phone: (02) 9212 4777 Email: ethics@ahmrc.org.au Fax: (02) 9212 7211 Project Title: Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledges in public health policies like Australia's National Aboriginal and Torres Strait Islander Health Plan AH&MRC HREC Ref. No.: [1354/17]	The Manager Ethic Administration University of Sydney NSW 2006 Phone: (02) 86278176 Email: ro.humanethics@sydney.edu.au Fax: (02) 86278177 Project Title: Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledges in public health policies like Australia's National Aboriginal and Torres Strait Islander Health Plan UoS HREC Project No.: [2018/069]

This information sheet is for you to keep

THE UNIVERSITY OF SYDNEY

Poche Centre
School of Public Health
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Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledge in public health policies – A Case Study: The National Aboriginal and Torres Strait Islander Health Plan (the Health Plan) 2013 - 2023

PARTICIPANT CONSENT FORM

I, …… ……
have consented to participate in the above research project on the following basis:

1. I have received the Participant Information Statement and have had the opportunity to ask questions. I understand the purpose of the research study and my involvement in the yarning workshop.

2. I have the right to withdraw my consent and cease any further involvement in the research project at any time without giving reasons and without any penalty. This will not affect any services that I receive.

3. Any information I provide during this research will remain confidential. Where the results of the research are published, my involvement and my personal results will not be identified

4. I understand that the yarning workshop will be digitally audio recorded, but the digital recording file will be secured and then destroyed at the completion of the project.

I consent to:

Receiving feedback about the yarning workshop	YES	☐	☐
Receiving feedback about the overall results of this study	YES	☐	☐

If you answered **YES**, please indicate your preferred form of feedback and address:

☐ Postal: _____

_____

☐ Email: _____

.....

Signature

....

PRINT name

.....

Date

Aboriginal Health & Medical Research Council of NSW

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20/10/2019

Adjunct Associate Professor Carmen Parter
Poche Centre for Indigenous Health
University of Sydney
Camperdown
NSW 2006

AH&MRC Ethics Committee
02 9212 4777
ethics@ahmrc.org.au

Dear Adjunct A/Prof Parter,

HREC Reference number: 1354/17
Project title: Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledge (IC&IK) in public health

The amendment to this project submitted on 10/10/2019 was approved/ratified by the AH&MRC HREC on 21/10/2019.

The documents listed below are approved:

Document
[SURNAME]_PIL_[DATE SENT]
135417-AHMRCRefNo-Ethics-Committee-amendment-request-form signed
Individual Participant Consent Form_V1_06Oct2019
Paticipant Information Statement_V1_06Oct2019

You must forward a copy of this letter to all Principal Investigators and to your institution.

Please note that all requirements of the original ethical approval for this project still apply.

Should you wish to discuss this matter, please contact either Tania Skerry, Acting Executive Officer - Ethics on 02 9212 4777 or ethics@ahmrc.org.au .

The AH&MRC Ethics Committee wishes you every continued success in your research.

Yours faithfully,

[REDACTION]

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Ms Val Keed
Chair
AH&MRC Ethics Committee

Thursday, 12 December 2019 Yarning Workshop Feedback Report

When the culture of Aboriginal and Torres Strait Islander people has been incorporated into a public policy instrument like the Australian Government's National Aboriginal and Torres Strait Islander Health Plan (the Health Plan) 2013 – 2023, how do policy makers implement culture?

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Introduction

On the 12 December 2019, a yarning workshop (the Workshop) was hosted by the National Health Leadership Forum (NHLF) in Canberra to hear about the findings of the stories told by policy actors (formerly known as policy elites). These policy actors had agreed to participate in a research study led by Carmen Parter, a PhD candidature with the Sydney Poche Centre for Indigenous Health.

This study is exploring how policy makers implement culture once incorporated in a public policy instrument like the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023 (the Health Plan) [1]. As culture is central to the Health Plan, it is being used as a case study in a wider research study [2].

A discussion paper was provided prior to Workshop that summarised some of these stories arising from the study (Appendix 2).

Purpose of Report

The purpose of this report is to provide feedback to participants of the Workshop.

Participants are invited to provide further comments regarding the contents of this report and can do so by emailing Carmen at carmen.parter@sydney.edu.au .

This report and its contents are provided in confidence and not for further distribution.

The Workshop

The Workshop involved conversations about

1. Reframing culture, and
2. Identifying a set of key strategic actions in a proposed systemwide translational model of practice.

The Workshop Participants

The NHLF and the Australian Health Ministers Advisory Council's (AHMAC) National Aboriginal and Torres Strait Islander Health Standing Committee (NATSIHSC) agreed to participate in the Workshop. As did representatives of the Mayi Kuwayi (MK) Study – a longitudinal study that is quantifying cultural factors and their impact on improving health outcomes for Aboriginal and Torres Strait Islander people [3].

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These participants together with the research study's academic team were presented with preliminary findings of the stories that policy actors told including a systemwide translational model of practice (the model of practice) before the Workshop began.

The stories told by the study's policy actors informed the development of the model of practice. The model of practice utilises concepts drawn from system thinking [4] that offers an alternative to understanding social phenomena such as the challenges of implementing culture [5]. The model of practice also helps to understand these challenges and then offers implementation ideas in relation to targeting leverage points within systems [6, 7]. It remains a conceptual framework at this moment in time.

Ethics

An invitation letter was sent to participants including additional information about yarning workshop and a consent form.

Ethics approval has been secured from the Aboriginal Health and Medical Research Council (Ref. No.:1354/17) and the University of Sydney (Project No.: 2018/069) Human Research Ethic Committees.

The Yarning Workshop – A Summary

Reframing Culture

The Workshop heard of the extensive work that had been undertaken to reframe culture as a determinant of health. Importantly, the inclusion of the six cultural domains into the second iteration of the Health Plan's Implementation Plan was noted [8]. These cultural domains are country and caring for country, knowledge and beliefs, language, self-determination, kinship and cultural expressions [9]. The domains have been identified as cultural determinants of health. Additionally, unpublished commissioned work relating to implementing these cultural determinants is currently under consideration with a policy response impending. Given these developments, participants agreed to work on the model of practice.

The model of practice contextualised

The Workshop considered the model of practice further. The stories that informed the model of practice provided examples of how culture can be implemented against leverage points identified by the Intervention Level Framework (handout at Appendix 1). Additionally, the use of the 3Es of implementation of enabling, embedding and enacting the cultural determinants of health were also considered. The following summarised themes arose.

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The Workshop Themes

The following is a summary of the themes arising from the Workshop that are not in any priority order.

1. The need for
    a. System performance targets and indicators aimed to make systems accountable. Instead of the standard targets placed on Aboriginal and Torres Strait Islander people that infers it to be their problem
    b. System accountability to community an imperative
    c. Constitutional accountability a requirement
2. A model of practice that is clearly about
    a. Dealing with issues of power and control inherent in the systems and organisations that we work in
    b. Disrupting the dominant culture so the knowledges and cultures of Indigenous Australians are front and centre to responses
    c. Necessitating a requirement to change the value systems and mindsets of governments to deliver a systemwide cultural shift that aligns with those of Aboriginal and Torres Strait Islander ways of being, knowing and doing
    d. Changing goals for greater impact that is informed by culture in a cultural context. Although value systems must align for this to occur
    e. Decolonising white paradigms of practice that are so ingrained in how systems and organisations behaviour
    f. Reaffirming the value and contributions that the knowledges and cultural knowledges held by Indigenous people is paramount
    g. Catering for the diverse cultural needs of Aboriginal and Torres Strait Islander communities in being able to practice their cultures outside institutional and policy frameworks but within their unique cultural frames of reference of ways of being, knowing and doing
    h. Ensuring governance structures protect the knowledges and cultures that are held by knowledge keepers including maintaining data sovereignty
    i. Decentralising power and decision making – people power
    j. Achieving health, healing and economic impact for community and people – nation building – of revitalising, reclaiming and embedding language and lore into our nations

We would welcome Workshop participant's comments about the above synthesised summary of the themes of the proceedings. Please send your comments to carmen.parter@sydney.edu.au

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Discussion

Overall, workshop participants were reaffirming of the findings from yarning sessions, including the model of practice.

The themes listed above offer a sense of the enormity of the task ahead and the work that needs to occur to decolonise those westernised governmental values so ingrained in systems that play out in the way that organisations and individuals' behave.

Changing or disrupting the goals of ingrained paradigms to align with Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing is a necessity because the dominance of the non-Indigenous western worldviews of ways of being, knowing and doing is not appropriate. Changing these goals would have a much greater impact on the lives of Indigenous Australians then the current goals that are in operation. Critical to any response aimed at authenticating the value of Indigenous knowledges and Indigenous cultures in policy and programme design is nation building. Nation building involves the revitalisation and reclaiming of the knowledges and cultures that are held by Indigenous Australians.

Importantly, we are dealing with paradigm issues of institutional and systemic racism, and racist attitudes. Racism continues to be a critical issue that had been raised on more than one occasion by participants of yarning sessions and reflected in the Health Plan with strong evidence that racism has an association of making individuals sick [2, 10, 11].

The rules, norms and behaviours that act out in the way that systems, organisations and individuals behave requires additional investment aimed at disrupting those racialized institutional paradigms that prevent genuine implementation of Indigenous people's knowledges and cultures of ways of being, knowing and doing. It is argued that these racist paradigms will prevent the realisation of the cultural determinants of health that are now well embedded into the impending 2nd iteration of the Health Plan's Implementation Plan. Furthermore, Australia will never achieve COAG's target of closing the life expectancy gap by 2031 until real and sustained effort and investment is made to address racism.

The model of practice is a tool that can assist in identifying those system levers required to decolonise and deconstruct culturally inappropriate value systems embedded in organisations. This model is a useful tool to aid in bringing meaning and understanding to the significant complexities experienced of organisations mentioned above. It is also a tool that can assist in identifying those system levers required to achieve those transformative system changes that aims to recognise, value and implement Indigenous knowledges and Indigenous cultures.

However, there are fundamental principles that underpin future work in Australia's endeavours to strive for a health system that is rightfully free from racism, and a health system that is rightfully equipped to recognise, value and implement the knowledges and cultures of

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Indigenous Australians of ways of being, knowing and doing. These principles follow in the recommendations.

Recommendations

It is recommended that any implementation framework and strategies must be designed with the intent to disrupt, deconstruct, and decolonise those racialized paradigms of power, control and dominance that act out in the inappropriate way that systems, organisations and individuals behave. Importantly, that value systems must be commensurate with the values, knowledges and cultures of ways of being, knowing and doing that are held by Indigneous Australians.

As highlighted by the Intervention Level Framework, examining leverage points in systems and identifying appropriate policy tools to enact the necessary transformational changes in such systems is a necessity if culture, as a determinants of health, is to be implemented.

Central to any response is

1. The voice, knowledges and cultures, and worldviews of Indigenous communities of ways of being, knowing and doing that makes it permissible to work within that cultural context - a cultural match
2. Community led, community owned and community determined solutions and priorities that adopts a place based approach to co-designing initiatives in equal partnership with governments
3. Community directed inclusive decision making coalitions that are elected by community and are held accountable to community
4. Re-building nations by means of revitalising, reclaiming and embedding language and lore throughout communities in Australia
5. Governance structures that are conducive to embedding Indigenous Australian's voices, knowledges and cultures, and worldviews of ways of being, knowing and doing into policy and program production, implementation and evaluation
6. Accountability mechanisms that hold governments accountable to communities (D. Murray, personal communication, 10 June 2020)

Presently, in Australia such principles are already in operation through the national Coalition of Peaks who are represented on the Council of Australian Government's Closing the Gap Ministerial Council. Furthermore, Indigenous health public policy frameworks have been led and continues to be directed by community through the national Aboriginal and Torres Strait Islander health leadership – the NHLF – as they progress the next iteration of the Implementation and Health Plans.

Although, further investment is necessary to now establish as to what does policy mean in practice? And, how is it addressing institutional and systemic racism to make that change? (D. Murray, personal communication, 10 June 2020).

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Next Steps

It was agreed that the outcomes of the Workshop would be provided back to participants including a further presentation to the NHLF & NATSIHSC latter in 2020.

Participants are encouraged to provide comments about the contents of this report particularly in relation to the recommendations that can be sent to carmen.parter@sydney.edu.au . Carmen is also happy to discuss any parts of this feedback report and can be contacted on 0427 972 511.

Conclusion

This report provides feedback to participants who participated in the 12 December 2019 Yarning Workshop.

The Workshop themes identified reaffirm the stories that policy actors told during yarning sessions. They also provide clarity as to the impediments that will prevent implementation of culture as a determinant of health. If governments and policy makers are not willing to tackle the issues of institutional and systemic racism any future efforts of closing the life expectancy gap will be futile.

Fundamentally, government's must be willing to provide the means to surrender absolute power and control to community. Also, they must be prepared to facilitate the structural and system reforms to enable Indigenous voices, their knowledges and cultures of ways of being, knowing and doing to direct policy design, implementation and evaluation. Finally, policy makers need to be courageous to champion and assist communities to enact the necessary transformational change through appropriate policy instruments. Specifically, implementing the Uluru Statement of the Heart and Truth Telling must be imperative.

The systemwide translational model of practice provides a tool to understand these challenges. More importantly, it also offers a tool to tackle issues of institutional and systemic racism that continue to make Indigenous Australians sick.

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APPENDIX 1: Intervention Level Framework and 3Es of Implementation

Intervention Level Framework and 3Es – Enable, Embed & Enact ICsKs&CKs YARNING WORKSHOP HANDOUT			
Intervention Level Framework	**3Es of Implementation**	**Examples from Yarning Sessions & the Why**	**Example Recommendations**
PARADIGM (a) • Systems 'mindset' • Deepest held beliefs, often unspoken beliefs about the way the system works • Goals, rules, and structures arise out of the paradigm • Actions and ideas at this level propose to either shift or reinforce the current paradigm • It is very difficult to intervene at this level but can be very effective **GOALS** (b) • Conform to system's paradigm • Are targets that need to be achieved for the paradigm to shift • Actions at this level focus or change the aim of the system • The levels below conform to and enable the system's goals	**ENACT** Enact are the policy tools and instruments to persuadably sanction and coercively compel systems, organisation and individuals	"… our knowledge is not valued …" (P21) "… get off your … black arses … get your mongrel kids to school … and stop bashing your women …." (P21) "…. We needed to interrogate culture …." (P21) "… the system is not ready for all this thinking …" (P2) "…. We can't rely on cultural safety and cultural awareness to implement culture …." (P6) "…Like how do we measure culture and set the clock … um, 'cause it's not the easiest thing to measure is it? No, hm …" (P11)	*Sample Enacting e.g. - The Uluru Statement of the Heart and the Makarrata Commission on Truth Telling*
SYSTEM STRUCTURE (c) • All of the elements that make up the system as a whole, including the subsystems, actors, and interconnections between these elements • Conforms to the system goals and paradigms • Actions at this level will change the entire system structure by changing the linkages within systems or incorporating novel types of structural elements or incorporation novel elements • System structures gives rise to the dynamic behaviour of the system over time	**EMBED** Embed is about how to fix into place permanently ICsKs&CKs of ways of being, knowing and doing like targets or proxy indicators maybe	"… I think it was hugely ambitious to put it in there, to have a health system, um, free of racism ... um, was hugely ambitious, because you think that was put in, what? Seven years ago, and we still can't talk about racism now and it's 2018. Do you know what I mean? …." (P2) "… Yes, as a national system, we don't have a policy position on racism, and we have no way of chewing through that to- to- to get to that …" "… So, and I think it's- it's one of those things that as we mature as a system, we've got to work through …" (P2)	*Sample Embedding e.g. – Activities of Statutory Authorities*

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Intervention Level Framework and 3Es – Enable, Embed & Enact ICsKs&CKs YARNING WORKSHOP HANDOUT			
Intervention Level Framework	**3Es of Implementation**	**Examples from Yarning Sessions & the Why**	**Example Recommendations**
FEEDBACK & DELAYS (d) • Feedback allows the system to regulate itself by providing information about the outcome of different actions back to the source of the actions • Feedback occurs when actions by one element of the system in turn affect the flows into or out of that same element • Can be simple and direct or involve multiple variables • Can be self-regulating/balancing or self-reinforcing • Actions at this level attempt to create new, or increase the gain around existing, feedback loops • Adding new feedback loops or changing feedback delays has the potential to restructure the system			
STRUCTURAL ELEMENTS (e) • Subsystems, actors, and the physical elements of the system Connected through feedback loops and information flows Actions at this level affect specific subsystems, actors, or elements of the system • Many actions at this level are usually required to create system-wide change	**ENABLE** Enable is about providing the means and opportunities for Indigenous people to practice their Cultures and Knowledges.	"… but that's just, that's system bias. People don't even have any insight into their behaviour … in the system where they actually have no insight into, sometimes, this stereotype, stereotypically attitudinal behaviour …" (P1) "…would be horrified to think that you think, your, is it, is that institutionalized racism? Horrified …" (P1)	*Sample Enabling e.g. – National Health Leadership Forum and their organisations*

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APPENDIX 2: Pre-workshop Discussion Paper

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Discussion Paper

Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledge in public health policies: A Case Study – The National Aboriginal and Torres Strait Islander Health Plan (the Health Plan) 2013 – 2023.

Thursday, 12 December 2019 Yarning Workshop

By Carmen Parter

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NHLF National Health Leadership Forum

Share Your Story!

Yarning Session Participants

Mentors, Family & Friends

Mayi Kuwayu
The National Study of Aboriginal & Torres Strait Islander Wellbeing

PhD Academic Team

Dr John Skinner

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Introduction

In 2013, the centrality of culture was a significant achievement when incorporated in the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023 (the Health Plan) that aims to address the health disparity, inequities and social inequalities experienced by Indigenous Australians [2]. However, how to implement culture once incorporated in a policy instrument like the Health Plan presents implementation challenges for policy makers who work in governments.

An evidence gap is apparent [5] and the work being undertaken by this research study will contribute towards creating scholarly information that has the potential to influence future policy work. Specifically, bringing meaning and understanding to culture and, indeed Indigenous knowledges in a public policy context is being explored. Similarly, a systemwide translational model of practice that supports the implementation of cultures and knowledges held by Indigenous Australians has been developed.

The Yarning Workshop

The purpose of the 12 December 2019 Yarning Workshop (the Yarning Workshop) is to workshop

3. The reframing of culture being recommended in this discussion paper, and
4. To identify a set of key strategic actions against system leverage points in a proposed systemwide translational model of practice aimed to implement – enable, embed and enact – Indigenous Cultures, Knowledges and Cultural Knowledges.

This discussion paper is provided to prepare yarning workshop participants. Its content has been informed by policy elite yarning sessions and complemented by relevant literature.

The report and its content are provided in confidence and <u>not for further distribution.</u>

Research Study Overview

Research Study's Title:

Bringing meaning and understanding to Indigenous Culture and Indigenous Knowledge in public health policies: A Case Study – The National Aboriginal and Torres Strait Islander Health Plan (the Health Plan) 2013 – 2023.

Research Question:

When the culture of Indigenous Australians is incorporated in a public policy like the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023, how do policy makers implement - enable, embed and enact - culture, and indeed Indigenous knowledges?

Ethics

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Those participating in the Yarning Workshop will have received a letter inviting their participation, a participant information statement and a participant consent form. Participation in the Yarning Workshop is voluntary, and a consent form **must** be signed by all those participating. The signing of a consent form is required to meet ethic requirements because the yarning workshop is in addition to previously approved University of Sydney and Aboriginal Health and Medical Research Council Human Research Ethic Committee's ethic applications.

Background:

The Yarning Sessions with Policy Elites

Following ethical approval in May 2018, nineteen (19) yarning sessions with policy elites commenced from June to December 2018. In this report, policy elites will sometimes be referred to as participants and represented by a P.

Policy elites were purposively selected based on their involvement with the development and implementation of the Health Plan. Similarly, they were also drawn from the Indigenous public health policy sub-system of Australia's very large and complex public health policy system.

The yarning sessions were designed to allow policy elites to tell their story. They were asked as to why culture was incorporated into the Health Plan, whether any meaning was bought to culture, what challenges had been encountered to put culture in the Plan and during its implementation, and what they considered were the enablers to implement culture. Importantly, whether the knowledges held by Indigenous people were ever considered when bringing meaning to culture.

In total, twenty-six (26) policy elites had been identified as eligible to participate in yarning sessions. Of the 26, twenty-one (21) policy elites were willing to participate in a yarning session with consent forms signed accordingly. However, two (2) of the 21 were not able to participate in a yarning session due to the difficulties of finding a convenient time. Nonetheless, nineteen (19) yarning sessions with policy elites were held. Of the 19, seventeen (17) were face-to-face yarning sessions with 2 conducted over the telephone. 60% of the 19 were of Aboriginal or Torres Strait Islander descendant drawn from across government and non-government sectors. All yarning sessions were audio recorded and transcribed. An inductive coding and thematic analysis process were undertaken with the assistance of NVivo, a software data management tool.

In addition to these yarning sessions, engagement with relevant literature occurred to assist in contextualising policy elite stories into a scholarly form that is understood. Critically, to inform the development of a systemwide translational model of practice designed to assist governments and their policy makers to implement Indigenous Cultures, Knowledges and Cultural Knowledges of ways of being, knowing and doing.

Currently

This section of the discussion paper provides a brief discussion about the need to reframe culture. Also, the disinclination of systems, organisations and individuals being ready and able to accept, recognise, and value Indigenous Australian's cultures and knowledges will be

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explored that sets the context. Additionally, how culture is represented in the national public policy arena is provided to set the content. Specifically, culture's current representation is helpful but limiting if policy makers are to be able to facilitate implementation of culture.

The implementation processes of the 3Es to enable, embed and enact culture is discussed briefly. Then leverage points within the system will be examined with the use of the Intervention Level Framework (ILF) that will assist in conceptualising those leverage points to enable, embed and enact culture.

Summary - Preliminary Findings

Interrogating Culture

> *... did that Plan really, interrogate culture and provide guidance on culture? ... there's a whole lot of work around that in a rigorous, intellectual way ... it's a fairly superficial treatment of culture, in the sense it's very descriptive ... it talks about our connection to culture, culture being protective ... those sorts of things, identity in culture .... But the Plan, itself doesn't interrogate that in any great detail and it signals the need for further work to be done ... (P21).*

As highlighted by the above quote, further work was recognised as a necessity to aid in bringing meaning and understanding to culture in the Health Plan. The below discussion begins to interrogate culture and proposes six ways to reframe culture. This reframing of culture is informed by several stories told by policy elites and complemented by relevant literature.

Reframing Culture – The Stories

One thing was certain that when referring to culture it was also about knowledge with one policy elite saying

> *... our culture is to share knowledge ... (P16)*

It is for this reason that knowledge will be referenced alongside culture to give recognition to the innate relationship between culture and knowledge. This innate relational bond between culture and knowledge represents the first of six ways in which culture begins to be reframed.

What do participants think about this first reframing of culture and referencing culture with knowledge?

Also, a number of stories alluded to the inherent dismissal of Indigenous Australian's knowledge as pointed out by one policy elite who said

> *... the impediments or the barriers to that is the continuing devaluing of Indigenous knowledges .... (P21)*

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Given this, the second reframing of culture being recommended by this research study is to capitalise Culture and Knowledge to acknowledge their importance, existence, relevance and value.

2. What do participants think about this second reframing of culture and knowledge by capitalising them to acknowledge their importance, existence, relevance and value?

In addition, it became apparent that governments, policy makers and the general public found it difficult to understand culture in relation to Indigenous peoples. As one policy elite said

> *... non-Indigenous Australians often struggle with the construct ... that reflects, in part ... kind of the ways in which culture, as a concept, can be a little bit slippery ... and its representation is sometimes unclear .... (P13)*

Another said

> *... uh, you know, don't find it easy to understand the concept of culture in a very tangible way ... (P2)*

While another said in relation to understanding culture

> *... that's a limitation to just their imagination to be able to understand. Because we don't we – we may never actually fully understand ... (P12)*

Despite such difficulties there was a consistent message that governments, policy makers and the broader community must understand and have a knowingness of the nuances of culture that is expressed through Indigenous people's connection to country, languages, traditional healing practices and laws and lore's. As mentioned by several policy elites, these cultural expressions are often in tension with western and scientific worldviews including the holistic nature of Indigenous health, which is not just about the physical well-being of the individual but the cultural, social and emotional wellbeing of the family and whole-community [12].

The Mayi Kuwayi (MK Study) project team recently confirmed the difficulties of defining Indigenous people's culture but were able to identify six global cultural domains from the literature that include

1. Connection to country involving spiritual connection, living on country, land rights and autonomy and caring for country
2. Cultural beliefs and knowledge, including spiritual and religious beliefs, traditional knowledge, traditional healing and knowledge transmission and continuity
3. Languages and its relevance to health and education
4. Family, kinship and community is essential
5. Expressions of cultural identity, traditional practices, art and music community practices and sport
6. Indigenous people's leading and determining their destiny concerning cultural safety and wellbeing [9].

Given these six-cultural domains, the third reframing of culture being recommended by the research study is to identify these as Indigenous Culture.

3. What do participants think about this third reframing of culture to include Indigenous Culture that reflects the six-cultural domains identified by the Mayi Kuwayi team?

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Further, as confirmed by policy elites the diversity of culture and the many knowledge systems that exist amongst Indigenous Australians must be acknowledged. This is to be represented by pluralising Culture and Knowledge, so they become Cultures and Knowledges being the fourth recommended reframing of culture suggested by this research study.

4 What do participants think about this fourth reframing of culture to pluralise Culture and Knowledge so they become Cultures and Knowledges that acknowledges the diversity of cultures and knowledge systems amongst Indigenous Australians?

The fifth recommended reframing is to recognise the lived experiences that is gained from individual life stories and from the knowledges learnt from Indigenous communities. Knowledges represents the fifth reframing of culture (P6 & P16).

5. What do participants think about this fifth reframing of culture that recognises the lived experiences gained by individuals and the knowledges learnt from Indigenous communities?

Finally, the sixth recommended reframing of culture is to acknowledge the distinctively relevant and underpinning cultural knowledges held by culturally grounded Indigenous people, leaders and communities that is to be represented by Cultural Knowledges (P17).

These Cultural Knowledges relate to the realities of what is real to Indigenous Australians – known as ways of being (ontology). Also, how Indigneous Australians know the things that they know – known as ways of knowing (epistemology). Similarly, why it is that Indigenous Australians do the things in the way that they are done – known as ways of doing (axiology). This was expressed by one policy elite as follows

> *... we also have these cultural leadership responsibilities about what is the being ... and culture ... is a being. It's not a thing. It's not a commodity. It's something within that defines who we are and our identity and what that means ... so in a cultural leadership space, I think that's really important because being really confident and, culturally responsible with authority from my own people's ... I can then be very firm and in, or assertive in, in the cultural leadership space, knowing that I have integrity and support from my elders ... because really then underpins my worldview in an holistic being ... and that our language and our lore that's embedded in that is, is all about what is important ....* *(P7, personal communication, June 2018)*

These inter-connective holistic cultural worldviews and responsibilities of ways of being, knowing and doing are further expressed in the research literature as an Indigenist paradigm that centrally privileges Indigenous knowledges and Indigenous cultural knowledges of ways of being, knowing and doing in research (Rix et al, 2018). The centrally of such knowledges and cultural knowledges is also relevant in the public policy space. Furthermore, the 4Rs of respect, obligatory responsibilities, relational accountability and reciprocity underpin such an

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Indigenist paradigm (Wilson, 2008) that is often in opposition to western and scientific non-Indigenous worldviews of ways of being, knowing and doing.

6. What do participants think about this sixth reframing of culture that acknowledges Cultural Knowledges of ways of being, knowing and doing?

As highlighted in the above interrogation discussion, an opportunity to move beyond the superficial description and treatment of culture is provided. Additionally, intellectual rigour to reframe culture that moves the policy conversations beyond the superficial descriptors is the work that was warranted and missing from the Health Plan.

In summary, the interrogation of culture captures the six-cultural domains (identified by Salmon et al of the MK Study) that is represented as Indigenous Cultures. Also, lived experiences of knowledges gained from individual life stories and learnt from communities is represented as Knowledges. Cultural Knowledges gives recognition to an Indigenist paradigm and worldview that recognises the inherent relevance of those unique cultural ways of being, knowing and doing. Importantly, the capitalisation and the pluralisation of Culture and Knowledge provides for the recognition of the diversity, importance, relevance and value of Indigenous culture and Indigenous knowledge systems. Hence, the reframing of culture to be represented as Indigenous Cultures, Knowledges and Cultural Knowledges of ways of being, knowing and doing is being recommended in this research study. Culture's reframing is visualised in Figure 1 at Appendix 1.
Although, as confirmed by some policy elites the work underway to distinguish the differences between cultural determinants to those of social determinants will need to be considered in the course of the final deliberations of this research study (P2 & P5). Importantly, that this research study and the cultural determinants project complement each other.

7. Is there any other issues that need to be considered when interrogating and reframing culture?

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Systemwide Translational Model of Practice

This section of the report begins to conceptualise and introduce a systemwide translational model of practice that aims to contribute to discussions about how governments and policy makers implement Indigenous Cultures, Knowledges and Cultural Knowledges (ICsKs&CKs).

Context – System, Organisational and Individual Readiness

Whilst the incorporation of culture and also racism in the Health Plan was a significant milestone, the resistance of systems, organisations and individuals became apparent from stories of policy elites. With one policy elite saying

> *... the system, the system's not ready for all this thinking ... (P2)*

And, another saying

> *... I don't think government has been ready for it [culture] ... (P6)*

Indeed, the incorporation of culture in the Health Plan was a catalyst for conversations that differentiated the differences between social determinants and cultural determinants of health (P2 & P5). Importantly, that the work to further understand culture and cultural determinants of health must be led, directed and owned by Indigenous leaders and communities (P5).

This work is without its challenges with several policy elites presenting a range of systemic system paradigm characteristics such as racialized, deficit and discriminatory policy language used in the Indigenous public policy narrative. As a demonstration of this underlying often invisible racist and negative racialized policy language one policy elite expressed it as

> *... get off your F#@KING BLACK arses and get a job ... and get your mongrel black kids to school ... get into work, get your kids to school and men, stop basing your women ... (P21)*

A deficit position that is also argued by Pholi, Black and Craig who confirms that public health policy discourse and targets often tends to blame Indigenous people and communities [13]. As one policy elite said, to combat such negative policy language

> *... Culture is the strength ... Aboriginal people are the strengths, culture and identities are the strengths. So, then let's use that as the strength ... (P7)*

Also, organisational and workplace structural issues such as the lack of funding to fund culture and the greater representation of Indigenous Australians in the workforce particularly those in key leadership and decision-making roles were a common occurrence of policy elite's stories (P8, P6, P17 and 21). Finally, the culturally unsafe behaviours displayed by individuals due to either their racist attitudes, cultural biases or westernised worldviews of ways of being, knowing and doing was rife (P6, P15 & P14). Importantly, not having a knowingness of Indigenous worldviews (as expressed above as ICsKs&CKs) was common (P5, P9 and P12). Specifically, that a set of professional attributes such as a willingness to learn were a necessity if policy makers are to provide the means and opportunities for Indigneous people to express ICsKs&CKs in the public health policy space (P3).

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Despite these challenges, many positive policy elite stories provided comprehensive examples of implementing ICsKs&CKs including the identification of policy tools and instruments to enact culture. Clearly, a multi-faceted response is a necessity to reform those racialized and prejudicial systems and sub-systems, detrimental institutional wide rules and behaviours, and structural norms that pervade the way that governments and policy makers think, behave and act. These colonialist and imperialist rules, norms and behaviours of systems, organisations and individuals [(P16) [14] that manifest themselves through the current social, political, economic, and health inequalities experienced by Indigenous Australians are directly related to the impacts and legacy of colonisation [(P16) [15].

Importantly, if real sustainable system, organisational and individual change is to occur then the development and sustaining of strategic collaborative alliances and partnerships is a necessity (P8 & P14). Importantly, the aid of Indigenous led scholarly knowledge translatable into evidence-based practice is pivotal (P8 and P21). Critically, a prerequisite for being an effective Indigenous leader, either as an individual or as a community led organisation, is about having a sound grounding in one's Cultures, Knowledges and Cultural Knowledges of ways of being, knowing and doing (P7 & P21) particularly when supporting the 3Es of implementation (discussed below). Without such grounding, Indigenous leaders or Indigenous organisations become ineffectual (P7 & P21).

Finally, whilst frameworks like cultural respect, cultural competency and cultural safety aim to change systems, organisations and behaviours of individuals, they are not the answer when implementing ICsKs&CKs. As one policy elite said

> *... we can't rely on cultural safety and cultural awareness training to support the implementation of culture ...(P6)*

So, the question then becomes, how do governments and policy makers facilitate the implementation of ICsKs&CKs?

Content –Culture's Representation

As alluded to above several policy elites confirmed that governments and policy makers just did not get ICsKs&CKs. Nonetheless, most policy elites confirmed that despite governments and policy makers not understanding culture they must be knowers of ICsKs&CKs of ways of being, knowing and doing. This knowingness is a prerequisite when supporting the implementation of the 3Es that follow below. Additionally, work to further understanding of culture and cultural determinants is critical particularly within a policy context – mentioned above (P13).

Process – The 3Es of Implementation - Enable, Embed and Enact

Many policy elites spoke of enabling, embedding and enacting ICsKs&CKs. They offered many stories about ways that policy makers, governments, healthcare providers and individuals can introduce strategies to provide Indigenous Australians with the means and opportunities to enable their Cultures and Knowledges within a public policy space. Similarly, examples of how to permanently integrate Indigenous people's CsKs&CKs of ways of being, knowing and doing into the public policy health domain was also offered. Particularly, the policy instruments required to enact the Cultures and Knowledges that Australian Indigenous peoples

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hold. Some of these strategies will be presented at the Thursday 12 December 2019 Yarning Workshop and will be further refined with participating participants.

Discussion: New Thinking, New Way – The Missing Link

Despite the challenges identified briefly in this paper, there remains a level of excitement and optimism with a 'can do attitude' evident in the stories told by policy elites. Clearly, the challenges of implementing culture that is contained in the Health Plan requires a new approach. ICsKs&CKs is the missing link to addressing the health disparities, inequities and social inequality exhibited by Indigenous Australians.

Presently, the limitations of a reductionist public health cause and effect response to Indigenous health and wellbeing is ineffectual that is demonstrated in the consistent failings of the Council of Australian Government's Closing the Gap reform agenda [13, 16, 17]. It is for this reason that new thinking and a new way of working is required particularly when it comes to further implement the Health Plan.

Critically, to change ingrained racialized and discriminatory paradigms, culturally biased rules and norms of systems, organisations and individuals, a system thinking approach is warranted. System thinking examines the inter-connectedness of complex social phenomenon relating to often invisible factors involving paradigms, structures and actors within and across systems and sub-systems like those briefly mentioned above [4, 18]. The examination of leverage points in the system to effect such change is a necessity and this was expressed by one policy elite as

> *... cause it won't, it won't work. But what are some of the systems and levers ... (P5)*

System Leverage Points - Intervention Level Framework (ILF)

Based on Meadows 12 leverage points in systems, Malhi et al have identified system levers relating to food systems – known as the Intervention Level Framework (ILF) [7, 19].

The ILF, to be discussed further at the 12 December 2019 Yarning Workshop, offers a useful conceptual model aimed to assist policy makers working in government to implement Indigenous Australian's CsKs&CKs of ways of being, knowing and doing. A copy of the ILF is at Appendix 2 that provides a brief description of the five (5) leverage points in a system. Additionally, quotes from policy elites provide examples that attempts to demonstrate the 5 ILF's system lever descriptors.

Conclusion

This discussion paper commenced by providing background to the intent of the research study that aims to bring meaning and understanding to Indigenous culture once included in a public health policy like the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023.

Last year, several yarning sessions held with policy elites were conducted and a summary of preliminary findings have been presented above.

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With the help of policy elite stories and relevant literature culture has been interrogated and a reframing is recommended - as Indigenous Cultures, Knowledges & Cultural Knowledges. However, this reframing of culture will be further developed at the 12 December 2019 Yarning Workshop.

As discussed, a brief context and content has been provided to set the scene about the experiences of and representation of ICsKs&CKs within public policy. Importantly, to reform inherently racist, culturally biased and western ways of being, knowing and doing across systems, organisations and individual is a necessity. The Intervention Level Framework that examines system leverage points is a useful tool to assist in developing a range of strategies to implement ICsKs&CKs of ways of being, knowing and doing. The 3Es of implementation of enabling, embedding and enacting ICsKs&CKs will be presented at the yarning workshop together with a systemwide translational model of practice.

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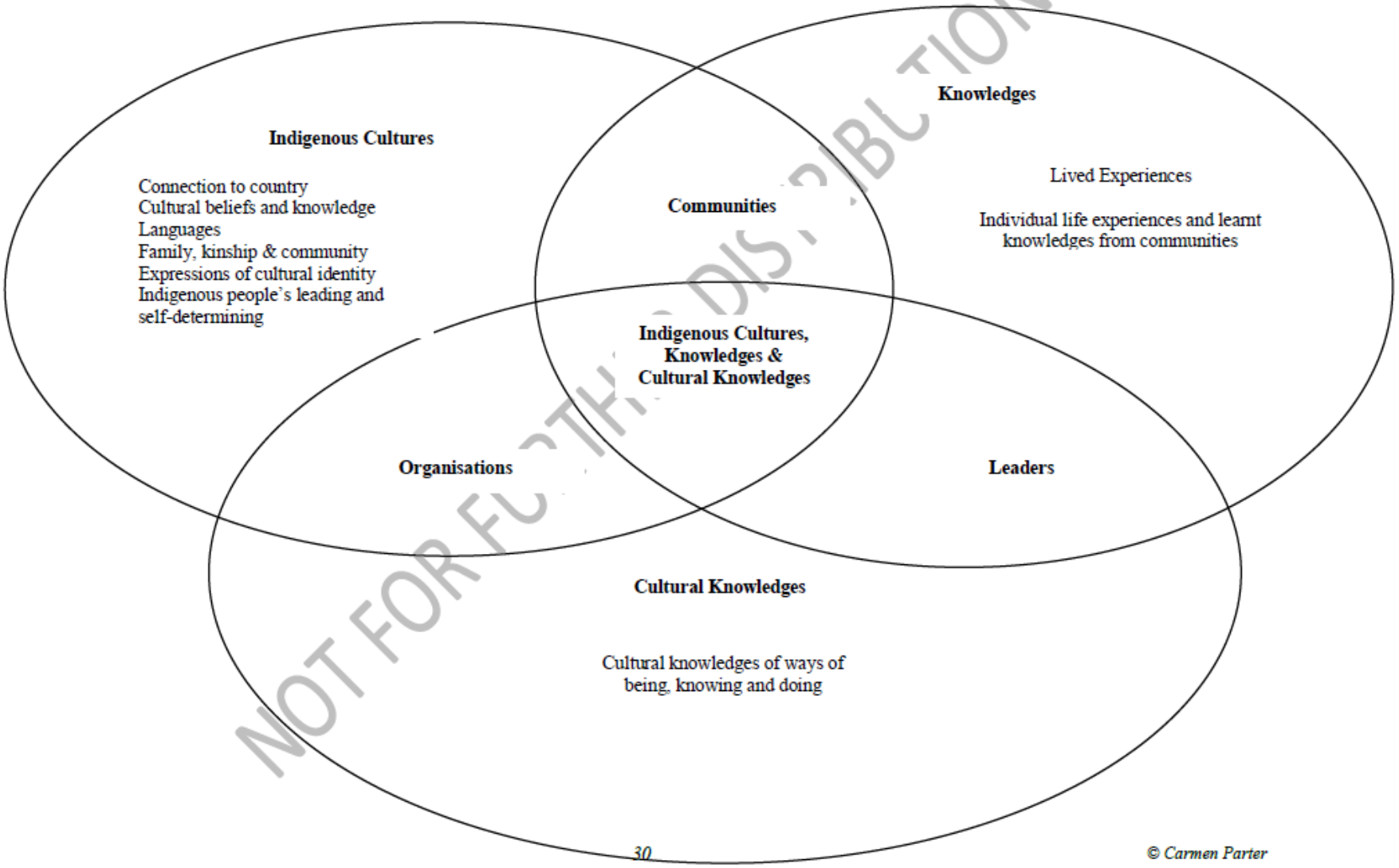
Appendix 1: Figure 1 - Indigenous Cultures, Knowledges and Cultural Knowledges



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Appendix 2: Intervention Level Framework & Yarning Session Examples

The Intervention Level Framework (ILF) and Yarning Session Examples		
	Intervention Level Framework	**Some Yarning Session Examples**
LEVERAGE POINTS IN THE SYSTEM	**PARADIGM** (a) • Systems 'mindset' • Deepest held beliefs, often unspoken beliefs about the way the system works • Goals, rules, and structures arise out of the paradigm • Actions and ideas at this level propose to either shift or reinforce the current paradigm • It is very difficult to intervene at this level but can be very effective	… our knowledge is not valued …" (P21) … get off your black asses … get your mongrel kids to school … and stop bashing your women …." (P21)
	GOALS (b) • Conform to system's paradigm • Are targets that need to be achieved for the paradigm to shift • Actions at this level focus or change the aim of the system • The levels below conform to and enable the system's goals	…. We can't rely on cultural safety and cultural awareness to implement culture …. (P6) … but, um … it's, it would be a shame to see … to … go for targets that I think are … potentially expedient because we can- we'll be able tick them off … versus targets that will actually make a difference … (P6)
	SYSTEM STRUCTURE (c) • All of the elements that make up the system as a whole, including the subsystems, actors, and interconnections between these elements • Conforms to the system goals and paradigms • Actions at this level will change the entire system structure by changing the linkages within systems or incorporating novel types of structural elements or incorporation novel elements • System structures gives rise to the dynamic behaviour of the system over time	… I think it was hugely ambitious to put it in there, to have a health system, um, free of racism ... um, was hugely ambitious, because you think that was put in, what? Seven years ago, and we still can't talk about racism now and it's 2018. Do you know what I mean? …. (P2) … but that's just, that's system bias. People don't even have any insight into their behaviour … in the system where they actually have no insight into, sometimes, this stereotype, stereotypically attitudinal behaviour …(P1)
	FEEDBACK & DELAYS (d) • Feedback allows the system to regulate itself by providing information about the outcome of different actions back to the source of the actions • Feedback occurs when actions by one element of the system in turn affect the flows into or out of that same element • Can be simple and direct or involve multiple variables • Can be self-regulating/balancing or self-reinforcing • Actions at this level attempt to create new, or increase the gain around existing, feedback loops • Adding new feedback loops or changing feedback delays has the potential to restructure the system	… if you don't have a target you don't have anything to measure … (P4) … we often focus on data on the back end of the health system and not trying to build some longer-term trends and objectives … (P5)
	STRUCTURAL ELEMENTS (e) • Subsystems, actors, and the physical elements of the system Connected through feedback loops and information flows Actions at this level affect specific subsystems, actors, or elements of the system • Many actions at this level are usually required to create system-wide change	… because that's [culture] not honoured, and that's not funded … yeah? Um, you know we-we worked so hard to wipe out d – colonisation – and the colonisers worked so hard to wipe out our culture … but what have they done to restore it? Have they really funded culture? Have they really funded our nation building? … (P8)

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Appendix 9: Impending book chapter – Co-designing the Health Plan

Australian Institute of Aboriginal and Torres Strait Islander Studies

ABSTRACT

Title:

Aboriginal and Torres Strait Islander leadership in action: Co-designing the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023 – A Case Study of exemplary practice.

Abstract:

Co-designing policies and programs with Aboriginal and Torres Strait Islander people involve '... doing things with and not to Indigenous peoples ...' [1]. However, co-design is often not translatable into practice. Nonetheless, a useful tool of inquiry that identifies elements of good practice is a case study where lessons can be learnt [2].

The Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013-2023 [3] (the Health Plan) is an exemplary case study of '... doing things with and not to Indigenous peoples ...' [1]. The centrality of culture and striving for a racist free health system is a demonstration of the achievements when Aboriginal and Torres Strait Islander people control, direct, and co-design a public policy instrument like the Health Plan.

Adapting the health policy triangle, a retrospective analysis [4] will inform the book chapter by drawing data from historical documents and policy actor yarning sessions*. The National Health Leadership Forum** members will confirm the findings of the data while authoring the chapter. The chapter will provide a context about the health of Aboriginal and Torres Strait Islander people. Content in terms of the background to the Health Plan, including events leading up to its development, will be provided. Also, policy actors are identified. Additionally, the processes to develop the Plan will be described. Finally, concluding by identifying co-design principles and elements of exemplary practice.

Reference:

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Biography:

Carmen is a proud descendent of the Darumbal and Juru clans of the Birra Gubba Nation of the Australian State of Queensland. She also has South Sea Islander heritage of Tanna Island of the Republic of Vanuatu.

Carmen has been a clinician, educator, researcher, policy advisor, project officer, manager and senior executive spanning a public servant career of over 30 years. After six years with the NSW Ministry of Health as the state-wide Director for Aboriginal Health, Carmen is now embarking on a Doctorate of Philosophy (PhD) at the Poche Centre for Indigenous Health at the University of Sydney as a full-time academic fellow.

Her research study is about how policymakers implement culture once incorporated in a public policy instrument like the Australian Government's Health Plan.

The **National Health Leadership Forum** (NHLF) is a coalition of national organisations who represent a united voice on Aboriginal and Torres Strait Islander health and wellbeing with expertise across service delivery, workforce, research, healing and mental health and social and emotional wellbeing. They are committed to achieving health equality, and draw their strength from cultural integrity, the evidence base and community. They provide advice and direction to the Australian Government on initiatives aimed to improve the health and wellbeing of communities.

Notes:

* The Aboriginal Health and Medical Research Council (Ref No.: 1354/17) and University of Sydney Human Research Ethics Committees (Ref No.: 2018/069) have previously approved the ethics for yarning sessions with policy actors that aligns with the AIATSIS's ethical research framework.
** The NHLF is a partnership of national organisations that include the Aboriginal and Torres Strait Islander Healing Foundation and the Australian Indigenous Doctors' Association. Also, the Australian Indigenous Psychologists Association and Congress of Aboriginal and Torres Strait Islander Nurses and Midwives. Further, the Indigenous Allied

Health Australia Incorporation and the Indigenous Dentists' Association of Australia. The Lowitja Institute, National Aboriginal and Torres Strait Islander Health Workers Association, National Aboriginal Community Controlled Health Organisation, National Aboriginal and Torres Strait Islander Leadership in Mental Health, National Association of Aboriginal and Torres Strait Islander Physiotherapists, and the Torres Strait Regional Authority (personal communication, NHLF Terms of Reference, April 2016).

Subject: RE: Abstract - AIATSIS's invite to submit an abstract for an edited book chapter
Date: Friday, 4 September 2020 at 1:57:43 pm Australian Eastern Standard Time
From: Culture and Heritage
To: Carmen Parter, Culture and Heritage
CC: Colleen Gibbs, Donna Murray

Good afternoon,

I am writing in regards to your abstract submission for the Nyiyanang wuunggalu! Edited Volume.

Apologies for the delayed response, we received a number of great submissions which were required to be reviewed as part of a selection process.

I am happy to advise that your abstract submission *Aboriginal and Torres Strait Islander leadership in action: Co-designing the National*
Aboriginal and Torres Strait Islander Health Plan 2013 – 2023 – A Case Study of exemplary practice met the guidelines and has been accepted on this occasion.

We are asking successful applicants to provide a full draft of their respective papers by the end of October 2020.

Please note that all papers are required to meet the word limit of between five to ten thousand words maximum.

Please let me know if you have any questions.

Kind regards,
Hope Davison
Indigenous Culture and Heritage.

From: Carmen Parter <carmen.parter@sydney.edu.au>
Sent: Wednesday, 18 March 2020 6:24 PM
To: Culture and Heritage <ICH@aiatsis.gov.au>
Cc: Colleen Gibbs <NHLF.Colleen@iaha.com.au>; Donna Murray <donna@iaha.com.au>
Subject: Abstract - AIATSIS's invite to submit an abstract for an edited book chapter

To Whom It May Concern

I write in regards to AIATSIS's invitation to submit an abstract for an edited book that aligns with the theme of the Culture and Policy Symposium - *Nyiyanang wuunggalu! Indigenous insights into effective policy engagement and design* - held on the 19 and 20 February 2020.

Please find attached an abstract for your consideration to write a book chapter about co-designing the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 from the National Health Leadership Forum and myself. We would welcome confirmation of receipt of this email as soon as is practical.

Importantly, we look forward to hearing about the outcomes of our abstract.

Thanks and if required please contact myself at this email address or either Donna or Colleen at the cc emails above.

Carmen

Associate Professor (Adjunct) Carmen Parter
Poche-Wingara Mura Fellow
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